UNITED STATES COAST GUARD

REPORT OF THE INVESTIGATION

INTO THE

MAN OVERBOARD WITH LOSS OF LIFE ON THE TOWING VESSEL CHERYL STEGBAUER (O.N. 568268) AT LOCK AND DAM 25, MILE MARKER 241.5 ON THE UPPER MISSISSIPPI RIVER NEAR WINFIELD, MO ON DECEMBER 11, 2022

MISLE ACTIVITY NUMBER: 7608546

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

Commandant
United States Coast Guard

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16732/IIA #7608546
29 May 2025

FALL OVERBOARD FROM THE INSPECTED TOWING VESSEL CHERYL STEGBAUER (O.N. 568268) AND SUBSEQUENT LOSS OF ONE LIFE WHILE TRANSITING THROUGH LOCK AND DAM 25 AT MILE MARKER 241.5 ON THE UPPER MISSISSIPPI RIVER NEAR WINFIELD, MISSOURI ON DECEMBER 11, 2022

ACTION BY THE COMMANDANT

The record and the report of the investigation completed 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. This marine casualty investigation is closed.

ACTION ON RECOMMENDATIONS

Administrative Recommendation 1: It is recommended that this case be referred to Sector Upper Mississippi River, Marine Investigations for potential Suspension & Revocation against the Pilot for violation of Title 46 Code of Federal Regulations Part 4.05-1, Notice of Marine Casualty for failure to report a grounding on December 9, 2022.

> **Action:** I concur with this recommendation. U.S. Coast Guard Sector Upper Mississippi River conducted an enforcement investigation into the violations identified during the marine casualty investigation and took appropriate administrative action against the responsible party.

Administrative Recommendation 2: It is recommended that the Officer in Charge, Marine Inspection of Sector Upper Mississippi River direct the Third-Party Oversight Coordinator to conduct an audit of Sabine Surveyors LTD and Southern Duval, formally known as Southern Towing Company, L.L.C. at the time of the incident, to verify compliance with the training requirements under Title 46 Code of Federal Regulations Part 140.515, internal surveys are being conducted appropriately, and any unsafe practices are corrected.

> **Action:** I concur with the recommendation. U.S. Coast Guard Sector Upper Mississippi River's Third-Party Oversight Coordinator completed an audit of the CHERYL STEGBAUER's Third-Party Organization as directed by the unit's Officer in Charge, Marine Inspection.

[redacted]

E. B. SAMMS
Captain, U.S. Coast Guard
Chief, Office of Investigations & Casualty Analysis (CG-INV)

U.S. Department of Homeland Security

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16732

APR 15 2025

MAN OVERBOARD WITH LOSS OF LIFE ON THE TOWING VESSEL CHERYL STEGBAUER (O.N. 5682680 AT LOCK AND DAM 25, MILE MARKER 241.5 ON THE UPPER MISSISSIPPI RIVER NEAR WINFIELD, MO ON DECEMBER 11, 2022

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 deckhand was a tragic and preventable accident. I offer my sincere condolences to the friends and family of the deckhand who lost their lives.

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

[redacted]

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

U.S. Department of Homeland Security
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16732
October 28, 2024

MAN OVERBOARD WITH LOSS OF LIFE ON THE TOWING VESSEL CHERYL STEGBAUER (O.N. 568268) AT LOCK AND DAM 25, MILE MARKER 241.5 ON THE UPPER MISSISSIPPI RIVER NEAR WINFIELD, MO ON DECEMBER 11, 2022

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.

ENDORSEMENT ON RECOMMENDATIONS

Administrative Recommendation 1: It is recommended that this case be referred to Sector Upper Mississippi River, Marine Investigations for potential Suspension & Revocation against the Pilot for violation of 46 CFR §4.05-1, Notice of Marine Casualty for failure to report a grounding on December 09, 2022.

> **Endorsement:** I concur with this recommendation. Possible failure to report a marine casualty is a serious offense and a basic requirement of both vessel operators and marine employers. When failing to report these incidences, it limits the U.S. Coast Guard's ability to work with the maritime industry to correct and prevent future incidences from occurring.
>
> **Action:** Direct Marine Inspectors and Marine Casualty Investigators within the Prevention Department to outreach and educate industry personnel on proper marine casualty reporting requirements. In addition, the Marine Investigations Division shall evaluate this case for Suspension and Revocation and follow up as appropriate.

