UNITED STATES COAST GUARD

REPORT OF THE INVESTIGATION

INTO THE

UNINSPECTED TOWING VESSEL JOEY DEVALL (O.N. 599385), DECKHAND LOSS OF LIFE ON SEADRIFT BAY IN SEADRIFT, TX ON JUNE 30, 2017

MISLE ACTIVITY NUMBER: 6323290

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

Commandant
United States Coast Guard

2703 Martin Luther King Jr. Ave. SE
Washington, DC 20593-7501
Stop 7501
Staff Symbol: CG-INV
Phone: (202) 372-1032
E-mail: CG-INV1@uscg.mil

16732/IIA #6323290
13 June 2025

FALL OVERBOARD AND SUBSEQUENT LOSS OF LIFE INVOLVING THE UNINSPECTED TOWING VESSEL JOEY DEVALL (O.N. 599385) ON SEADRIFT BAY, NEAR SEADRIFT, TEXAS ON JUNE 30, 2017

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)

U.S. Department of Homeland Security

United States Coast Guard

Commander
Eighth Coast Guard District

Hale Boggs Federal Bldg.
500 Poydras Street
New Orleans, LA 70130
Staff Symbol: dp
Phone: (504) 671-2087

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UNINSPECTED TOWING VESSEL JOEY DEVALL (O.N. 599385), DECKHAND LOSS OF LIFE ON SEADRIFT BAY IN SEADRIFT, TX ON JUNE 30, 2017

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. POTBERGILL
Commander, U.S. Coast Guard
Chief of Prevention, Acting
Eighth Coast Guard District
By Direction

U.S. Department of Homeland Security

United States Coast Guard

Commander
United States Coast Guard
Sector Corpus Christi

Valent Hall
249 Glasson Drive
Corpus Christi, TX 78406
Phone: 361-939-5140

16732
13 Mar 2024

UNINSPECTED TOWING VESSEL JOEY DEVALL (O.N. 599385), DECKHAND LOSS OF LIFE ON SEADRIFT BAY IN SEADRIFT, TX ON JUNE 30, 2017

ENDORSEMENT BY THE OFFICER IN CHARGE, MARINE INSPECTION SECTOR CORPUS CHRISTI, TX

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 subject to the following comments. It is recommended that this marine casualty investigation be closed.

COMMENTS ON THE REPORT

1. My sincerest condolences go out to the family and friends of Tony Bergeron.

2. The investigation and report contain valuable information which can be used to address the chain of events that resulted in loss of life, and to prevent similar incidents from occurring in the future.

ENDORSEMENT/ACTION ON RECOMMENDATIONS

Administrative Recommendation 1: Recommend this investigation be closed.

Endorsement: Concur. This investigation should be closed.

[redacted]

J. B. GUNNING
Captain, U.S. Coast Guard
Officer in Charge, Marine Inspection

Enclosures: (1) Executive Summary
(2) Investigating Officer's Report

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

Commander
United States Coast Guard
Sector Corpus Christi

Valent Hall
249 Glasson Drive
Corpus Christi, TX 78406
Phone: 361-939-5140

16732
12 Mar 2024

UNINSPECTED TOWING VESSEL JOEY DEVALL (O.N. 599385), DECKHAND LOSS OF LIFE ON SEADRIFT BAY IN SEADRIFT, TX ON JUNE 30, 2017

EXECUTIVE SUMMARY

On June 30, 2017, at 0920L, the Uninspected Towing Vessel (UTV) JOEY DEVALL (O.N. 599385) departed Invista terminal in Victoria, TX heading for Chocolate Bayou while pushing Tank Barge (T/B) DBL 704 (O.N. 1249173). There were four persons onboard at the time, the Captain, Relief Captain, Deckhand 1, and Deckhand 2. The recorded weather included 20 knot winds, gusts up to 35 knots, with one-foot choppy seas and five nautical miles of visibility.

The Captain was on the first watch while underway and had directed Deckhand 1 to conduct maintenance on the starboard aft quarter main deck cabin. At 1130L, the Relief Captain assumed watch and shortly after at 1140L Deckhand 2 relieved Deckhand 1 of his maintenance duties. The vessel was still in the Victoria Barge Canal at this point. At approximately 1315L, the UTV JOEY DEVALL exited Victoria Barge Canal and entered Seadrift Bay. Shortly after entering Seadrift Bay, Deckhand 2 went to the wheelhouse to ask the Relief Captain how much longer they would be in Seadrift Bay since he was getting wet while working. The Relief Captain told Deckhand 2 to hold off on further deck work until they were out of the Seadrift Bay. This was the last time Deckhand 2 was heard from.

