



UNITED STATES COAST GUARD

**REPORT OF THE INVESTIGATION
INTO THE CREWMEMBER LOSS OF LIFE ONBOARD THE
COMMERCIAL FISHING VESSEL MASTER WAYNE IN
THE VICINITY OF WEST BAY NEAR VENICE LOUISIANA
ON SEPTEMBER 23, 2021**



U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
United States Coast Guard

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16732/IIA # 7319906
23 October 2025

**FALL OVERBOARD AND SUBSEQUENT LOSS OF ONE LIFE FROM
THE COMMERCIAL FISHING VESSEL MASTER WAYNE (O.N. 621112)
IN THE VICINITY OF WEST BAY NEAR VENICE, LOUISIANA
ON SEPTEMBER 23, 2021**

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)



16732

**CREWMEMBER LOSS OF LIFE ONBOARD THE COMMERCIAL FISHING VESSEL
MASTER WAYNE IN THE VICINITY OF WEST BAY NEAR VENICE, LOUISIANA ON
SEPTEMBER 23, 2021.**

**ENDORSEMENT BY THE COMMANDER,
COAST GUARD HEARTLAND 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 life was a tragic, yet preventable accident. I offer my sincerest condolences to the family and friends of the deckhand who lost his life.
2. This report highlights the importance of safety education and outreach to our commercial fishing vessel fleet. Although this industry is not regulated by the Coast Guard, I encourage our Captains of the Port to continue efforts to educate these constituents on the dangers of their occupation.
2. The investigation and report contain valuable information which can be used to address the factors that contributed to this marine casualty and ensure awareness of the dangers associated with this industry.



Captain, U.S. Coast Guard
Chief of Prevention
Coast Guard Heartland (Eighth) District
By Direction



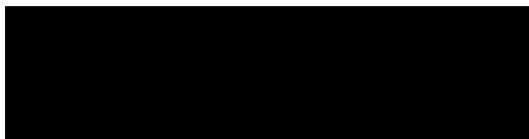
**CREWMEMBER LOSS OF LIFE ONBOARD THE COMMERCIAL FISHING
VESSEL *MASTER WAYNE* IN THE VICINITY OF WEST BAY NEAR
VENICE, LOUISIANA ON SEPTEMBER 23, 2021.**

ENDORSEMENT BY THE OFFICER IN CHARGE, MARINE INSPECTION

The record and the report of the investigation for the subject casualty were reviewed. The findings of fact, analysis, conclusions, and recommendations, subject to the following comments, are approved. It is recommended that this marine casualty investigation be closed.

COMMENTS ON REPORT

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



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

16732
September 5, 2025

**CREWMEMBER LOSS OF LIFE ONBOARD THE COMMERCIAL FISHING
VESSEL *MASTER WAYNE* IN THE VICINITY OF WEST BAY NEAR
VENICE, LOUISIANA ON SEPTEMBER 23, 2021.**

EXECUTIVE SUMMARY

On September 23, 2021, at approximately 1300 local time, the commercial fishing vessel Master Wayne was engaged in shrimping operations with one captain and two deckhands in the vicinity of West Bay near Venice, Louisiana. The Captain and Deckhand 1 realized that Deckhand 2 was no longer onboard the vessel and determined that Deckhand 2 went overboard. Deckhand 2 was last seen approximately one hour prior on the aft deck of the vessel. The crew searched the vessel before proceeding on a reciprocal course of their previous track line.

At 1326, Coast Guard Sector New Orleans Command Center received a notification of the missing deckhand from the Master Wayne via very high frequency (VHF) radio channel 16 and commenced search and rescue operations. The Coast Guard notified the Plaquemines Parish Sheriff's Office and the Louisiana Department of Wildlife and Fisheries, who assisted with the search. The Sheriff's Office obtained a search warrant for the Master Wayne and found no signs of a physical altercation or foul play during their search of the vessel.

On September 25, 2021, at 1853, Active Search Suspended Pending Further Developments (ACTSUS) was granted by the Sector Commander of Sector New Orleans and the search efforts subsequently suspended. On September 29, 2021, Sector New Orleans issued a Letter of Presumed Death for Deckhand 2.

