UNITED STATES COAST GUARD

REPORT OF THE INVESTIGATION INTO THE LOSS OF LIFE ABOARD THE COMMERCIAL FISHING VESSEL LISA JEAN (AK9001AR), TRANSITING SALISBURY SOUND ON AUGUST 19, 2024

MISLE Activity Number: 8095320

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

Commandant
United States Coast Guard

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

16732/IIA #8095320
08 July 2025

LOSS OF LIFE ABOARD THE COMMERCIAL FISHING VESSEL LISA JEAN (AK9001AR) WHILE TRANSITING SALISBURY SOUND NEAR KRUZOF ISLAND, ALASKA ON AUGUST 19, 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.

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
United States Coast Guard
Seventeenth District

709 W. 9th Street
Juneau, AK 99801
Staff Symbol: (dp)
Phone: (907) 463-2803

16732 /IIA 8095320
June 6, 2025

REPORT OF THE INVESTIGATION INTO THE LOSS OF LIFE ABOARD THE COMMERCIAL FISHING VESSEL LISA JEAN (AK9001AR), TRANSITING SALISBURY SOUND ON AUGUST 19, 2024

ENDORSEMENT BY THE DISTRICT COMMANDER

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

The *LISA JEAN* was an uninspected commercial fishing vessel with limited regulatory oversight, operating in Salisbury Sound near Sitka, AK with a Master and a deckhand on board. Concur with investigation conclusions that human factors, removed machinery guards, and rough seas remain the most significant causal factors of this particular loss of life of the Master aboard the *LISA JEAN.*

ENDORSEMENT/ACTION ON RECOMMENDATIONS (if required)

Safety Recommendation. – 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.

Endorsement: Concur.

Administrative Recommendation. – Recommend this investigation be closed.

Endorsement: Concur.

[redacted]

M. M. Dean
RADM, U.S. Coast Guard
Seventeenth District Commander

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

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

Commander
United States Coast Guard
Sector Southeast Alaska

P.O. Box 25517
Juneau, AK 99802-5517
Staff Symbol: (s)
Phone: (907) 463-2450
Email: [redacted]@uscg.mil

16732
May 02, 2025

LOSS OF LIFE ABOARD THE COMMERCIAL FISHING VESSEL LISA JEAN (AK9001AR), TRANSITING SALISBURY SOUND ON AUGUST 19, 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]

S. P. FIELDS
Captain, U.S. Coast Guard
Officer in Charge, Marine Inspection, Southeast Alaska

Enclosure: Investigating Officer's Report

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

Commander
United States Coast Guard
Sector Southeast Alaska

P.O. Box 25517
Juneau, Alaska 99801
Staff Symbol: (spv)
Phone: (907) 463-2840
Email: Seakinvestigations@uscg.mil

16732
March 20, 2025

LOSS OF LIFE ABOARD THE COMMERCIAL FISHING VESSEL LISA JEAN (AK9001AR), TRANSITING SALISBURY SOUND ON AUGUST 19, 2024

EXECUTIVE SUMMARY

On August 19, 2024, at approximately 0904 hours, the master of the commercial fishing vessel LISA JEAN was fatally injured as a result of entanglement in the vessel's propeller shaft while the vessel was underway and making way in Salisbury Sound, Alaska. The LISA JEAN was engaged in commercial coho salmon trolling in approximately 6-8 foot seas with two crew members aboard at the time of the incident.

Several days prior to the incident, the master of the LISA JEAN noticed that the vessel was taking on a significant amount of water from an unknown source. At the time of this discovery, the LISA JEAN was plying the waters offshore of Craig, Alaska and the crew enjoyed little success fishing for salmon. Due to the leak and poor fishing results, the master elected to steam the LISA JEAN north to Sitka, Alaska with the intent of placing the vessel on the tidal grid[1] to further diagnose the leak. While dockside in Sitka, the master accessed the shaft alley via a hatch at the bottom of the fish hold in search for the source of water ingress. This search yielded no positive findings. After a day at the dock in Sitka, the master elected not to place the LISA JEAN on the tidal grid as planned. Instead, he got the LISA JEAN underway and proceeded offshore to the trolling grounds. The master explained to the deckhand that, as long as he ran the Rule 2000 electric bilge pumps for 15 minutes every half hour, they would be fine. He further emphasized that if they didn't keep up with the leak, the LISA JEAN would sink.