At 1715L, the Captain awakened for watch change and walked out on deck to find an air hose being dragged off the starboard side and a 2-step ladder left on deck nearby. He started looking for Deckhand 2 and was unable to find him, the vessel proceeded to conduct man overboard procedures. It was estimated to be 4 hours between the time Deckhand 2 entered the water and recognition of his absence. Deckhand 2 was found deceased the following morning on July 1, 2017 on the north bank in the vicinity of intracoastal waterway (ICWW) Mile Marker 490.

Post-casualty alcohol and DOT drug testing were conducted on the UTV JOEY DEVALL crew, all results were negative. Post-mortem toxicology was conducted on Deckhand 2, all results were negative.

As a result of its investigation, the Coast Guard has determined that the initiating event for this casualty was Deckhand 2 entering the water. The subsequent event was the death of Deckhand 2. The causal factors that led to the casualty include: (1) Unfavorable weather conditions for deck work, (2) Disregard of the Relief Captain's direction, (3) Lack of railing, (4) Lack of communication between the Relief Captain and Deckhand 2, and (5) Failure to wear a life jacket.

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12 Mar 2024

UNINSPECTED TOWING VESSEL JOEY DEVALL (O.N. 599385), DECKHAND LOSS OF LIFE ON SEADRIFT BAY IN SEADRIFT, TX ON JUNE 30, 2017

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 Coast Guard was the lead agency for all evidence collection activities involving this investigation. No other federal or state organizations assisted with the investigation.

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

2. Vessel Involved in the Incident

Figure 1. Uninspected Towing Vessel JOEY DEVALL, railings were not installed at the time of accident. (Date Unknown / Marine Traffic)

Official Name:	JOEY DEVALL
Identification Number:	599385 – Official Number (US)
Flag:	United States
Vessel Class/Type/Sub-Type	Towing Vessel/Pushing Ahead hauling alongside/Inland Service
Build Year:	1978
Gross Tonnage:	96 GT
Length:	60.7ft
Beam/Width:	23ft
Draft/Depth:	6.5ft
Main/Primary Propulsion:	Diesel Reduction , 1200 HP
Owner:	Devall Towing & Boat Service of Hackberry LLC 2244 Swisco Road Sulphur, Louisiana 70665 / US
Operator:	Devall Towing & Boat Service of Hackberry LLC 2244 Swisco Road Sulphur, Louisiana 70665 / US

3. Deceased, Missing, and/or Injured Persons

Relationship to Vessel	Sex	Age	Status
Deckhand 2	Male	37	Deceased

4. Findings of Fact

4.1. The Incident:

4.1.1. On the morning of June 30, 2017, the UTV JOEY DEVALL departed Invista terminal in Victoria, TX heading for Chocolate Bayou while pushing ahead T/B DBL 704 with 163 barrels of remaining cargo. The UTV JOEY DEVALL had four crew members onboard, consisting of a Captain, Relief Captain, Deckhand 1, and Deckhand 2.

4.1.2. At 0600 on June 30, 2017, the Captain and Deckhand 1 began their six hour watch.

4.1.3. At 0700, Deckhand 1, as directed by the Captain, commenced sanding and chipping maintenance on the starboard aft quarter with a needle scaler and 2-step ladder (Figure 4) on the UTV JOEY DEVALL.

4.1.4. At 1130, the Relief Captain assumed watch in the wheelhouse at mile 19 on the Victoria Barge Canal.

4.1.5. At 1140, Deckhand 2 relieved Deckhand 1 from maintenance duties. Deckhand 1 overheard the Captain directing Deckhand 2 to sand and chip what he could on the main deck cabin.

4.1.6. At 1315, the UTV JOEY DEVALL exited the Victoria Barge Canal and entered Seadrift Bay.

4.1.7. At 1330, Deckhand 2 went to the wheelhouse to ask the Relief Captain how much longer they would be in Seadrift Bay since he was getting wet while working. The Relief Captain estimated another hour and told Deckhand 2 to delay sanding and chipping until UTV JOEY DEVALL was out of the Seadrift Bay. This was the last time the Relief Captain spoke to Deckhand 2.