Administrative Recommendation 2: It is recommended that the Officer in Charge, Marine Inspection of Sector Upper Mississippi River direct the Third-Party Oversight Coordinator to conduct an audit of Sabine Surveyors LTD and Southern Devall, formally known as Southern Towing Company, LLC at the time of the incident to verify compliance with the training requirements under 46 CFR 140.515, internal surveys are being conducted appropriately, and any unsafe practices are rectified.

Endorsement: I concur with the intent of this recommendation.

Action: I direct attendance of SOUTHERN DEVALL LLC's next mid-period company management audit by SUMRs' Third-Party Oversight Coordinator (TPOC), as an audit observer. Prior to the audit, SUMR's TPOC should contact Owner / Managing Operator (OMO)'s Third Party Organization (TPO), Towing Vessel Inspection Bureau (TVIB), to discuss outstanding concerns that were not addressed during the OMO's internal audit subsequent to the casualty, further outlined in the ROI's findings. During the audit, the OMO's TSMS elements should be sampled as they relate to internal surveyor and auditor training/experience review, verifying mariner credentials and documentation, marine casualty reporting requirements, drug and alcohol testing policy and procedures, crew training for TSMS compliance and new hire shadowing assignments. The direct TSMS elements to be focused on relating to the outstanding concerns above include 46 CFR 138.220 (a) - Administration and Management Organization; 138.220(b) - Personnel; 138.220 (c) - Verification of vessel compliance; and 138.220 (d) – Compliance with this subchapter.

[redacted]

A. R. BENDER
Captain, U.S. Coast Guard
Officer in Charge, Marine Inspection

U.S. Department of Homeland Security

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16732
January 8, 2024

MAN OVERBOARD WITH LOSS OF LIFE ON THE TOWING VESSEL CHERYL STEGBAUER (O.N. 568268) AT LOCK AND DAM 25, MILE MARKER 241.5 ON THE UPPER MISSISSIPPI RIVER NEAR WINFIELD, MO ON DECEMBER 11, 2022

EXECUTIVE SUMMARY

In the midafternoon on December 11, 2022, the U.S. flagged inspected towing vessel (ITV) CHERYL STEGBAUER was locking through, up bound, at Lock and Dam 25 on the Upper Mississippi River (UMR) at mile marker (MM) 241.5 near Winfield, MO, when Crewmember 3 fell overboard.

The CHERYL STEGBAUER was pushing 02 loaded tank barges (CF-102-T, O.N. 502773 and A-1, O.N. 699680) upriver in tandem at Lock and Dam 25. After entering the lock, Crewmember 1 and Crewmember 2 were responsible for breaking tow and securing the barges port side to the lock wall. Crewmember 3, while still learning his new deckhand position, shadowed Crewmember 2 in these operations. After the 02 barges were secured via bow and stern lines, Crewmember 1 reported to the bow line on the barge CF2-102-T while Crewmember 2 and Crewmember 3 were responsible for breaking the CHERYL STEGBAUER from the tow at the stern end of barge A-1 and securing the towing vessel via a single working line from the port bow of the towing vessel to the starboard side of the A-1. This arrangement positioned the CHERYL STEGBAUER at a slight angle, commencing from the port bow corner and widening towards the stern. This single line also allowed for natural drift and movement of the CHERYL STEGBAUER.

After Crewmember 2 and Crewmember 3 secured the CHERYL STEGBAUER with the working line, Crewmember 2 instructed Crewmember 3 to remain on the CHERYL STEGBAUER while Crewmember 2 returned to man the stern line of the A-1. Crewmember 3 asked to follow along to learn and Crewmember 2 obliged. Crewmember 2 crossed from the port bow of the CHERYL STEGBAUER onto the A-1 and waved to Crewmember 3 to step over onto the barge. In his attempt to cross over to the barge, Crewmember 3 fell overboard into the water between the angled opening of the CHERYL STEGBAUER and A-1. Crewmember 2 immediately attempted to pull Crewmember 3 up onto the deck.