A few months later in 2021, a human left femur and right tibia were discovered along the shore of Grand Isle State Park. Those bones were positively identified as those of Deckhand 2 through familial DNA comparison. The scientific analysis conducted by the Louisiana State University Forensic Anthropology and Computer Enhancement Services (FACES) Laboratory identified only postmortem trauma consistent with animal scavenging. The Jefferson Parish Coroner's Office classified the manner and cause of death as undetermined.

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 as the incident resulted in a loss of life. The initiating event was the entry of Deckhand 2 into the water followed by Deckhand 2's loss of life. The causal factors contributing to this casualty were: 1) Undetermined 2) Delay in notification to Coast Guard 3) Failure to request assistance from vessels in the vicinity and 4) Failure to use personal floatation device.

16732
September 5, 2025

**CREWMEMBER LOSS OF LIFE ONBOARD THE COMMERCIAL FISHING
VESSEL *MASTER WAYNE* IN THE VICINITY OF WEST BAY NEAR
VENICE, LOUISIANA ON SEPTEMBER 23, 2021.**

INVESTIGATING OFFICER’S REPORT

1. Preliminary Statement

This marine casualty investigation was conducted and 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.

The U.S. Coast Guard was the lead Federal agency for this investigation. The Louisiana Department of Wildlife and Fisheries (LDWF), Plaquemines Parish Sheriff’s Office, Jefferson Parish Sheriff’s Office, and Jefferson Parish Coroner’s Office assisted Coast Guard Investigators with casualty response, witness interviews, and evidence collection. No other persons or organizations assisted in this investigation.

No other individuals, organizations, or parties were designated a party-in-interest by the Investigating Officer in accordance with 46 CFR Subsection 4.03-10.

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:	<i>Master Wayne</i>
Identification Number:	621112 – Official Number (US)
Flag:	United States
Vessel Class/Type/Sub-Type:	Fishing Vessel, Fish Catching Vessel, Trawler, Side
Build Year:	1980
Gross Registered Tonnage:	71 GRT
Length:	65.6 feet
Beam/Width:	21.7 feet
Depth:	7.5 feet
Main/Primary Propulsion:	Diesel
Owner/Operator:	



Figure 1. Photograph of *Master Wayne* (Google)

3. Deceased, Missing, and/or Injured Persons

Relationship to <i>Master Wayne</i>	Sex	Age	Status
Deckhand 2	M	28	Deceased

4. Findings of Fact

4.1. Incident:

4.1.1. On September 17, 2021, the MASTER WAYNE departed on a one-week fishing trip with a captain and two deckhands onboard. Deckhand 1 was considered the lead deckhand while Deckhand 2 was the secondary deckhand. During the trip, the vessel fished for shrimp along the coast of Southern Louisiana between Redfish Bay and Grand Isle.

4.1.2. On September 23, 2021, the MASTER WAYNE was completing its last day of fishing, with the intention to offload its catch early the following morning. The crew began their morning drag at approximately 0800, heading south in the vicinity of West Bay near Venice, Louisiana.

4.1.3. The weather and sea conditions on the day of the incident were seas three to four feet high, winds were light and variable and visibility was clear. The air temperature was 76 degrees Fahrenheit, and the water temperature was 79 degrees Fahrenheit. The depth of water was between seven to nine feet with approximately 2.8 feet of water beneath the keel of the vessel.

4.1.4. Around 0900, the crew raised the nets out of the water and brought them on deck. The two deckhands worked to load the shrimp into the hold. During this time, Deckhand 2 took a cell phone call that required him to step away.