4.1.8. At 1334, Deckhand 2 entered the water.

4.1.9. At 1715, the Captain awakened for watch change and walked out on deck. The Captain noticed an air hose being dragged off the starboard side and the step ladder on deck as shown in Figure 3. The Captain pulled the air hose with needle scaler still attached back on deck. He then started looking for Deckhand 2 onboard.

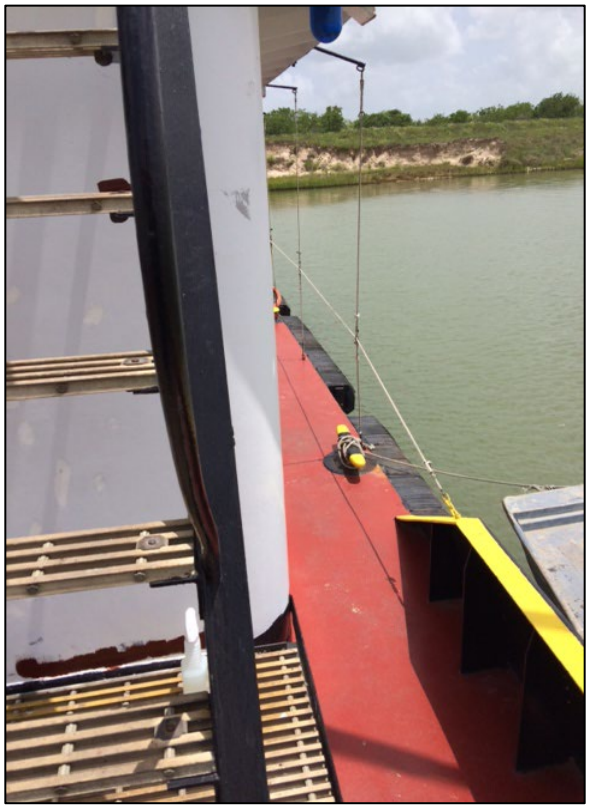

Figure 3. Looking at deck cabin Deckhand 2 was working at time of incident, starboard aft taken from stern. (July 1, 2017 / USCG)

Figure 2. Ladder location when Deckhand 2 discovered missing, starboard aft side. (July 1, 2017 / USCG)

4.1.10. At 1730, the Captain went to the wheelhouse and informed the Relief Captain piloting the UTV JOEY DEVALL of his findings and proceeded to awaken Deckhand 1 to assist in locating Deckhand 2.

4.1.11. At 1740, the crew of the UTV JOEY DUVALL presumed that Deckhand 2 had gone overboard. The Captain contacted the Coast Guard and turned the tow around to commence man overboard procedures starting at mile marker 464 on the Intracoastal Waterway (ICWW).

4.1.12. At 0830 on July 1, 2017, Deckhand 2 was found near ICWW Mile Marker 490 and determined to be deceased at 1037 by a local medical officer. Cause of death was ruled to be accidental drowning.

4.1.13. The Captain, Relief Captain, and Deckhand 1 were subject to mandatory chemical testing for evidence of drug and alcohol use in accordance with 46 CFR Subpart 4.06. All results were negative.

4.1.14. A post-mortem toxicological screen for alcohol and a panel of drugs was conducted on Deckhand 1 and all results were negative.

4.2. Additional/Supporting Information:

4.2.1. The UTV JOEY DEVALL did not have a railing installed above the bulwarks on the perimeter of the vessel.

4.2.2. The recorded weather on June 30, 2017 was 20 knot winds, gusts up to 35 knots, with one-foot choppy seas and five nautical miles of visibility.

4.2.3. Deckhand 2 was not wearing a lifejacket while chipping the main deck cabin. The maintenance equipment used is shown in Figure 4.

Figure 4. Needle scaler and ladder used by Deckhand 2 (July 1, 2017 / USCG)

4.2.4. Deckhand 2's cell phone was traced by the provider and indicated the last location at 1334 on June 30, 2017 near Seadrift Bay.

4.2.5. A Probability of Survival Detection Aid analysis was conducted by the USCG at 2257 on June 30, 2017 and water conditions were conducive for an individual to survive for up to 120 hours.

5. Analysis

5.1. Unfavorable weather conditions for deck work. Based on evidence obtained at the time and witness statements, it is presumed that the weather in the area was not optimal to conduct maintenance on deck using a ladder and other sanding equipment. When the UTV JOEY DEVALL entered Seadrift Bay, Deckhand 2 went to the wheelhouse to ask the Relief Captain how much longer they would be in the Bay as he was getting wet from seawater washing on the deck. The Relief Captain acknowledged the suboptimal weather and directed Deckhand 2 to hold off on further deck work. Had Deckhand 2 refrained from working on the deck, the likelihood of his entering the water could have been mitigated.

