UNITED STATES COAST GUARD

REPORT OF INVESTIGATION INTO THE JMC 300 (O.N. 1094810) LOSS OF LIFE IN THE GULF INTRACOASTAL WATERWAY NEAR AMELIA LOUISIANA, ON FEBRUARY 10, 2024

MISLE ACTIVITY NUMBER: 7969744

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

Commandant
United States Coast Guard

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16732/IIA #7969744
24 July 2025

FALL OVERBOARD INTO THE GULF INTRACOASTAL WATERWAY AND SUBSEQUENT LOSS OF LIFE FROM THE UNINSPECTED FREIGHT BARGE JMC 300 (O.N. 1094810) WHILE MOORED AT LAD SERVICES OF LOUISIANA SHIPYARD IN AMELIA, LOUISIANA ON FEBRUARY 10, 2024

COMMANDANT'S ACTION ON REPORT OF INVESTIGATION

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

JUN 11 2025

JMC 300 (O.N. 1094810) LOSS OF LIFE IN THE GULF INTRACOASTAL WATERWAY NEAR AMELIA LOUISIANA, ON FEBRUARY 10, 2024

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 paint supervisor was a tragic and preventable accident. I offer my sincere condolences to the family and friends of the person who lost their 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
Eighth Coast Guard District
By Direction

U.S. Department of Homeland Security

United States Coast Guard

Commanding Officer
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13732
C-24075
December 17, 2024

JMC 300 (O.N. 1094810) LOSS OF LIFE IN THE GULF INTRACOASTAL WATERWAY NEAR AMELIA LOUISIANA, ON FEBRUARY 10, 2024

ENDORSEMENT BY THE OFFICER IN CHARGE, MARINE INSPECTION

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

ENDROSEMENT ON RECOMMENDATIONS

Administrative Recommendation 1: It is recommended this investigation be closed.

[redacted]

Mary A. Gilday
Commander, U.S. Coast Guard
Officer in Charge, Marine Inspection

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

Commander
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16732
July 15, 2024

JMC 300 (O.N. 1094810) LOSS OF LIFE IN THE GULF INTRACOASTAL WATERWAY NEAR AMELIA LOUISIANA, ON FEBRUARY 10, 2024

EXECUTIVE SUMMARY

On February 10, 2024, at approximately 1338 CST, a Paint Supervisor was found deceased in the Gulf Intracoastal Waterway (ICW) while conducting a painting project aboard the JMC 300 barge located at LAD Services of Louisiana Shipyard in Amelia, LA. The supervisor was stationed on top of the JMC 300 which was in the water at the time of the incident. The task for the painters was to paint the port-side hull of the barge and the team utilized a small work barge which was moored along the port side of the JMC 300. The work barge had a rope, known as a mooring line, which tied around T-shaped metal devices known as cleats located atop the JMC 300. The work barge had vertical scaffolding which provided the painters on board an elevated platform to paint areas on the barge that were otherwise out of reach.

When a section of the hull was completed, the work barge would be moved along the hull of the JMC 300 to allow the painters to begin painting a new section. At approximately 1055 CST, a section of the hull was completed, and the painters were prepared to move to the next section. The painters requested the help of the supervisor to untie the work barge from one cleat and assist with moving it to the next. This required the supervisor to untie the line from the cleat, pull the line, which would move the barge into its new position, and tie the line off to the next cleat. The supervisor untied the line from the cleat and began to walk backwards to pull the line and reposition the barge. As he was repositioning the barge, he tripped on another cleat and fell off the side of the barge into the water. When the painters could not locate the supervisor, they called 911 and notified U.S. Coast Guard Sector New Orleans Command Center who initiated Search and Rescue Operations. The body was found beneath the starboard side of the JMC 300 and recovered by law enforcement officers before being taken to shore. During recovery, lacerations were observed on the front side of the supervisor's face. A coroner pronounced the supervisor deceased at approximately 1338 CST, due to blunt force injuries to the head.