After several days at sea, and with the leak persisting, one of the vessel's bilge pumps failed. The deckhand replaced this pump with an onboard spare, but the master became increasingly concerned about the leak. On the morning of August 19, 2024, after several hours of salmon trolling, the master called the deckhand out of the trolling gear operating station at the stern, known as a "troll pit." The master explained to him that he needed to access the shaft alley and that he needed the deckhand to clear all of the ice in the hold away from the access hatch. This task took approximately 15 minutes, and the deckhand returned to the troll pit after task completion to continue working the gear as the LISA JEAN slowly moved ahead at trolling speed. After several minutes, the deckhand noticed that the main engine had suddenly shut down. He called out to the master and heard no response. He quickly left the troll pit and proceeded toward the wheelhouse along the starboard side of the LISA JEAN. As he passed the starboard

[1] Tidal grid refers to a system of heavy planks set in the beach next to a reinforced dock, used for boat maintenance, where boats can be tied to pilings and rest on the planks at low tide, allowing for work on the hull below the waterline.

access to the fish hold, he saw the master in the shaft alley in way of the access hatch. The deckhand quickly went into the hold and observed that the master was twisted around the propeller shaft. The deck hand did not know that the master had left the wheelhouse and accessed the shaft alley. He checked the master for breathing and for a pulse but detected neither. The deckhand quickly exited the hold and proceeded to the wheelhouse. Having limited knowledge regarding the use of very high frequency (VHF) radios, he first attempted to call 911 on his cell phone. The deckhand lives out of state and this call went to emergency services in his hometown. The deckhand desperately searched for local emergency contact information before making VHF contact with a local charter boat operator who was nearby. Unable to help the master and fearing the LISA JEAN would sink, the deckhand abandoned LISA JEAN onto the responding charter boat.

The LISA JEAN was later towed into Sitka, AK where the master was extracted from the shaft alley and transported to the Alaska State Medical Examiner's Office.

As a result of its investigation, the Coast Guard has determined that the initiating event for this casualty was the entanglement of the master in the rotating propeller shaft of the LISA JEAN which resulted in the subsequent death of the master. Causal factors contributing to this casualty include: 1) master's decision to access the shaft alley while the propeller shaft was turning, 2) removed machinery guard, 3) rough seas, and 4) the main engine did not stall quickly enough to prevent fatal injury.

U.S. Department of Homeland Security

United States Coast Guard

Commander
United States Coast Guard
Sector Southeast Alaska

P.O. Box 25517
Juneau, Alaska 99801
Staff Symbol: (spv)
Phone: (907) 463-2840
Email: Seakinvestigations@uscg.mil

16732
May 02, 2025

LOSS OF LIFE ABOARD THE COMMERCIAL FISHING VESSEL LISA JEAN (AK9001AR), TRANSITING SALISBURY SOUND ON AUGUST 19, 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 parties-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 persons or organizations assisted in this investigation.

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

2. Vessel Involved in the Incident

Official Name:	LISA JEAN
Identification Number:	AK9001AR – State Number
Flag:	United States
Vessel Class/Type/Sub-Type	Fishing Vessel
Build Year:	1965
Gross Tonnage:	21 gross register tons
Length:	42.5 feet
Beam/Width:	Unknown
Draft/Depth:	Unknown
Main/Primary Propulsion:	Diesel/Single-Screw Conventional
Owner:	Barry Mckee
Operator:	Barry Mckee

Figure 1. Photograph of LISA JEAN taken by U.S. Coast Guard in Sitka, AK on August 19, 2024.

3. Deceased, Missing, and/or Injured Persons

Relationship to Vessel	Sex	Age	Status
Master of LISA JEAN	Male	75	Deceased

4. Findings of Fact

4.1. The Incident:

4.1.1. On or about August 15, 2024, the crew of the commercial fishing vessel LISA JEAN identified that the vessel had taken a significant leak. The master of LISA JEAN required the deckhand to operate the vessel's two Rule 2000 bilge pumps for 15 minutes every half hour.