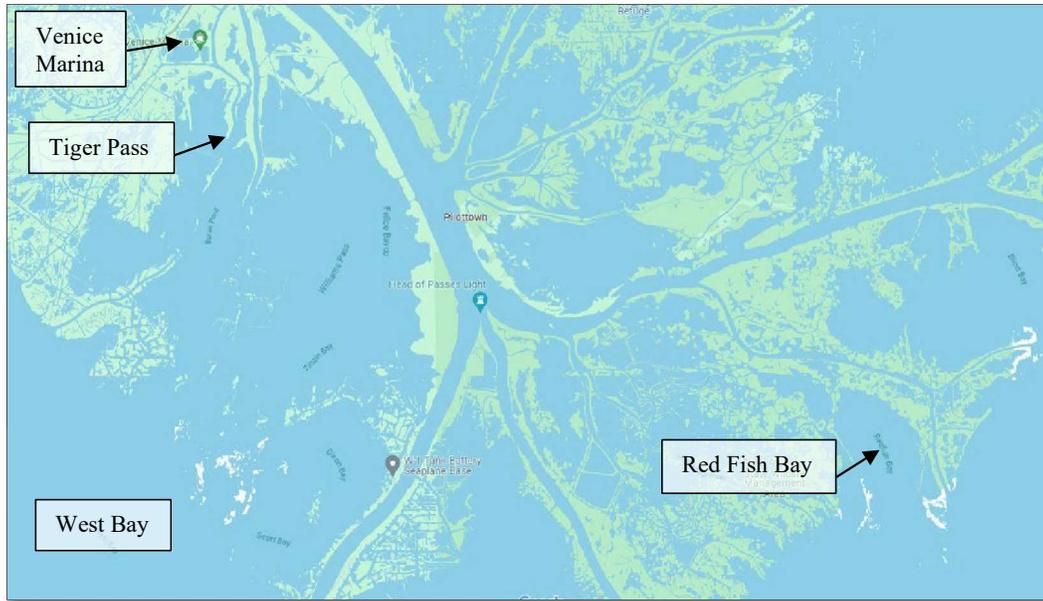


Figure 2. Waters along the coast of Southern Louisiana (June 12, 2024 / Google Maps)

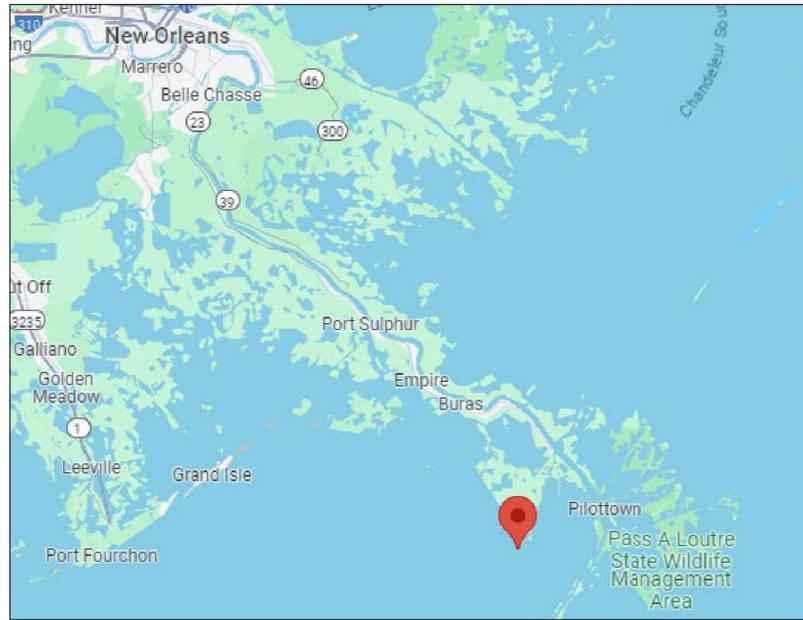
4.1.5. While Deckhand 2 was on the phone, the Captain assisted Deckhand 1 with cleaning and loading the catch. The Captain then instructed the deckhands to re-deploy the nets for another drag.

4.1.6. At around 1130, the vessel was dragging for shrimp on a north/northwest course in the direction of the Tiger Pass outlet. Deckhand 1 was laying in his bunk when Deckhand 2 came into the cabin and asked for a clean pair of shorts and a shirt. Deckhand 1 gave him the clothes and saw Deckhand 2 grab a black backpack. Deckhand 1 asked Deckhand 2 where he was going. Deckhand 2 responded, saying that he was going on deck to smoke a cigarette.