As a result of its investigation, the Coast Guard determined that the initiating event for this casualty was the supervisor falling over the side of the JMC 300 barge. Subsequent events include the death of the supervisor after his head struck the side of the work barge, and the supervisor ultimately entering the water. Causal factors contributing to these events were: 1) Trip, and fall hazards, 2) Failure of the shipyard to install temporary handrails aboard the JMC 300, 3) Failure of LAD Services of Louisiana to have a written policy for using assist boats, 4) Failure to wear PPE relative to the hazards presented, and 5) The paint team's inappropriate use of shortcuts.

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

Commander
United States Coast Guard
Marine Safety Unit Morgan City

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July 15, 2024

JMC 300 (O.N. 1094810) LOSS OF LIFE IN THE GULF INTRACOASTAL WATERWAY NEAR AMELIA LOUISIANA, ON FEBRUARY 10, 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. No individuals, organizations, or parties were designated a party-in-interest in accordance with 46 CFR Subsection 4.03-10.

1.3. The United States Coast Guard (USCG) was the lead agency for all evidence collection activities involving this investigation. The Assumption Parish Sheriff's Office conducted a preliminary investigation and recovered the supervisor's body. An autopsy of the supervisor was performed at the Jefferson Parish Coroner's Office. Due to this incident involving a loss of life, the Coast Guard Investigative Service (CGIS) was notified and agreed to provide technical assistance as required. No other persons or organizations assisted in this investigation.

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

2. Vessel Involved in the Incident

Official Name:	JMC 300
Identification Number:	1094810 – Official Number (US)
Flag:	United States
Vessel Class/Type/Sub-Type	Barge/General/General
Build Year:	2000
Gross Tonnage:	4058 GT
Length:	288 feet
Beam/Width:	100 feet
Draft/Depth:	14 feet / 18 feet
Main/Primary Propulsion: (Configuration/System Type, Ahead Horse Power)	None
Owner:	Cashman Equipment Corp. Braintree, MA USA
Operator:	Cashman Equipment Corp. Braintree, MA USA

Figure 1. Photograph of JMC 300 moored at LAD Shipyard; taken February 10, 2024.

3. Deceased, Missing, and/or Injured Persons

Relationship to Vessel	Sex	Age	Status
Paint Supervisor	Male	30	Deceased

4. Findings of Fact

4.1. The Incident:

4.1.1. On February 10, 2024, at approximately 0500, the Paint Supervisor, Shipyard Foreman, and approximately eight painters arrived at LAD Shipyard in Amelia, LA, to commence work for the day.

4.1.2. At about 0530, the foreman led a team safety meeting to discuss the operations for the day which included painting the side hull of the JMC 300 barge and cleaning its top deck by sandblasting. The meeting also consisted of discussions on equipment and tool use, Personal Protective Equipment (PPE) to be utilized, and job tasking for all team members. Meetings like this were conducted daily.

4.1.3. The foreman determined what PPE was required for the project and decided that safety glasses, gloves, hardhats without chin straps, and boots were to be worn for the operations coinciding with the JMC 300. No guard rails were installed aboard the JMC 300 to protect the workers on the top deck from falling over the side, and Personal Flotation Devices (PFD) were not selected to be worn for this job despite company policy requiring both. The Paint Supervisor did not wear a PFD for the job.

4.1.4. At 0600, the team began working. Painting was to be accomplished by using a small work barge with vertical scaffolding on top of the barge which gave painters on the work barge access to sections of the side hull that were out of reach. The work barge was tied alongside the JMC 300 using mooring lines. These mooring lines were used to prevent the work barge from drifting away from the JMC 300. This was executed by tying the mooring lines to cleats on the work barge as well as the top deck of the JMC 300. These cleats and their housing areas are located directly adjacent to the edge of the barge. The team members that were not involved in painting were tasked to sandblast the top deck of the JMC 300. The foreman oversaw the entire operation while the Paint Supervisor oversaw the safety of the painters aboard the work barge.

Figure 2. Photograph of cleat with mooring line secured to it on the top deck of the JMC 300; taken on February 10, 2024.

Figure 3. Photograph of small work barge with scaffolding adjacent to the side hull of the JMC 300; taken February 10, 2024.