The drifting motion of the CHERYL STEGBAUER resulted in Crewmember 3 being crushed between the port bow of the CHERYL STEGBAUER and A-1. Crewmember 3 then lost consciousness. While he held onto Crewmember 3, Crewmember 2 used his free hand to report the man overboard to the Pilot who sounded the General Alarm and made emergency calls. Crewmember 1 heard this radio report and made his way aft to Crewmember 2 and Crewmember 3 to assist.

While the vessel was still attached to the A-1 via the working line, the Pilot maneuvered the CHERYL STEGBAUER to make enough space to safely remove Crewmember 3 from the water. At the same time, Crewmember 1 tried to remove the working line to allow the CHERYL STEGBAUER to move completely out of the way.

Four off-watch crewmembers heard the General Alarm and came to the port bow deck of the CHERYL STEGBAUER to assist. Crewmember 2 was unable to keep his hold and Crewmember 3 was briefly adrift in the water until retrieved by the off-watch crewmembers. The working line was released, the off-watch crewmembers brought Crewmember 3 onboard, and the CHERYL STEGBAUER maneuvered to the opposite lock wall where first aid and CPR was performed until first responders arrived. First responders declared Crewmember 3 deceased on-scene.

Through its investigation, the Coast Guard determined the initiating event to be Crewmember 3 falling into the water which resulted in his injuries that led to his death. Casual factors contributing to this casualty were: 1) failure of the CHERYL STEGBAUER to have the proper procedure or policy for determining crew assignment for new hires, 2) failure of Crewmember 2 to follow company policy that prohibited the crossing between vessels over open water, 3) failure of Crewmember 3 to follow company policy that prohibited the crossing over open water, and 4) Crewmember 3 did not know how to swim.

U.S. Department of Homeland Security

United States Coast Guard

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16732
January 8, 2024

MAN OVERBOARD WITH LOSS OF LIFE ON THE TOWING VESSEL CHERYL STEGBAUER (O.N. 568268) AT LOCK AND DAM 25, MILE MARKER 241.5 ON THE UPPER MISSISSIPPI RIVER NEAR WINFIELD, MO ON DECEMBER 11, 2022

INVESTIGATING OFFICER'S REPORT

1. Preliminary Statement

1.1. This marine casualty investigation was conducted and this report was submitted in accordance with Title 46, Code of Federal Regulations (CFR), Subpart 4.07, and under the authority of Title 46, United States Code (USC) Chapter 63.

1.2. No other organizations assisted in this investigation.

1.3. The owner/operator of the CHERYL STEGBAUER, Southern Towing Company, L.L.C. was designated as a Party in Interest to this investigation.

1.4. All times listed in the report are in Central Standard Time, using a 24-hour format, and are approximate. The Incident Investigation Activity Number is 7608546.

2. Vessel Involved in the Incident

Figure 1. Post incident photograph of the CHERYL STEGBAUER taken on December 12, 2022, by USCG.

Official Name:	CHERYL STEGBAUER
Identification Number:	O.N. 568268
Flag:	United States
Vessel Class/Type/Sub-Type	Towing Vessel/General/General
Build Year:	1975
Gross Tonnage:	390 GT
Length:	114.5 feet
Beam/Width:	35 feet
Draft/Depth:	8.5 feet
Main/Primary Propulsion: (Configuration/System Type, Ahead Horsepower)	Medium speed diesel, Diesel, 3,600 HP
Owner:	Southern Towing Company LLC Memphis, TN / United States
Operator:	Southern Towing Company, LLC Memphis, TN / United States

Figure 2. Post incident photograph of the CHERYL STEGBAUER and A-1 barge taken on December 12, 2022, by USCG.

Official Name:	A-1
Identification Number:	O.N 699680
Flag:	United States
Vessel Class/Type/Sub-Type	Barge/Bulk Liquid Cargo Tank Barge/Liquid Chemical Cargo Barge
Build Year:	1966
Gross Tonnage:	1,803 GT
Length:	295 feet
Beam/Width:	52 feet
Draft/Depth:	14 feet
Main/Primary Propulsion: (Configuration/System Type, Ahead Horsepower)	N/A
Owner:	Southern Towing Company, LLC Memphis, TN / United States
Operator:	Southern Towing Company, LLC Memphis, TN / United States

3. Deceased, Missing, and/or Injured Persons

Relationship to Vessel	Sex	Age	Status
Crewmember 3	Male	20	Deceased

4. Findings of Fact

4.1. The Incident:

4.1.1. On December 11, 2022, at 1400, the ITV CHERYL STEGBAUER (O.N. 568268) was underway, transiting upriver, pushing two loaded tank barges near MM 241.5 on the UMR. The tow was configured in a single string with the tank barge CF-102-T (O.N.

