UNITED STATES COAST GUARD

REPORT OF INVESTIGATION INTO

THE

TOWING VESSEL CSS ATLANTA (O.N. 647194) CREWMEMBER LOSS OF LIFE ON THE LOWER MISSISSIPPI RIVER, MILE MARKER 166 ON NOVEMBER 10, 2020

MISLE ACTIVITY NUMBER: 7679092

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

Commandant
United States Coast Guard

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16732/IIA #7679092
15 April 2025

FALL OVERBOARD AND SUBSEQUENT LOSS OF ONE LIFE INVOLVING THE INSPECTED TOWING VESSEL CSS ATLANTA (O.N. 647194) IN THE VICINITY OF MILE MARKER 166 ON THE LOWER MISSISSIPPI RIVER NEAR ST. JAMES, LOUISIANA ON NOVEMBER 10, 2020

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
Chief, Office of Investigations & Casualty Analysis (CG-INV)

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16732

APR 8 2025

TOWING VESSEL CSS ATLANTA (O.N. 647194) CREWMEMBER LOSS OF LIFE ON THE LOWER MISSISSIPPI RIVER, MILE MARKER 166 ON NOVEMBER 10, 2020.

ENDORSEMENT BY THE COMMANDER, EIGHTH COAST GUARD 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.

COMMENTS ON THE REPORT

1. The loss of the mariner was a tragic and preventable accident. I offer my sincere condolences to family and friends of the mariner who lost his life.

2. The investigation and report contain valuable information which can be used to address the factors that contributed to this marine casualty and prevent similar incidents from occurring in the future.

[redacted]

J. E. FOTHERGILL
Commander, U.S. Coast Guard
Chief of Prevention, Acting
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By Direction

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16732
March 31, 2025

TOWING VESSEL CSS ATLANTA (O.N. 647194) CREWMEMBER LOSS OF LIFE ON THE LOWER MISSISSIPPI RIVER, MILE MARKER 166 ON NOVEMBER 10, 2020

ENDORSEMENT BY THE OFFICER IN CHARGE, MARINE INSPECTION

After careful review, I approve the record and the report of investigation, including the findings of fact, analysis, conclusions, and recommendations, subject to the following comments. It is recommended that this investigation be closed.

COMMENTS ON REPORT

The loss of this crewmember was a preventable and tragic accident. I offer my sincere condolences to the families and friends of the mariner who lost his life.

[redacted]

G. A. CALLAGHAN
Captain, U. S. Coast Guard
Officer in Charge, Marine Inspection

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16732
March 24, 2025

TOWING VESSEL CSS ATLANTA (O.N. 647194) CREWMEMBER LOSS OF LIFE ON THE LOWER MISSISSIPPI RIVER, MILE MARKER 166 ON NOVEMBER 10, 2020

EXECUTIVE SUMMARY

On 10 November 2020, at approximately 0610 local time, Deckhand 1 from the inspected towing vessel (ITV) CSS ATLANTA fell overboard at mile marker 166 on the Lower Mississippi River. Deckhand 1 was assisting with mooring operations at the Mosaic Faustina Ammonia Plant in St. James, Louisiana. The CSS ATLANTA crewmembers on duty were the Master, Deckhand 1, and Deckhand 2. For approximately two years the CSS ATLANTA was contracted to move two phosphoric barges (barge CY-11 and barge FC 2) to and from the Mosaic Faustina facility and the Mosaic Uncle Sam facility for loading and off-loading.

Deckhand 1 was on the CY-11 and secured its port bow line to the FC 2. The Master saw Deckhand 1 start walking toward the stern of the CY-11. The Master then checked the gap between the stern of the barges, which was approximately five feet. When the Master looked back toward the port bow of the CY-11, Deckhand 1 was no longer visible. Deckhand 2 radioed the Master that there was a man overboard. The Master put the engines of the CSS ATLANTA in reverse and the flanking rudders to starboard to keep a gap between the two barges. The general alarm was sounded and the Master proceeded out to the deck of the CY-11 to assist in retrieving Deckhand 1. Deckhand 1 had been pinned between the two barges and was pulled onboard the CY-11 by Deckhand 2 before the Master arrived. The Master and Deckhand 2 provided immediate basic medical attention. Neither the Master nor Deckhand 2 saw Deckhand 1 fall overboard.