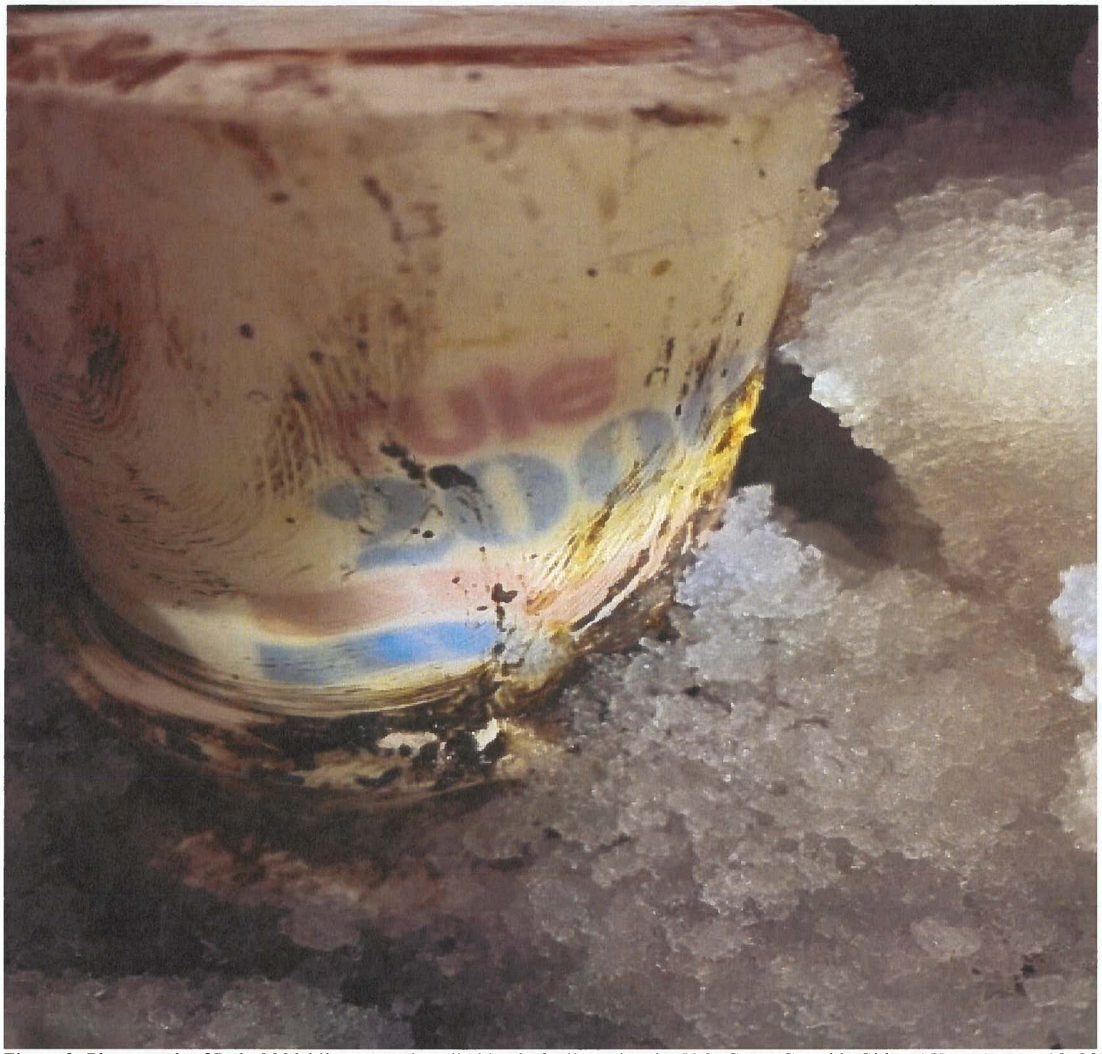

Figure 2. Photograph of Rule 2000 bilge pump installed in shaft alley taken by U.S. Coast Guard in Sitka, AK on August 19, 2024.

4.1.2. On August 15, 2024, the master steamed the LISA JEAN to Sitka, Alaska with the expressed intent to place the vessel on the tidal grid to identify the source of water ingress.