4.1.7. Shortly thereafter, the Captain was walking from the aft deck towards the wheelhouse when he observed Deckhand 2 on the deck with a backpack in his hands, which was not typical. The Captain asked, “Are you keeping your money safe or something?” to which the deckhand replied, “Something like that”. Following the conversation, the Captain proceeded to the wheelhouse.

4.1.8. Deckhand 2 was last seen wearing a blue shirt with a gray and black North Carolina baseball hat. Deckhand 2 was approximately six foot four inches tall and weighed between 160-180 pounds.

4.1.9. At approximately 1300, the Captain checked the nets and found shrimp. He yelled to Deckhand 1 to get ready to pick up the nets, as the Captain planned to transit further north towards Empire. Not seeing Deckhand 2 on deck, Deckhand 1 went to the forward hold after the Captain suggested that Deckhand 2 was probably taking a shower.



i.
Figure 3. Approximate location of incident in vicinity of West Bay (June 12, 2024 / Google Maps)

4.1.10. After searching the vessel, Deckhand 1 informed the Captain that he could not find Deckhand 2. The Captain and Deckhand 1 pulled in the nets and then searched the vessel for approximately 20 minutes.

4.1.11. Unable to locate Deckhand 2, the Captain and Deckhand 1 decided to call the vessel's owner to report that Deckhand 2 was missing and was presumed to have gone overboard. The Captain then proceeded to turn the vessel around and retrace the vessel's trackline. Deckhand 1 went to the top of the wheelhouse to scan the area with binoculars while the Captain navigated the vessel on a reciprocal course.

4.1.12. At 1326, the Captain hailed the Coast Guard Sector New Orleans Command Center via very high frequency (VHF) radio channel 16 to report the missing deckhand. The Command Center issued an Urgent Mariner Information Broadcast (UMIB) and commenced search and rescue operations. Notifications were made to the Plaquemines Parish Sheriff's Office and LDWF by 1332.

4.1.13. While the MASTER WAYNE was in West Bay, approximately one quarter to half a mile from shore, the Captain observed other fishing vessels nearby. The MISS MELISSA was fishing in the vicinity, approximately one mile from shore. There were also two fishing vessels anchored below Tiger Pass, as well as several oil wells and pilings in the vicinity. The Captain also observed a skiff transiting toward Tiger Pass. The Captain did not hail these vessels to request assistance.