502773) at the head, the tank barge A-1 (O.N. 699680) behind it with the CHERYL STEGBAUER pushing the tow. The overall length of tow and ITV was 707 feet.

4.1.2. The vessel had ten personnel onboard; six Coast Guard credentialed mariners and four unlicensed crewmen. These made up two watch sections: a front watch (0600-1200 and 1800-0000) and aft watch (0000-0600 and 1200-1800). The front watch (off watch at the time of the subject incident) consisted of the Master, Steersman, Off Watch Crewmember 1, Off Watch Crewmember 2, and Off Watch Crewmember 3. The aft watch consisted of the Pilot, Crewmember 1, and Crewmember 3. The Engineer and Crewmember 2 could operate within both watches in an "on call" status.

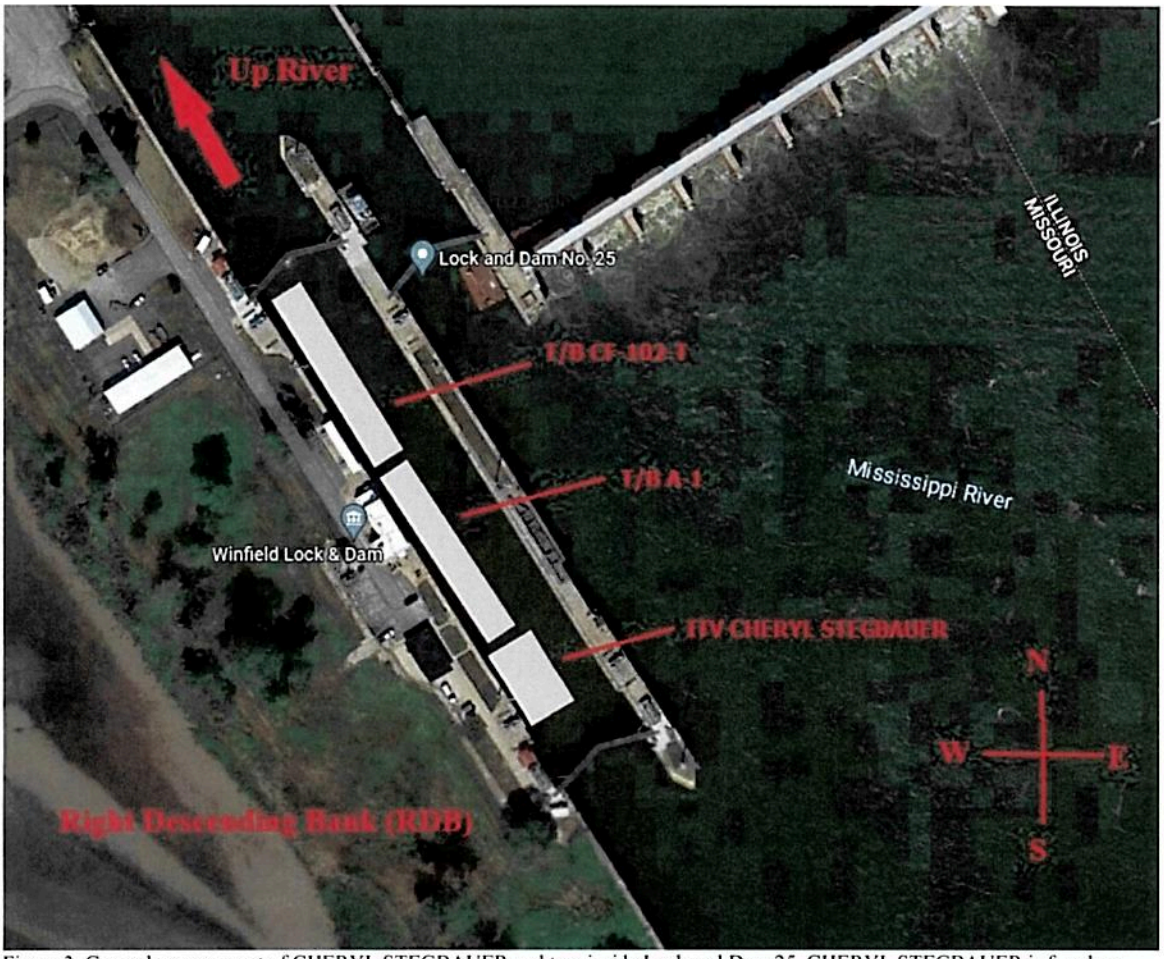

Figure 3. General arrangement of CHERYL STEGBAUER and tow inside Lock and Dam 25. CHERYL STEGBAUER is faced-up to the A-1 heading upriver. Vessels not to scale.

4.1.3. At 1445, the Pilot began his approach to Lock and Dam 25 at MM 241.5 on the UMR. Due to the lock chamber length (600 feet) and overall length (707 feet), the CHERYL STEGBAUER had planned to break tow to lock all vessels through in one evolution.

4.1.4. Crewmembers 1, 2, and 3 were on watch with the Pilot. As a new hire, Crewmember 3 was assigned to shadow Crewmember 2 by the Master.

4.1.5. At 1500, the Pilot maneuvered the CHERYL STEGBAUER into Lock and Dam 25 to prepare for lockage. Crewmember 2 and Crewmember 3 manned the stern line on

the stern of the barge A-1 while Crewmember 1 manned the bow line on the bow of barge CF-102-T. Crewmember 3 was wearing a serviceable Type-V work vest.

4.1.6. At 1503, after securing the stern line of the A-1 to the lock wall, Crewmember 2 and Crewmember 3 removed the facing lines from the A-1 to the CHERYL STEGBAUER, left the stern line, boarded the CHERYL STEGBAUER, and stood by on the bow in preparation to come alongside the A-1.

4.1.7. At 1504, after un-facing, the Pilot maneuvered the CHERYL STEGBAUER alongside the A-1 with Crewmember 2 and Crewmember 3 on the bow who were standing by to secure a working line between the two vessels.