4.1.3. On the morning of August 17, 2024, the master of the LISA JEAN elected to depart Sitka enroute for the fishing grounds without having first placed the vessel on the tidal grid to diagnose the leak. Fishing operations took place on August 17 and 18.

4.1.4. On the morning of August 19, 2024, the crew of the LISA JEAN commenced commercial salmon trolling operations. To accomplish this, the LISA JEAN's engine was clutched into the running gear and the vessel was slowly making headway at troll speed.

4.1.5. The master of the LISA JEAN became increasingly concerned about the vessel's leak and, shortly before 0900, ordered the deckhand to clear the ice from the shaft alley access hatch located in the bottom of the fish hold.

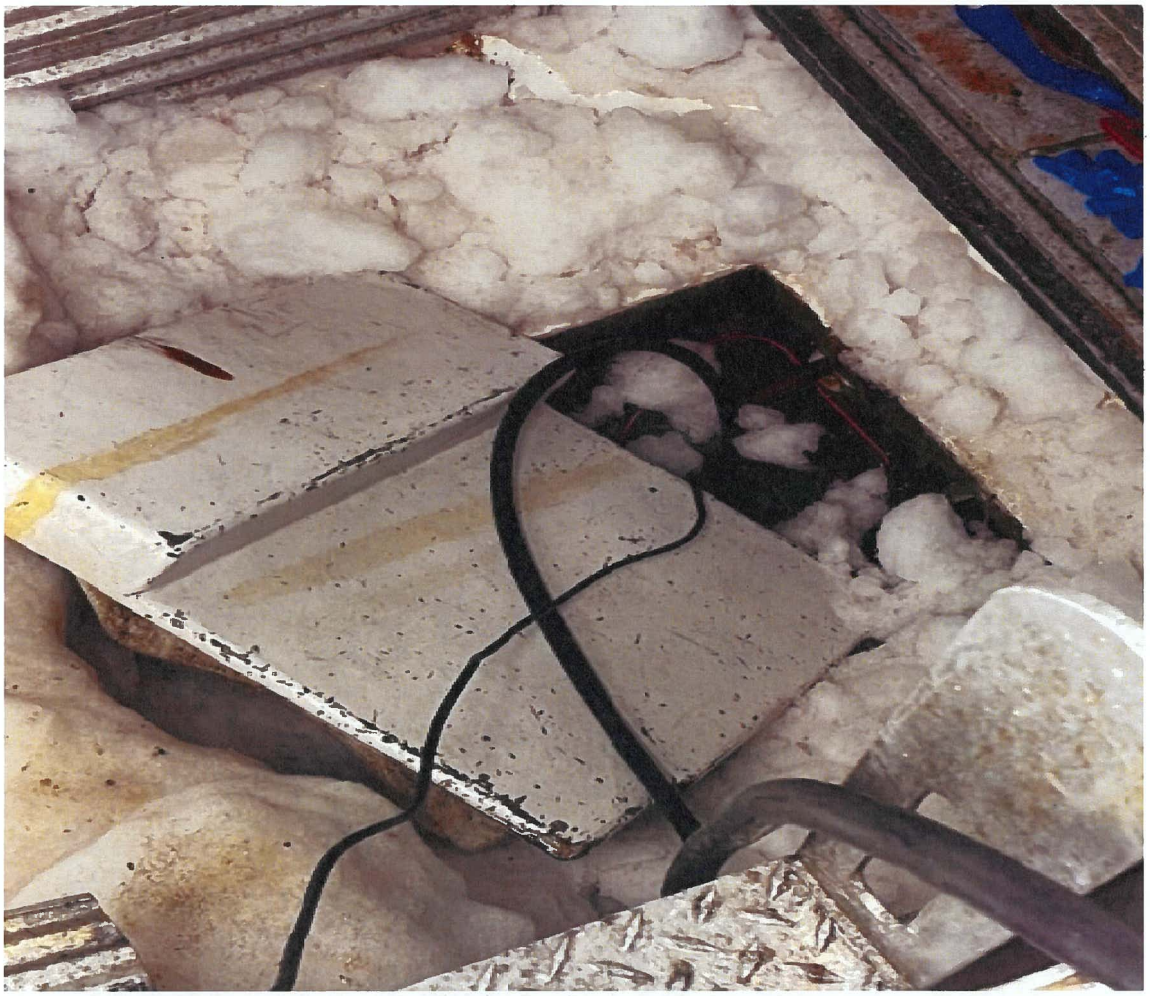

Figure 3. Photograph of shaft alley access hatch taken by U.S. Coast Guard on August 19, 2024.