Deckhand 1 was transferred to the dock and then to an ambulance. Upon arrival at the hospital, Deckhand 1 was pronounced deceased. An autopsy determined that Deckhand 1 died because of blunt force injuries to the upper body.

As a result of its investigation, the Coast Guard determined this incident met the criteria for a reportable marine casualty and a serious marine incident (SMI) under 46 CFR Part 4 and the level of investigative effort was an enhanced investigation because of a loss of life. The initiating event was Deckhand 1 falling into the water. After falling into the water, Deckhand 1 sustained serious trauma and subsequently died. Causal factors that contributed to this casualty included: 1) Partially worn non-skid coating on deck, 2) Inherent tripping hazards, 3) Inadequate situational awareness, 4) Inadequate vessel movement, and 5) Fatal injuries.

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

Commander
United States Coast Guard
Sector New Orleans

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16732
March 24, 2025

TOWING VESSEL CSS ATLANTA (O.N. 647194) CREWMEMBER LOSS OF LIFE ON THE LOWER MISSISSIPPI RIVER, MILE MARKER 166 ON NOVEMBER 10, 2020

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. No other persons or agencies assisted with the investigation.

1.3. No other individuals, or organizations were designated a party-in-interest in accordance with 46 CFR Subsection 4.03-10.

1.4. All times listed in this report are in Central Daylight-Savings Time using a 24-hour format and are approximate.

2. Vessels Involved in the Incident

Official Name:	*CSS ATLANTA*
Identification Number:	647194 – Official Number (US)
Flag:	United States
Vessel Class/Type/Sub-Type	Towing Vessel
Build Year:	1982
Gross Tonnage:	143 GT
Length:	61 Feet
Beam/Width:	26 Feet
Draft/Depth:	8 Feet
Main/Primary Propulsion:	High Speed Diesel – 1590 Horsepower
Owner:	CSS Atlanta Inc Gonzales, Louisiana 70707
Operator:	Carline Companies Gonzales, Louisiana 70707

Figure 1. Undated photograph of *CSS ATLANTA*. Photograph obtained from https://www.carlinecompanies.com/css-atlanta.

Official Name:	*CY-11*
Identification Number:	611607 – Official Number (U.S.)
Flag:	United States
Vessel Class/Type/Sub-Type	Barge – Bulk Liquid Cargo (Tank)
Build Year:	1979
Gross Tonnage:	597 GT
Length:	195 Feet
Beam/Width:	35 Feet
Draft/Depth:	11 Feet
Main/Primary Propulsion:	Not Self-Propelled
Owner:	Van Stroom Inc. North Olmsted, Ohio 44070
Operator:	Mosaic Fertilizer LLC Uncle Sam, Louisiana 70792

Figure 2. Undated photograph of *CY-11*. Photograph from https://www.vtbarge.com/vtbourfleet.

Official Name:	*FC 2*
Identification Number:	513391 – Official Number (U.S.)
Flag:	United States
Vessel Class/Type/Sub-Type	Barge – Bulk Liquid Cargo (Tank)
Build Year:	1968
Gross Tonnage:	569 GT
Length:	215 Feet
Beam/Width:	25 Feet
Draft/Depth:	10 Feet
Main/Primary Propulsion:	Not Self-Propelled
Owner:	Van Stroom Inc North Olmsted, Ohio 44070
Operator:	Mosaic Fertilizer LLC Uncle Sam, Louisiana 70792