4.1.5. As the morning continued, new portions of the JMC 300 side hull had to be painted, requiring the work barge to be moved into new positions. Moving the work barge was accomplished by team members, including the Paint Supervisor, who were on the top deck of the JMC 300 were not otherwise engaged in sandblasting. They utilized the mooring line to pull the work barge to new locations alongside the JMC 300 and secured the work barge to the cleats that coincided with those locations.

4.1.6. At 1030, the painters aboard the work barge were ready to move it to a new location for painting and requested help from anyone who was on top of the JMC 300. Approximately eight individuals were on the top deck of the JMC 300, but only the Paint Supervisor and one additional team member provided aid as the other individuals were engaged in sandblasting operations. The foreman was positioned on land to watch the moving operation take place.

4.1.7. The Paint Supervisor and additional team member untied the work barge from the cleat it was secured to, and with his back turned to the nearby edge of the JMC 300, the Paint Supervisor began pulling on the mooring line to move the work barge.

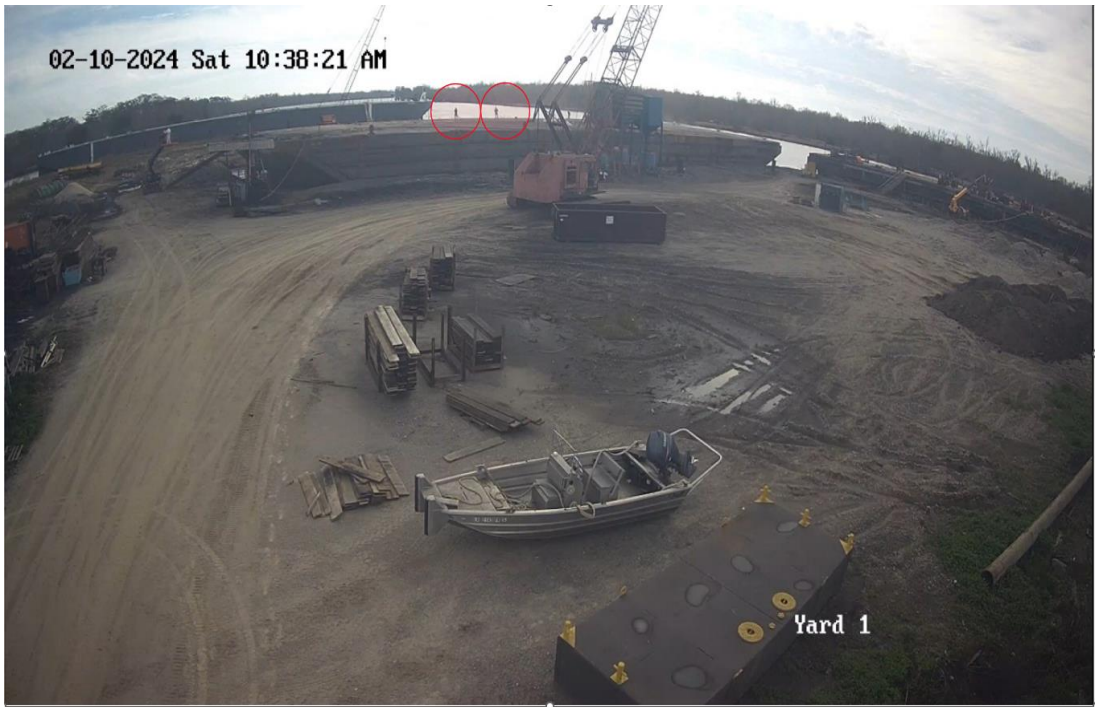

Figure 4. Screenshot of security camera footage showing the Paint Supervisor and paint team member on top of the JMC 300 assisting in moving the work barge.

4.1.8. At 1038, the Paint Supervisor, with his back still facing the nearby edge of the JMC 300, tripped on a cleat aboard the JMC 300 and fell over the side of the barge. As he was falling, his hardhat fell from his head.

Figure 5. Photo of cleat that the Paint Supervisor tripped over aboard the JMC 300 with the work barge in the background.

Figure 6. Screenshot of security camera footage showing the Paint Supervisor falling off of the JMC 300.

4.1.9. As the Paint Supervisor fell off the JMC 300, his head hit the side of the work barge, causing him to suffer a blunt force trauma to the head and killing him before he eventually fell into the water.