4.1.6. The deckhand spent approximately 15 minutes clearing the ice away from the shaft alley access hatch and returned to his station at the transom, known as a "troll pit," to continue operating the trolling gear.

4.1.7. At approximately 0900, the master went into the fish hold and opened the access hatch to the shaft alley. This was done without notifying the deckhand.

4.1.8. At approximately 0904, the master became entangled in the propeller shaft of the LISA JEAN which subsequently stalled the main engine.

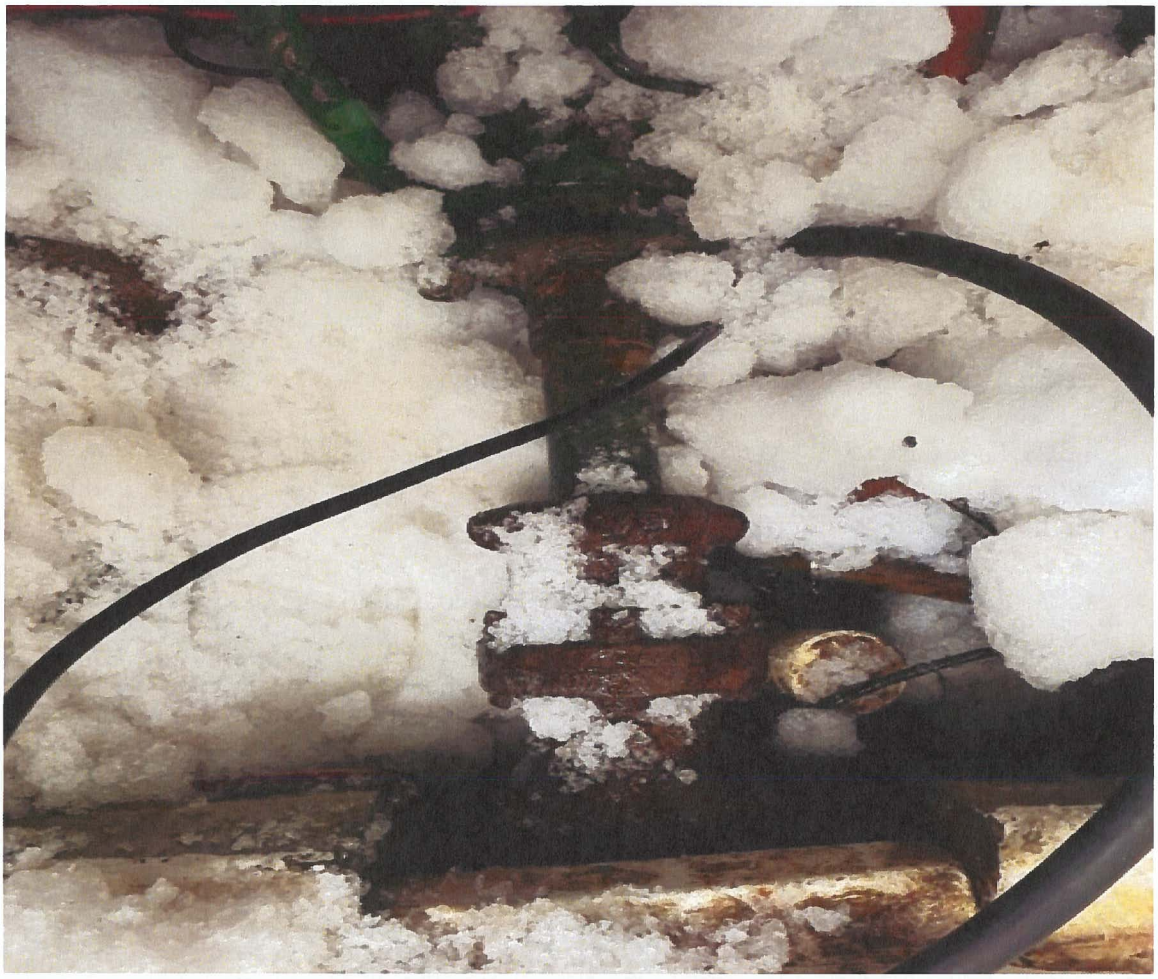

Figure 4. Photograph of propeller shaft taken by U.S. Coast Guard on August 19, 2024.