4.1.8. At 1507, after coming alongside, Crewmember 2 and Crewmember 3 began securing the working line from the port bow cavel of the CHERYL STEGBAUER to the 5th cavel from the bow of the A-1. Once made off, there was approximately 4 feet of slack in the line.

4.1.9. At 1507, the Lock Operator for Lock and Dam 25 was in the lock operation booth at the south miter gate. He began the lock evolution, and the miter gate began to close.

4.1.10. After securing the working line with approximately 4 feet of slack, Crewmember 2 notified the wheelhouse that the line was made off and instructed Crewmember 3 to remain onboard the CHERYL STEGBAUER while Crewmember 2 returned to man the A-1 stern line. However, Crewmember 3 requested to shadow Crewmember 2 to learn more about the lock evolution. Crewmember 2 obliged.

4.1.11. Approximately 4 feet of slack in the working line allowed the CHERYL STEGBAUER to drift about while alongside the A-1.

4.1.12. Crewmember 2, without notifying the wheelhouse, crossed over from the port bow of the ITV CHERYL STEGBAUER to the A-1. There was no gap between the vessels.

4.1.13. Due to the approximate 4 feet of slack in the working line and natural drift/movement of the floating towing vessel, the bow of the CHERYL STEGBAUER was drifting away from the A-1 barge.

4.1.14. After crossing onto the A-1, Crewmember 2 waved to Crewmember 3 to cross over onto the A-1.

4.1.15. At 1508, Crewmember 3 approached the edge of the port bow and attempted to cross onto the A-1 barge. In doing so, he fell overboard in between the port side of the CHERYL STEGBAUER and the A-1.

4.1.16. Crewmember 2 immediately dropped to the deck of the A-1 barge, grabbed the hand of Crewmember 3, and attempted to pull him from the water.

4.1.17. The bow of the CHERYL STEGBAUER drifted towards the A-1 barge and crushed Crewmember 3. Crewmember 3 lost consciousness while still in the grip of Crewmember 2.

4.1.18. With his free hand, Crewmember 2 reported the man overboard via handheld radio.

4.1.19. After the Pilot received the man overboard report, he sounded the general alarm and then exited the wheelhouse to observe and evaluate the situation. He then returned to the operating station and attempted to maneuver the vessel away from Crewmember 3.