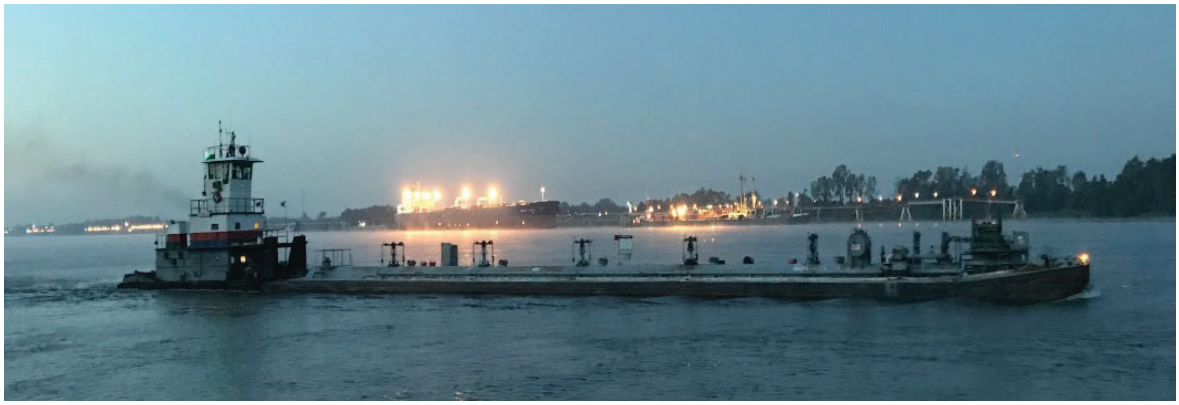

Figure 3. Undated photograph of *FC 2*. Photograph obtained from https://www.vtbarge.com/vtbourfleet.

3. Deceased, Missing, and/or Injured Persons

Relationship to Vessel	Sex	Age	Status
Deckhand 1	Male	22	Deceased

4. Findings of Fact

4.1. Incident

4.1.1. On November 10, 2020, at 0430 local time, the CSS ATLANTA was conducting barge shifting operations at the Mosaic Faustina Ammonia Plant in the vicinity of mile marker 166 on the Lower Mississippi River. The CSS ATLANTA and its crew were working on barges CY-11 and the FC 2.

4.1.2. At 0430, the Master, Deckhand 1, and Deckhand 2 came on watch to assume navigation and operational duties for the CSS ATLANTA. The CSS ATLANTA and the loaded barge CY-11 were moored to the dock at the Mosaic Faustina Ammonia Plant. The tow configuration at the time had the stern of the CY-11 attached to the bow and push knee of the CSS ATLANTA.

4.1.3. At 0600, the CSS ATLANTA received orders to proceed approximately 300 feet downriver to retrieve the unloaded barge FC 2.

4.1.4. At 0605, while pushing ahead the CY-11, the CSS ATLANTA began mooring operations against the FC 2. The port bow of CY-11 was tied off to the starboard bow of FC 2.

4.1.5. At 0609, Deckhand 1 tied off the CY-11 port bow line to the FC 2 and then walked toward the stern of the vessel to assist with final mooring operations.

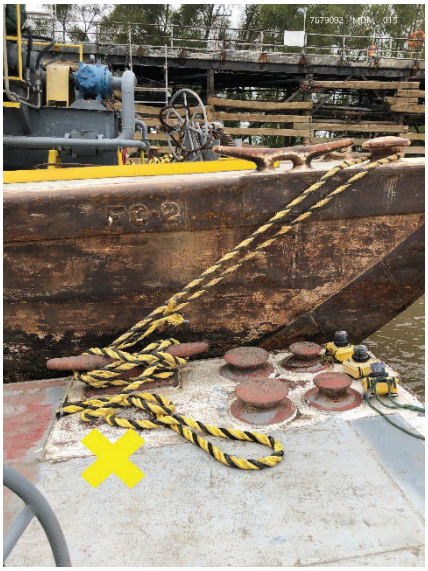

Figure 4. Tow configuration of *CY-11* and *FC-2* and last known location of deckhand 1. Photo taken by Coast Guard Sector New Orleans.