4.1.10. At 1045, Assumption Parish Sheriff's office was notified that the Paint Supervisor had fallen off the JMC 300 into the water. U.S. Coast Guard Sector New Orleans was notified shortly after and began conducting search and rescue efforts alongside the Assumption Parish Sheriff's office and St. Mary Parish Water Patrol.

4.1.11. At approximately 1100, U.S. Coast Guard Marine Safety Unit (MSU) Morgan City office was notified by the Sector New Orleans Command Center of a body in the water and possible death in their area of responsibility.

4.1.12. Wheel Job Diving Services was dispatched and located the body of the Paint Supervisor at 1338. The Paint Supervisor was found beneath the JMC 300 and brought to the surface by the diver, where he was pronounced dead by the Assumption Parish Coroner's office. The Paint Supervisor was transferred to Jefferson Parish Coroner's office. Preliminary autopsy results indicated that the preliminary cause of death was blunt force injuries to the head.

4.1.13. A subsequent autopsy indicated the approximate time of death for the Paint Supervisor to be 1338 due to blunt force injuries to the head.

4.1.14. The foreman was deemed directly involved in the incident and completed post casualty alcohol and drug testing. All drug and alcohol tests conducted were negative.

4.2. Additional/Supporting Information:

4.2.1. Cashman Equipment Corp. of Braintree, MA, owned and operated the JMC 300, which was one of over 30 barges, operating in the waterways of the United States. The JMC 300 does not have a Certificate of Inspection (COI), meaning that the U.S. Coast Guard does not perform periodic or annual inspections of the Barge.

4.2.2. The JMC 300 was a 300ft general cargo deck barge engaged in freight service. The barge was built at the Corn Island Shipyard in Grandview, IN on April 5, 2000. The JMC 300's port of registry is Houma, LA.

4.2.3. LAD Services of Louisiana, which was created in 1996, owns and operates out of three different facilities in Southern Louisiana, including the 19 Acre LAD Services of Louisiana Shipyard in Amelia, LA, where the JMC 300 was drydocked on February 10, 2024.

4.2.4. The Paint Supervisor was an employee for LAD Services of Louisiana for approximately three years prior to the incident and had experience working as a shipyard Paint Supervisor for barges that were located at the LAD Services of Louisiana Shipyard in Amelia, LA. He received formal training on workplace safety to include PPE selection determinations, how to properly check and inspect PPE, and general safety awareness prior to starting work with LAD Services of Louisiana. This training was given by the Company's safety representative during crew orientation. Additional trainings include crew refresher trainings done weekly.

4.2.5. The Foreman was an employee for LAD Services of Louisiana for approximately 13 years prior to the incident and had overseen multiple barge painting projects that

were located at LAD Services of Louisiana Shipyard in Amelia, LA. He received formal training on workplace safety to include PPE selection determinations, how to properly check and inspect PPE, and general safety awareness prior to starting work with LAD Services of Louisiana. This training was given by the Company's safety representative during crew orientation. Additional trainings include crew refresher trainings done weekly.

4.2.6. The Paint Supervisor normally wore a personal flotation device for jobs such as painting the side hull of barges. He was not wearing one during the JMC 300 job on February 10, 2024.

4.2.7. Chapter 15 Section 5 Paragraph B of LAD Services of Louisiana's Health, Safety, and Environment (HSE) states that prior to the start of jobs involving hazardous processes, supervisors shall complete a Task Exposure Analysis. If the analysis determines hazards are present or are likely to be present, the supervisor shall select the types of PPE that will protect the affected employee from the hazards identified in the analysis.

4.2.8. Chapter 15 Section 5 Paragraph D of LAD Services of Louisiana's HSE manual states all employees shall wear a protective helmet when working in areas where there is a potential for injury to the head from falling objects. The policy does not address or require chin straps to be worn with the hardhats.

4.2.9. Chapter 15 Section 5 Paragraph H of LAD Services of Louisiana's HSE Manual requires that all personnel who are working in locations where they would likely fall into the water are required to wear a work vest meeting the requirements of 33 Code of Federal Regulations (CFR) 146.20 or a life preserver that meets the requirements of 46 CFR 160.002.