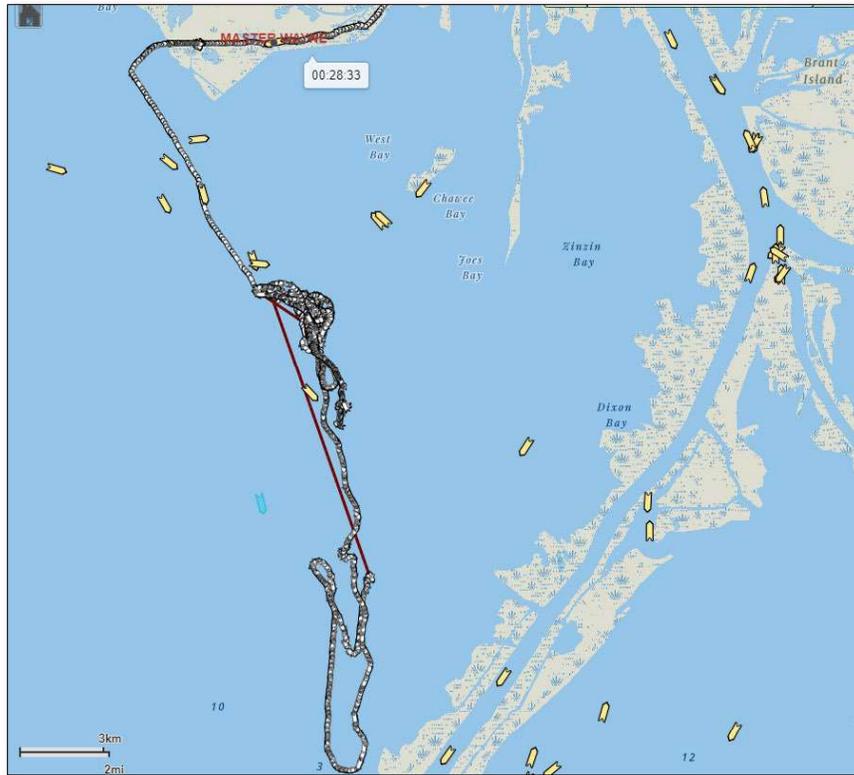


Figure 4. *Master Wayne* trackline around time of incident (September 23, 2021/USCG)

4.1.14. After approximately one hour transiting on the reciprocal course, the Captain again turned the vessel around and instructed Deckhand 1 to drive the vessel while he went to the top of the wheelhouse with the binoculars to look for Deckhand 2.

4.1.15. A short while later, the Captain saw a Coast Guard helicopter and decided to position the vessel just south of the search area to wait for further instructions. The Plaquemines Parish Sheriff's Marine Division and LDWF boarded the *MASTER WAYNE* and directed the vessel to Venice Marina.

4.1.16. Upon arrival to the marina, the Captain and Deckhand 1 were transported to the Plaquemines Parish Sheriff's Office where they were interviewed until approximately 0130 on September 24, 2021. A search warrant for the *Master Wayne* was obtained by the Sheriff's Office and a lawful search of the vessel was conducted. The deputy sheriffs located Deckhand 2's phone on the vessel and collected it as evidence. The Sheriff's Office found no signs of a physical altercation, foul play, or other evidence indicating criminal activity onboard.

4.1.17. On September 25, 2021, at 1853, Active Search Suspended Pending Further Developments (ACTSUS) was granted by the Sector Commander of Coast Guard Sector New Orleans and the search efforts were suspended.

4.1.18. In total, the Coast Guard completed 27 search patterns, including first light searches and covered a total of 3,528 square nautical miles. The involved Coast Guard assets included an Air Station New Orleans MH-65 helicopter, Aviation Training Center

Mobile HC-144 aircraft, Station Venice Response Boat Medim (RBM) and Special Purpose Craft – Shallow Water (SPC-SW), Coast Guard Cutter (CGC) Amberjack, and CGC Daniel Tarr. Plaquemines Parish Sheriff's Office and LDWF also provided assets to assist with the search. All completed searches returned with negative results.

4.1.19. On September 29, 2021, Coast Guard Sector New Orleans issued a Letter of Presumed Death for Deckhand 2.

4.1.20. Forensic analysis of Deckhand 2's cellular phone revealed what would be described by the Plaquemines Parish Sheriff's office as self-taken ("selfie") photos of Deckhand 2 on board the vessel in daring positions, such that with one false step serious injury or death could result.

4.2. Discovery of Personal Items and Remains

4.2.1. On October 25, 2021, Plaquemines Parish Sheriff's Office was notified by the Port Fourchon Police Department that a backpack and identification card belonging to Deckhand 2 washed up on the beach in Port Fourchon.

4.2.2. On October 30, 2021, Jefferson Parish Sheriff's Office responded to a report that a resident had found a possible human femur while walking along the beach in Grand Isle State Park. The remains were transported to the Jefferson Parish Coroner's Office.

4.2.3. On November 2, 2021, Jefferson Parish Sheriff's Office responded to a report that a resident had found a possible human tibia while walking along the shoreline in Grand Isle State Park. The remains were transported to the Jefferson Parish Coroner's Office.

4.2.4. The Jefferson Parish Coroner's Office determined the remains found at Grand Isle State Park were a left femur and a right tibia, both of human origin. The remains were delivered to the Louisiana State University (LSU) Forensic Anthropology and Computer Enhancement Services (FACES) Laboratory on November 16, 2021, for DNA collection and scientific analysis.

4.2.5. LSU FACES Laboratory observed no antemortem¹ nor perimortem² trauma on the remains. Observed postmortem damage was consistent with sharp trauma caused by animal scavenging.