4.1.9. Immediately after becoming entangled in the propeller shaft, the master of the LISA JEAN fell victim to the fatal wounds sustained to his abdomen and chest.

4.1.10. Upon observing the engine shutdown, the deckhand called out to the master and heard no response.

4.1.11. The deckhand departed the troll pit and walked past the fish hold along the starboard side of LISA JEAN enroute to the wheelhouse. While passing the fish hold, the deckhand noticed the master tucked into the shaft alley access.

4.1.12. The deckhand proceeded into the fish hold and noticed that the master was tightly wrapped around the propeller shaft. He checked the master for breathing and a pulse but detected neither.

4.1.13. At approximately 0905, the deckhand attempted to summon emergency services by dialing "911" on his cell phone. As a resident of another state, this call reached an office in his hometown.

4.1.14. A short time after the incident, the deckhand was able to make contact with a nearby charter boat via very high frequency (VHF) radio. The charter boat arrived on scene quickly and the deckhand safely boarded it and was taken to Sitka.

4.1.15. The LISA JEAN was later towed into Sitka where the master was extracted from the shaft alley and transported to the Alaska State Medical Examiner's Office.

4.1.16. On August 22, 2024, The Alaska State Medical Examiner performed an autopsy and determined the cause of death of the master as "crushing injuries of trunk with traumatic amputation of right arm."

4.2. Additional/Supporting Information:

4.2.1. The master of the LISA JEAN was prescribed at least 8 different medications for a variety of potential physical ailments or conditions.

4.2.2. The Alaska State Medical Examiner's Office noted clinical hypertension, hypercholesterolemia, type 2 diabetes, gout, prostatic hyperplasia, and elevated bilirubin on the autopsy report for the master of the LISA JEAN.

4.2.3. Post-mortem toxicology tests of urine, vitreous fluid, and blood samples taken from the master yielded positive results for caffeine.

4.2.4. On-scene conditions at the time of the incident; fog and seas reported at 6 to 8 feet.

5. Analysis

5.1. Water ingress. The crew of the LISA JEAN identified what was described as a significant leak. It is unclear how quickly the LISA JEAN was taking on water, and a source of the leak was not determined. The pumps installed aboard the LISA JEAN were Xylem brand Rule 2000 electric pumps rated at 2000 gallons per hour. This particular model was not fitted with an integral automatic activation switch and no external float-activated switches were identified the during post-casualty survey of the vessel. The master instructed the deckhand to turn on the pumps every half hour for approximately 15 minutes. It is unclear whether the full 15 minutes were necessary or if the master simply had the deckhand run them extra-long to ensure the water ingress was kept at bay. In any event, the severity of the leak was enough to concern the master, though maybe not enough to prevent him from taking the LISA JEAN out to sea. While at sea, the master was demonstrably preoccupied with his concerns about the leak and finding its source. This sense of urgency likely factored into the master's decision to access the shaft alley while the vessel's engine was clutched into the running gear.

5.2. The master's decision to enter the shaft alley while the propeller shaft was turning. The deckhand stated that the master had accessed the shaft alley on several prior occasions, all of which while the engine was secured. During the interview, the deck hand stated that he considered opening the shaft alley access hatch while the engine was running to be extremely dangerous. It is unclear whether the master had become complacent or if he intended for the propeller shaft to be turning when he accessed the shaft alley. Considering that the master had checked the shaft alley multiple previous times in search of the leak, it is plausible that the master might have considered a compromised shaft seal as the source of the leak and wanted to observe the shaft seal while the vessel was making way. In any event, this decision exposed the master to unguarded rotating machinery.