4.2.10. Chapter 5 Section 6 Paragraph A of LAD Services of Louisiana's HSE Manual states that each employee on a vertical or horizontal walking/working surface with an unprotected side or edge which is six feet or more above a lower level shall be protected from falling using guard rail systems, safety net systems, or personal fall arrest systems. This was also common shipyard practice. Despite this, guard rails were not installed.

4.2.11. LAD Services of Louisiana's Amelia Shipyard occasionally employs the use of an assist vessel or "assist boat" to move the small work barges which serve as the platform for painters in projects of similar nature to the JMC 300 paint project on February 10, 2024. No assist vessel was used for this project as the crew believed they could quickly accomplish painting the JMC 300 without high risk.

4.2.12. The cleats on the JMC 300 were permanently fixed to the barge. They were housed in a manner which required small sections of the top deck to be cut out to fit the cleat, which meant the portions of the deck surrounding the cleat were lower than the rest of the top deck, creating small holes around the cleats. This design allowed the cleat to be flush with the top deck of the barge and provided ample room for the mooring line to be tied around the cleat.

4.2.13. LAD Shipyard had no written policy on when to employ the use of assist boats to move the work barges within their shipyard.

5. Analysis

5.1. Trip and fall hazards. The installed cleats on the JMC 300 presented unforeseen trip and fall hazards. They were installed in such a manner that increased the chances of tripping and falling by having the cleat placed in a housing area which was slightly below the top deck of the JMC 300. Although this eliminated the hazard of tripping over the mooring line configuration, it created a hole on the surface of the top deck in the area surrounding the cleat. This created a dangerous situation when someone unintentionally steps in this area as it causes a portion of body weight to shift down to the level where the cleat is housed, creating an uneven distribution of weight as it's now placed on two horizontal surfaces with differing vertical heights. This greatly increases the risk of losing balance. Additionally, the cleats and their housing areas are located directly adjacent to the edge of the barge, so the unevenly distributed weight can also be shifted to the direction of the edge of the barge depending on the direction an individual is coming from when they step into the housing area. This poses risk of falling over the side of the barge. The Paint Supervisor was also not facing the cleats, which created a trip hazard as his back was to the cleats, eliminating the ability to see the cleats while engaged in work thus increasing the chances of tripping and falling. This also made it increasingly difficult to regain balance after it was lost when his foot stepped into the cleat housing area. Had the trip and fall hazards created by the cleat installation and the Paint Supervisor having his back to the cleats not existed, it is reasonable to believe that the Paint Supervisor may not have tripped and fallen into the water while he was utilizing the mooring line to pull the work barge into a new position.

5.2. Failure of the shipyard to install temporary handrails aboard the JMC 300. On the date of the incident, temporary handrails were not installed on the edges of the JMC 300 despite this being common shipyard practice and a direct requirement from LAD Services of Louisianas HSE manual for certain situations in which the painting of the JMC 300 would apply. Guard rails were not installed as the crew believed they could quickly accomplish the painting of the JMC 300 without high risk. Temporary handrails serve as a defense against falling over the side of barges as they provide something to grab on to in the event someone is placed in a situation in which falling overboard is a risk, such as tripping. These handrails also provide a constant support option for individuals who are simply standing near the edge of the barge by facilitating continuous anchor point, even if they are NOT performing actions that pose a direct risk of falling overboard. Once the Paint Supervisor tripped, he had nothing to grab or hold on to due to the absence of handrails. Had temporary handrails been installed by the shipyard aboard the JMC 300, it is reasonable to believe that the Paint Supervisor would have utilized them and therefore, may not have fallen overboard.