4.1.20. At 1509, the lock and dam south miter gate closed, the Lock Operator in the booth began to raise the water in the lock chamber, and then headed towards the Lock House.

4.1.21. While the Lock Operator returned to the Lock House, he heard the CHERYL STEGBAUER's general alarm sounding. As soon as the Lock Operator entered the Lock House, he and the Shift Chief heard the radio report of a man overboard from the Pilot and notified emergency responders.

4.1.22. Crewmember 2 lost his grip of Crewmember 3. Crewmember 3 was adrift and floated between the CHERYL STEGBAUER and the A-1 barge. Crewmember 2 yelled for help.

4.1.23. The Off Watch Steersman was the first to arrive at the muster station on the CHERYL STEGBAUER's bow. The Off Watch Steersman heard Crewmember 2 yell that there was a man overboard and immediately went to assist Crewmember 3.

4.1.24. The Off Watch Crewmember 1 arrived at the muster station on the CHERYL STEGBAUER bow. He saw the Off Watch Steersman on the deck and immediately assisted the Off Watch Steersman.

4.1.25. The Off Watch Steersman now had hold of Crewmember 3, still in the water off the port bow and was now joined by Off Watch Crewmember 1 in trying to get Crewmember 3 onboard the CHERYL STEGBAUER.

4.1.26. At 1510, after Crewmember 1 heard the man overboard reports via hand-held radio, he arrived on scene from manning the bow line of the forward barge and began to remove the working line and free the CHERYL STEGBAUER to maneuver.

4.1.27. The Engineer arrived on scene to assist.

4.1.28. Crewmember 1 removed the working line between the CHERYL STEGBAUER and the A-1. The Pilot maneuvered the CHERYL STEGBAUER to the opposite lock wall. Crewmember 1 and Crewmember 2 remained on the starboard deck of the A-1 and watched the efforts of the Off Watch Crewmembers onboard the CHERYL STEGBAUER.

4.1.29. Off Watch Steersman and Off Watch Crewmember 1 had difficulty bringing Crewmember 3 aboard and believed it would be easier to retrieve Crewmember 3 from the water and into the skiff. The Engineer departed the scene to launch the skiff.

4.1.30. At 1511, Off Watch Crewmember 2 arrived on scene to assist Crewmember 3.

4.1.31. The Pilot maneuvered the CHERYL STEGBAUER against the opposite lock wall. The Off Watch Steersman, the Off Watch Crewmember 1, and Off Watch

Crewmember 2 held onto Crewmember 3 and tried to get him aboard as the vessel was maneuvered.

4.1.32. Off Watch Crewmember 1 departed the scene to assist with launching the skiff.

4.1.33. At 1512, the Shift Chief and Lock Operator departed the Lock House in carts to assist.

4.1.34. Off Watch Crewmember 3 arrived on scene to assist the Off Watch Steersman and the Off Watch Crewmember 2 as they attempted to pull Crewmember 3 aboard.

4.1.35. At 1514, the Off Watch Steersman, Off Watch Crewmember 2, and Off Watch Crewmember 3 successfully brought Crewmember 3 onboard the port side main deck of the CHERYL STEGBAUER. Initial first aid by Off Watch Crewmember 3 identified Crewmember 3 was not breathing and had no pulse.

4.1.36. The Off Watch Steersman, Off Watch Crewmember 2, and Off Watch Crewmember 3 removed the work vest and shirt from Crewmember 3 in order to perform cardiopulmonary resuscitation (CPR).

4.1.37. After Off Watch Steersman and Off Watch Crewmember 3 brought Crewmember 3 onboard, Off Watch Crewmember 1 terminated launching the skiff and returned to the port side main deck to assist. The skiff was never deployed into the water.

4.1.38. At 1515, the Off Watch Steersman and Off Watch Crewmen performed CPR on Crewmember 3. CPR continued by the Off Watch Crewmen until later relieved by emergency first responders.

4.1.39. The Master arrived on scene to assist.

4.1.40. At 1517, lock and dam personnel delivered an AED (automated external defibrillator) to the Master.

4.1.41. At 1518, the crew applied the AED to Crewmember 3. The AED provided prompts for operation. No shocks were delivered by the AED and instructions to continue CPR were provided and followed.