5.2. Disregard of the Relief Captain's direction. The Relief Captain recalled Deckhand 2 going to the wheelhouse to ask how much longer they would be in the Bay as he was getting wet while working. The Relief Captain told him they would be in the Bay for an hour or so and to hold up on working until they were out of the Bay. The Relief Captain stated this was the last time he spoke with Deckhand 2. Approximately 4 hours after his interaction, the Captain awoke to find the air hose, needle scaler still attached, hanging overboard on the starboard side. There was also a two-step ladder still on the starboard side deck where needling had been completed on the main deck house. Deckhand 2's last cell phone location time was traced to shortly after his interaction with the Relief Captain and presumed to have been on him at the time. Whether Deckhand 2 returned to the deck to resume work or tidy up remains unknown, but it's evident that he disregarded the Relief Captain's instruction to refrain from deck work. Had Deckhand 2 complied with the Relief Captain's directive and remained in the house, it is plausible that he would not have entered the water.

5.3. Lack of railing. As seen in Figures 2, 3, and 4, the UTV JOEY DEVALL did not have a railing on the perimeter of the vessel. Without a railing, there is an increased risk of individuals inadvertently falling overboard. Although the specific bulwark heights were not measured, they appear relatively low compared to the height of the 2-step ladder observed on deck. Additionally, regulations applicable to the UTV JOEY DEVALL at the time of the incident did not have a bulwark height or railing height requirement. Had there been a railing along the perimeter, it may have prevented Deckhand 2 from entering the water if he fell.

5.4. Lack of communication between the Relief Captain and Deckhand 2. The Relief Captain had not heard from Deckhand 2 after he departed the wheelhouse. Given that the Relief Captain was the only other crewmember awake at the time, Deckhand 2's absence went unnoticed for approximately four hours, significantly delaying the discovery of his disappearance and expanding the search area required. Had Deckhand 2 maintained regular check-ins or utilized radio communication to update the Relief Captain of his whereabouts every 30 minutes or hour, any deviation from his expected activities would have been promptly detected. This proactive communication would have triggered immediate concern

for his safety and allowed for the initiation of man overboard procedures much sooner after Deckhand 2 entered the water, thereby increasing the chances of a successful rescue.

5.5. Failure to wear a lifejacket. It was reported to the USCG Command Center by the Captain that Deckhand 2 was not wearing a lifejacket. The cause of death as determined by the Travis County Medical Examiner was drowning. USCG approved life jackets that are worn properly significantly reduce the risk of drowning. According to U.S. Coast Guard Recreational Boating Safety Statistics in 2017, a staggering 82% of drowning victims were not wearing a life jacket at the time of incident. Furthermore, the deployment of search and rescue efforts is considerably enhanced when individuals wear USCG approved life jackets. With an increase in the aircraft's level of detection, the likelihood of locating Deckhand 2 would have notably improved. Deckhand 2 was in water conditions conducive for an individual to survive for up to 120 hours and would have likely been found before drowning if wearing a proper life jacket.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty was when Deckhand 2 entered the water from the UTV JOEY DEVALL. Causal factors leading to this event were:

6.1.1.1. Deckhand 2 working on deck during unfavorable weather conditions.

6.1.1.2. Deckhand 2 disregarded the Relief Captain's direction to hold off on deck work.

6.1.1.3. Lack of railing above the bulwark to prevent falling overboard.

6.1.2. The subsequent event for this casualty was Deckhand 2's loss of life. Causal factors leading to this event were:

6.1.2.1. Lack of communication between the Relief Captain and Deckhand 2.

6.1.2.2. Failure of Deckhand 2 to wear a life jacket.

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: There were no acts of misconduct, incompetence, negligence, unskillfulness, or violations of law by a mariner identified as part of this investigation.

6.4. Evidence of Act(s) Subject to Civil Penalty: No acts discovered are subject to Civil Penalties.

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

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 other unsafe actions or conditions that were not causal factors.

7. Actions Taken Since the Incident

7.1. There have been no actions taken since the incident occurred.

8. Recommendations

8.1. Safety Recommendation: There were no proposed actions to add new or amend existing U.S. law 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]

[redacted]
Lieutenant Commander, U.S. Coast Guard
Investigating Officer