4.1.6. The Master checked the gap between the stern of the two barges, which was approximately five feet. The Master maneuvered the stern of the CY-11 inward to allow for the stern line to be secured.

4.1.7. At 0610, Deckhand 1 fell overboard, between CY-11 and FC 2.

4.1.8. Deckhand 2 contacted the Master on the radio and informed the Master that there was a man overboard.

4.1.9. The Master put the engines of the CSS ATLANTA in astern and the flanking rudders to starboard to keep a gap between the two barges.

4.1.10. Despite the Master's efforts, Deckhand 1 was pinned between CY-11 and FC 2 and sustained serious injuries.

4.1.11. At 0612, Deckhand 2 retrieved Deckhand 1 from the water. The Master and Deckhand 2 provided immediate medical attention to Deckhand 1.

4.1.12. At 0613, the CSS ATLANTA transited back to the Mosaic Faustina Ammonia Plant's dock to await emergency medical services.

4.1.13. Emergency medical services arrived at 0625 and Deckhand 1 was taken to Prevost Memorial Hospital in Donaldson, Louisiana.

4.1.14. Deckhand 1 was pronounced as deceased at 0746 on November 10, 2020.

4.2. Additional/Supporting Information:

4.2.1. The inspected towing vessel CSS ATLANTA was owned by CSS Atlanta Inc. and operated by Carline Companies. The vessel had a Coast Guard Approved Towing Safety Management System (TSMS) Certificate, issued by Sabine Surveyors, Ltd. Its initial Certificate of Inspection (COI) was issued on October 31, 2018.

4.2.2. The CSS ATLANTA had a crew of 1 master, 1 mate, and 4 deckhands.

4.2.3. Both deckhands on watch (Deckhand 1 and Deckhand 2) were wearing the Carline Companies required PPE. This included a personal flotation device, steel-toed boots, a radio, and a flashlight.

4.2.4. Carline Companies had the following policies and procedures in place: personal protective equipment (PPE), man overboard prevention/procedure, safety rules, and deckhand manual. These policies/procedures were given to all employees.

4.2.5. Deckhand 1 completed company required training. The training was provided in video format and included a risk assessment, man overboard prevention, and slips, trips, and falls prevention. On April 7, 2020, Deckhand 1 signed an acknowledgement form that all training videos had been completed.

4.2.6. Deckhand 1 was employed on CSS ATLANTA for approximately seven months and had several years of experience prior to his hiring. Deckhand 1 worked on the deck of the CY-11 nearly 100 times prior to this incident.

4.2.7. Deckhand 1 never notified the Master or the Carline Companies management of any potential safety issues along the deck of the CY-11.

4.2.8. Non-skid coating at the location where Deckhand 1 fell overboard was partially worn.

4.2.9. There was multiple inherent tripping hazards present along the deck of the CY-11, which included buttons, cleats, mooring lines, and various metal structures.

4.2.10. Neither the CY-11 nor the FC 2 was equipped with a fendering system.

4.2.11. Weather conditions at the time of the incident consisted of misting rain and little to no wind. It was dark at the time of the incident and sunrise occurred at 0622.

4.2.12. There was no report of a “jolt” or “bump” when the CSS ATLANTA maneuvered/moored.

4.2.13. The toxicology report from Jefferson Parish Forensic Center was negative for both drugs and alcohol for persons involved in this incident.

4.2.1. 4.2.14. The autopsy report from the Jefferson Parish Coroner's Office determined that Deckhand 1 died as a result of multiple blunt force head/neck injuries and injuries to the trunk. The manner of death was classified as an accident.