4.1.42. At 1540, emergency responders arrived on scene and began first aid efforts.

4.1.43. At 1602, emergency responders declared Crewmember 3 deceased.

4.1.44. At 1650, Crewmember 1 and Crewmember 2 departed the A-1 and returned to the CHERYL STEGBAUER via the 02 deck.

4.1.45. At 1700, the Pilot, Crewmember 2 and Crewmember 3 were subject to mandatory chemical testing for evidence of drug and alcohol use in accordance with 46 CFR Subpart 4.06. Crewmember 3 was not tested for drugs due to insufficient sample quantity. All test results were negative.

4.1.46. The Master did not know how to record alcohol test results and later submitted a statement attesting to alcohol testing.

4.1.47. On December 17, 2022, a coroner conducted an examination of Crewmember 3. The manner of death was declared as accidental and cause of death was multi system trauma crush injury.

4.2. Additional/Supporting Information:

4.2.1. *Southern Towing Company, LLC Operations and Policies.*

4.2.1.1. On December 11, 2022, the CHERYL STEGBAUER was an ITV owned and operated by Southern Towing Company, LLC. The Certificate of Inspection required a minimum of four crewmembers that included one licensed Master, one licensed Mate (Pilot), and two Deckhands for 24-hour operation. The CHERYL STEGBAUER was authorized to operate on Rivers routes and utilization of third-party oversight for compliance with Subchapter M. The CHERYL STEGBAUER utilized the Southern Towing Operating Procedures (STOP) Manual to comply with Towing Safety Management System (TSMS) requirements within Subchapter M.

4.2.1.2. The Fall Overboard Prevention and Protection (SAF-22-1) portion of the STOP Manual applicable to the CHERYL STEGBAUER prohibited crewmembers from crossing over open water and required deck crew to maintain frequent radio contact with the wheelhouse. However, there was no requirement for deck crew to notify the wheelhouse when embarking/disembarking the vessel.

4.2.2. On December 11, 2022, Crewmembers 1, 2, and 3 submitted to post casualty alcohol testing. The Master did not know how to record the test results and later submitted a statement attesting to the alcohol tests. On December 15, 2022, a Report of Mandatory Chemical Testing Following a Serious Marine Incident Involving Vessels in Commercial Service (CG-2692B) was submitted but was not factually accurate because Crewmember 1 was not listed as to having an alcohol test on the CG-2692B. The company representative denied Crewmember 1 was administered an alcohol test even though Crewmember 1 and the crewmembers stated Crewmember 1 took an alcohol test the day of the incident. An opportunity to submit a corrected CG-2692B was made, but no corrected form was submitted.

4.2.3. On November 23, 2022, a man overboard drill was conducted onboard the CHERYL STEGBAUER. Neither Crewmember 2 nor Crewmember 3 participated in this drill.

4.2.4. *Crew Composition and Experience.*

4.2.4.1. The Pilot held a Coast Guard credential since approximately February of 1976 and operated vessels for numerous companies all within the Western Rivers. For approximately the last 11 years, the Pilot worked solely for Southern Towing Company, LLC. After retiring, the Pilot worked for Southern Towing Company, LLC on contract for the 4 years preceding this incident. At the time of the incident, the Pilot on watch did not have the proper endorsement on his credential for operating a towing vessel on the Western Rivers. Southern Towing was designated as the Third-Party Administrator for this credential. This detail was acknowledged as an error committed by the National Maritime Center and was corrected.

4.2.4.2. On July 1, 2022, Crewmember 2 applied and was hired for the entry level deckhand position for Southern Towing. Crewmember 2 also completed all new hire training requirements. On November 25, 2022, Crewmember 2 reported aboard the CHERYL STEGBAUER. The incident occurred on his fourth trip.

4.2.4.3. On November 9, 2022, Crewmember 3 applied and was hired for the inexperienced deckhand position for Southern Towing. Crewmember 3 also completed all new hire training requirements. On November 14, 2022, Crewmember 3 participated in Southern Towing's new hire orientation. This orientation included training on STOP MANUAL, SAF 22-1 Man/Fall Overboard Prevention and Protection, which prohibited the crossing over open water. On December 9, 2022, Crewmember 3 reported aboard the CHERYL STEGBAUER. Crewmember 3 also completed the Vessel Orientation Checklist with Crewmember 1 as required by the vessel's STOP Manual. Afterwards, the Master assigned Crewmember 3 to shadow Crewmember 2 for deck operations. Crewmember 3 did not know how to swim. Additionally, Crewmember 3 was approximately 5 feet 10 inches tall and weighed 260 pounds.