4.2.6. Samples from the remains were extracted for DNA analysis by FACES personnel and submitted to the Louisiana State Police Crime Laboratory on December 6, 2021. Deckhand 2's familial DNA samples were submitted for comparison to the remains. On February 8, 2022, the remains were positively identified as belonging to Deckhand 2.

4.2.7. Drug and alcohol testing was unable to be performed on Deckhand 2's remains.

4.2.8. A Death Certificate for Deckhand 2 was issued by the State of Louisiana on March 14, 2022. The manner and cause of death were undetermined.

¹ Antemortem means occurring before death.

² Perimortem means occurring at or near the time of death.

4.3. Vessel Features and Applicable Federal Regulations

4.3.1. The MASTER WAYNE was a side trawling commercial shrimper with port and starboard outriggers. Each outrigger could deploy two drag nets with an additional forward tri-net for surveying and identifying areas with large shrimp concentrations.

4.3.2. The MASTER WAYNE was regulated under 46 CFR Subchapter C, *Uninspected Vessels*, and was not required to hold a Coast Guard Certificate of Inspection (COI). The vessel was under 200 gross tons and therefore was not required to be operated by a master holding a merchant mariner credential issued by the Coast Guard in accordance with 46 CFR Part 15.

4.3.3. In accordance with 46 CFR 28.105, the MASTER WAYNE was required to carry at least one Coast Guard approved personal flotation device (PFD) for each person onboard. The PFDs were required to be readily accessible from each person's normal workstation and berthing area. The PFDs onboard the MASTER WAYNE were located under bunks in the cabin and in the wheelhouse. The crew did not normally wear PFDs while on deck.

4.4. Crewmember Experience

4.4.1. Deckhand 2 had been working on the MASTER WAYNE for approximately six weeks. The trip at the time of the incident was his fifth fishing trip onboard the MASTER WAYNE.

4.4.2. The Captain had approximately 36 years of experience working on fishing vessels. This was the Captain's second trip with Deckhand 2. Deckhand 1 had completed several previous trips working with Deckhand 2.

4.4.3. Deckhand 2 was known to enjoy working as a commercial fisherman and being out on the water. The crewmembers got along with each other and did not report any significant disagreements.

5. Analysis

5.1. *Undetermined cause.* Deckhand 2 was last seen with a backpack on the aft deck of the vessel. The Captain and Deckhand 1 both asked what Deckhand 2 was doing when they saw him with the backpack noting that it was out of the ordinary. However, Deckhand 2's responses to their inquiries did not give cause for concern. Approximately one hour passed before the Captain and Deckhand 1 realized that Deckhand 2 was no longer onboard the vessel. It was later determined that Deckhand 2 did enter the water based on the discovery of two bones with DNA matching the missing deckhand along the shoreline of Grand Isle State Park. During its investigation, the Plaquemines Parish Sheriff's Office found insufficient evidence indicating a physical altercation, foul play, or criminal activity on board the vessel. LSU FACES Laboratory observed no antemortem nor perimortem trauma on the remains. Due to the inability to locate the complete remains of Deckhand 2, the investigation could not determine if drugs and/or

alcohol were in Deckhand 2's system at the time of the incident. The cause and manner of death could not be determined by Jefferson Parish Coroner's Office. Due to the lack of eyewitness observations and physical evidence, the investigation could not determine a definitive cause as to why Deckhand 2 entered the water, and whether it was intentional or accidental. Therefore, while the Coast Guard did not discover evidence of criminal activity or intent as a causal factor, it also cannot be ruled out. However, the vessel's Captain told investigators that both deckhands liked to climb up onto the rigging to hang out during a trawl, a practice that the Coast Guard would consider to be potentially hazardous. Additionally, photographic evidence found on Deckhand 2's cell phone by the Plaquemines Parish Sheriff's Office showed Deckhand 2 occasionally engaged in daring behavior, such as climbing into and loitering in the vessels rigging while underway. This evidence, combined with cross industry data available on common causes of marine casualties, means that a slip, trip, or fall overboard also cannot be ruled out.