4.2.2. Analysis

4.3. *Partially worn non-skid coating on deck.* The non-skid coating on the deck of the CY-11 was partially worn in the vicinity where Deckhand 1 fell overboard. Non-skid is a type of epoxy/paint which, once dry, offers an abrasive texture to reduce the chance of boots/shoes slipping while transiting the deck of a vessel. The Carline Companies incident report specified that there may have been dew on the deck of the CY-11 at the time, which was not unusual and would not render the barge unfit for use. It was also misting rain at the time of the incident. It was possible that the dew/moisture on the deck, coupled with the partially worn non-skid coating on the deck, led to Deckhand 1 slipping while walking and falling overboard. Had the non-skid coating on the deck of the CY-11 not been partially worn, it was possible that Deckhand 1 may have retained his footing and not fallen overboard.

4.4. *Inherent tripping hazards.* There were multiple inherent tripping hazards along the deck of the CY-11, which included buttons, cleats, mooring lines, and various metal structures. Considering Deckhand 1 walked toward the stern of the CY-11 to assist with final mooring operations, it was reasonable to assume that he would have stepped over various tripping hazards while walking. Additionally, Carline Companies safety rules warned crewmembers to "avoid an unsafe situation by paying close attention to what is happening around you". Had there been no tripping hazards on the deck of the CY-11, it was possible that Deckhand 1 may not have fallen into the water.

4.5. *Inadequate Situational Awareness.* Deckhand 1 had been aboard the CY-11 on nearly 100 occasions prior to this incident. Deckhand 1 never notified the Master or the Carline Companies management of any potential safety issues along the deck of the CY-11. It was possible that Deckhand 1 lost situational awareness as he attempted to walk to the stern of the CY-11 after connecting the bow line. The Master stated that he saw Deckhand 1 start walking toward the stern of the CY-11 just prior to the incident. Had Deckhand 1 retained situational awareness while transiting the deck, it was possible that he may not have fallen into the water.

4.6. *Inadequate vessel movement.* Once the Master was notified that Deckhand 1 had fallen overboard between the two barges, the Master put the engines of the CSS ATLANTA in reverse and the flanking rudders to starboard to attempt to keep a gap between the two barges. However, the maneuvering was not enough to keep the barges apart and Deckhand 1 was pinned between the two barges. Had the maneuvering of the CSS ATLANTA been substantial enough to keep the two barges separated, it was possible that Deckhand 1 would not have sustained severe injuries.

5. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty was Deckhand 1 unintentionally falling off the *CSS ATLANTA* into the Mississippi River for an unknown reason. Likely causal factors contributing to this event were:

6.1.1.1. Partially worn non-skid coating on deck.

6.1.1.2. Inherent tripping hazards.

6.1.1.3. Inadequate situational awareness.

6.1.2. The subsequent event was the death of deckhand 1.

6.1.2.1. Inadequate vessel movement.

6.2. Evidence of Act(s) or Violation(s) of Law by Any Coast Guard Credentialed Mariner Subject to Action Under 46 USC Chapter 77: There were no acts of misconduct, incompetence, negligence, unskillfulness, or violations of law by a credentialed mariner identified as part of this investigation.

6.3. Evidence of Act(s) or Violation(s) of Law by U.S. Coast Guard Personnel, or any other person: No acts or violations of law by Coast Guard personnel, or any other person, were identified as part of this investigation.

6.4. Evidence of Act(s) Subject to Civil Penalty: No violations of administrative law warranting civil penalty action were identified as part of this investigation.

6.5. Evidence of Criminal Act(s): No violations of criminal law were identified as part of this investigation.

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. Unsafe Actions or Conditions that Were Not Causal Factors: This investigation identified no unsafe actions or conditions that were not causal factors.

7. Actions Taken Since the Incident

7.1. As of October 10, 2024, the vessel has successfully completed five subsequent vessel inspections with no deficiencies noted.

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 Recommendation:

8.2.1. Recommend this investigation be closed.

[redacted]

Lieutenant Commander, U.S. Coast Guard
Investigating Officer