5.3. Removed machinery guards. The propeller shaft of the LISA JEAN was not fitted with machinery guards. The shaft alley of the LISA JEAN was not a normally occupied space and machinery guards would be both impractical and unnecessary to install. Nonetheless, the proximity of the vessel's fish hold and the shaft ally access hatch served, in the practical sense, as machinery guards and were sufficient to prevent injury during normal vessel operation. In essence, the master removed those defensive structures when he opened the shaft alley access hatch.

5.4. Rough Seas. The deckhand of the LISA JEAN estimated the seas to be 6 to 8 feet at the time of the incident. He noted that the seas tossed the LISA JEAN about quite substantially, causing him to become seasick. While it is unclear whether the master had reached into the shaft alley or if he merely intended to peer into the space, the sea conditions were conducive to one losing their balance. It is possible that the master lost his footing and slipped or fell into the rotating propeller shaft.

5.5. Main engine did not stall quickly enough to prevent fatal injury. The engine of the LISA JEAN was making turns to achieve salmon trolling speed, likely around 3 knots. At this slow speed, the entanglement of the master around the propeller shaft was sufficient to effectively stall the main engine. However, the engine did not stall before the master sustained fatal injuries. Had the engine stalled sooner, it is possible the master could have survived the entanglement. It should be noted that the stalling of the engine was not a designed nor intended safety defense mechanism. It was simply a product of the mechanical principles of internal combustion engine operation that, incidentally, had the potential to prevent or limit bodily injury.

5.6. Prescription drugs. After the LISA JEAN was towed to Sitka, a bag of drugs prescribed to the master was found aboard the vessel. Those drugs included: allopurinol, metformin, atorvastatin, hydrochlorothiazide, famotidine, naproxen, tadalafil, and colchicine. Many of those drugs have been known to cause side-effects including drowsiness, dizziness, lack of alertness, tiredness, weakness, confusion, nervousness, trouble sleeping, and blurred vision. It is unknown whether the master was actively taking those prescription drugs, but their use could have affected the master's judgment or ability to safely move about the vessel.

5.7. Master's medical conditions. As recorded in the Alaska State Medical Examiner's autopsy report, the master of the LISA JEAN suffered from a variety of clinical medical conditions including hypertension, hypercholesterolemia, type 2 diabetes, gout, prostatic hyperplasia, and elevated bilirubin. Many of the prescription medications found aboard the LISA JEAN were used to treat those conditions. Those medical conditions could have affected the master's judgment or ability to safely move about the vessel.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty was the entanglement of the master in the rotating propeller shaft of the LISA JEAN. Casual factors contributing to this event include:

6.1.1.1. Master's decision to access the shaft alley while the propeller shaft was turning.

6.1.1.2. Removed machinery guards.

6.1.1.3. Rough seas.

6.1.2. The master's entanglement in the rotating propeller shaft resulted in the death of the master. Casual factors leading to this event include:

6.1.2.1. The main engine did not stall quickly enough to prevent fatal injury.

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 U.S. Coast Guard Personnel or any other person.

6.4. Evidence of Act(s) Subject to Civil Penalty: No evidence of acts that would warrant civil penalty were identified.

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 did not yield any findings to support the need for new or amended U.S. Law or Regulation.

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

6.7.1. The master's decision to leave the port of Sitka, AK with a known leak of an unknown source. The master's original plan to haul the LISA JEAN onto the tidal grid, to identify the source of the leak prior to returning to the fishing grounds, was a sound plan that erred on the side of safety. The master instead, decided to immediately return to the grounds without identifying the source of water ingress. In lieu of ensuring satisfactory watertight integrity, the master relied solely on the vessel's bilge pumps to maintain buoyancy and stability while at sea. The master's entanglement and death notwithstanding, failure of one or all of those pumps could have resulted in the foundering of the LISA JEAN.

7. Actions Taken Since the Incident

7.1. No necessary corrective actions were identified as a result of this investigation.

8. Recommendations

8.1. Safety Recommendation:

8.1.1. No safety recommendations were generated during the course of this investigation.

8.2. Administrative Recommendations:

8.2.1. Recommend this investigation be closed.

[redacted]

GS-13, U.S. Coast Guard
Investigating Officer