5.2. *Delay in notification to Coast Guard.* Approximately one hour after the last sighting of Deckhand 2, the Captain yelled to Deckhand 1 to get ready to pick up the nets. Deckhand 1 went to look for Deckhand 2 in the forward hold but returned a short while later, informing the Captain that Deckhand 2 was missing. The Captain and Deckhand 1 then proceeded to pull in the nets and search the vessel for another 20 minutes. The Captain's first call concerning the man overboard was to the owner of the vessel. The Captain then proceeded to turn the vessel on a reciprocal course before notifying the Coast Guard on VHF channel 16. Had the Captain notified the Coast Guard upon Deckhand 1's initial report that Deckhand 2 was missing, it is likely that the search and rescue operations would have commenced earlier, which may have increased the likelihood of finding Deckhand 2 prior to his death.

5.3. *Failure to request assistance from vessels in the vicinity.* Once the Captain turned the vessel onto a reciprocal course, he noted several other vessels in the immediate vicinity of where he presumed Deckhand 2 went overboard. The Captain did not make any attempt to directly hail the vessels on the radio or by other means. Had the Captain made efforts to contact the other vessels and inform them of the situation, it is possible that the other vessels would have provided immediate assistance in the search for Deckhand 2. This additional assistance may have increased the likelihood of finding Deckhand 2, prior to his death.

5.4. *Failure to use personal floatation device.* The *Master Wayne* had PFDs onboard that were stowed in a location accessible to the crew. Although the crew had access to the PFDs, they did not normally wear the PFDs while working on the vessel's deck. PFDs provide extra buoyancy to keep a person's head above water and prevent drowning. Deckhand 2 was last seen on the aft deck wearing only a t-shirt. Although the cause and manner of Deckhand 2's death was undetermined, if Deckhand 2 had been wearing a PFD, the probability of death by drowning would have been reduced. Additionally, the use of a PFD may have increased the likelihood of the search and rescue locating Deckhand 2.

6. **Conclusions**

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty occurred when Deckhand 2 entered the water. The causal factor contributing to this event was undetermined.

6.1.2. The entry of Deckhand 2 into the water resulted in the subsequent next event, which was Deckhand 2's loss of life. The causal factors contributing to this event were:

6.1.1.1. Delay in notification to Coast Guard.

6.1.1.2. Failure to request assistance from vessels in the vicinity.

6.1.1.3. Failure to use personal floatation device.

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: The Coast Guard did not discover any evidence indicating any 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 any U.S. Coast Guard Personnel or any other person: The Coast Guard did not discover any evidence of act(s) or violation(s) of law by any U.S. Coast Guard personnel, or any other person were identified as part of this investigation.

6.4. Evidence of Act(s) Subject to Civil Penalty: The Captain of the F/V MASTER WAYNE failed to make immediate notification to the Coast Guard of a hazardous condition in violation of 33 CFR 160.216.

6.5. Evidence of Criminal Act(s): The Coast Guard did not discover any evidence of violations of criminal law as part of this investigation.

6.6. Unsafe Actions or Conditions that Were Not Causal Factors: The Coast Guard discovered evidence that the deckhand occasionally engaged in dangerous behavior such as climbing into and loitering in the rigging while the vessel was underway and/or engaged in fishing. However, the Coast Guard did not discover evidence that this behavior was directly involved in, nor a causal factor to the incident.

6.7. Actions Taken Since the Incident: Since the date of the incident, Coast Guard Sector New Orleans has completed 198 Commercial Fishing Vessel Examinations and 95 marine casualty investigations on board commercial fishing vessels in Southeast Louisiana in an effort to identify safety issues and prevent further loss of life.

7. **Recommendations**

7.1 Safety Recommendations:

7.1.1. There was no proposed action to add new or amend existing U.S. laws or regulations, international requirements, industry standard, or U.S. Coast Guard policies and procedures as part of this investigation.



CDR Chad A. Yeamans
U.S. Coast Guard
Senior Investigating Officer