5.3. Failure of LAD Services of Louisiana to have a written policy for using assist boats. This investigation determined that on occasion, LAD Services of Louisiana would employ the use of an assist boat for painting operations in their Amelia LA, shipyard. There were no written policies that required the use of assist boats. Shipyard workers would base the decision of employing assist boats according to the size of work barge the shipyard was using for the project. An assist boat can either push the work barge or tow the work barge by utilizing mooring lines which are tied between the work barge and assist boat. The assist boat was not utilized for the JMC 300 painting task. Utilization of an assist boat on the date of the incident would have eliminated the need for the Paint Supervisor to use a mooring line to pull the work barge to different locations as the movement of the work barge would have been accomplished by the assist boat. The Paint Supervisor's physical efforts would have been

reduced to only tying and untying the mooring line from the cleats aboard the JMC 300, which is a much safer task than pulling the work barge with mooring lines. Had a written policy for assist boats been in place, and an assist boat been utilized to push the work barge to different locations around the JMC 300, it is reasonable to believe that the risk of the Paint Supervisor tripping over a cleat and falling over would be drastically reduced, due to the increased safety of the task. In turn, this may have prevented any incident from occurring.

5.4. Failure to wear PPE relative to the hazards presented. Although PPE was worn, PPE relative to the hazards presented by the nature of the job was not utilized on the date of the incident. This included a hardhat which was equipped with a chin strap. Chinstraps were not required by company policy and not provided to the workers. After he had tripped and began to fall, his hardhat, which had no chinstrap, fell from his head, causing his head to make direct contact with the work barge below him. The contact resulted in a blunt force trauma to the head that ultimately rendered him deceased. A chinstrap on the hardhat, if properly worn, could have prevented the direct contact between the Paint Supervisor's head and work barge by preventing the hardhat from falling off his head. Had PPE relative to the hazards presented by the nature of the job such as a hardhat with chinstrap been utilized, it is reasonable to believe the blunt force trauma caused by the Paint Supervisor's head colliding with the barge would have been reduced and the resulting death may not have occurred.

5.5. The paint team's inappropriate use of short cuts. The paint team believed they could quickly accomplish painting the JMC 300 without high risk. This mentality resulted in shortcuts such as the failure to install handrails aboard the JMC 300 and the absence of an assist boat being utilized. These shortcuts had a role in creating the many unsafe conditions and practices that were present on the date of the incident. If the paint team did not perform the task at a quicker pace than required, it is reasonable to believe the incident may not have occurred.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty occurred when the Paint Supervisor tripped and fell over the side of the JMC 300 barge. Causal factors leading to this event were:

6.1.1.1. Trip and fall hazards present aboard the JMC 300.

6.1.1.2. The failure of LAD Service of Louisiana shipyard to install temporary handrails aboard the JMC 300.

6.1.1.3. The failure of LAD Services of Louisiana to have a written policy for the use of assist boats.

6.1.2. Once the Paint Supervisor fell over the side of the JMC 300, his head hit the side of the adjacent work barge, causing blunt force trauma to the head and killing him before he fell into the water. Factors which may have prevented these events were:

6.1.2.1. The Paint Supervisor failing to wear proper PPE to include a hardhat with a chinstrap.

6.1.2.2. The paint team using shortcuts as they believed they could complete the task without high risk.

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 potential acts of misconduct, incompetence, negligence, unskillfulness, or violations of law by a Coast Guard Credentialed Mariner 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: There were no potential acts of misconduct, incompetence, negligence, unskillfulness, or violation of law by Coast Guard employees that contributed to this casualty.

6.4. Evidence of Act(s) Subject to Civil Penalty: This investigation did not identify potential violations which warrant Civil Penalty.

6.5. Evidence of Criminal Act(s): This investigation did not identify potential violations of criminal law.

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

6.7. Unsafe Actions or Conditions that Were Not Causal Factors.

6.7.1. This investigation did not identify any unsafe actions or conditions that were not Causal Factors.

7. Actions Taken Since the Incident

7.1. No Letters of Warning, Violations of Law or Regulation, or Civil Penalties were recommended.

- A findings of Concern has been released encouraging shipyards to create and enforce policies requiring assist vessels when moving small work barges to eliminate the hazard of personnel pulling on mooring lines and potentially tripping or falling. It is also recommended shipyards create and enforce policies regarding use of a guard rail system, safety net or personal fall arrest system while working on vertical or horizontal walking/working surface with a side or edge six feet or more above a lower level as well as the use of hardhats with chinstraps. Hardhats without chinstraps are susceptible to falling of the person's head should they fall off a high surface.

8. Recommendations

8.1. Safety Recommendation: 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.

Lieutenant Junior Grade, U.S. Coast Guard
Investigating Officer