4.2.5. *Lock and Dam 25 Operations and Policies.*

4.2.5.1. Lock and Dam 25 had lock operation booths located at both the upper and lower lock gates. The Lock House is located roughly in the middle of both lock gates and the lock can be operated at both lock operation booths and the Lock House.

4.2.5.2. Lock and Dam 25 had emergency procedures and shutdown for man overboard evolutions. However, these procedures were limited to sound signals and specific to falls overboard between vessels and the lock wall. Additionally, the emergency shutdown only de-energized electrical equipment in the lock; it did not have the capability to close valves used to raise/lower the water within the lock chamber.

4.2.6. *Weather Conditions at the Time of Incident.* Weather conditions were overcast, visibility was 9 nautical miles, air temp was 39°F, water temp was 42°F, and winds were out of the Northeast at 6 knots.

4.2.7. *Vessel Conditions at the Time of Incident.* The steep angle of visibility from the Wheelhouse to the port bow created a blind spot for the Pilot over the crossing point on the port bow taken by Crewmember 2 and Crewmember 3 as pictured in Figure 4.

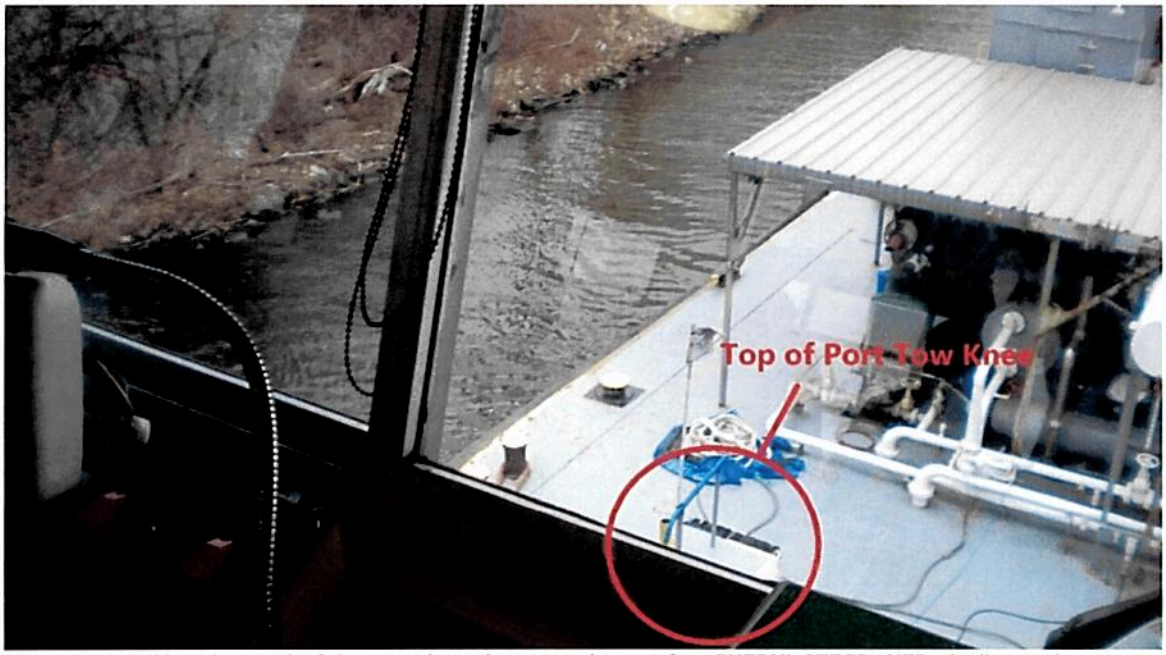

Figure 4. Post incident photograph of view towards port bow (normal stance) from CHERYL STEGBAUER wheelhouse taken on December 12, 2022, by USCG. Only top of port tow knee is visible.

4.2.8. With the CHERYL STEGBAUER alongside the A-1 barge, the difference in deck height between the vessels was approximately 24 inches as pictured in Figure 5.

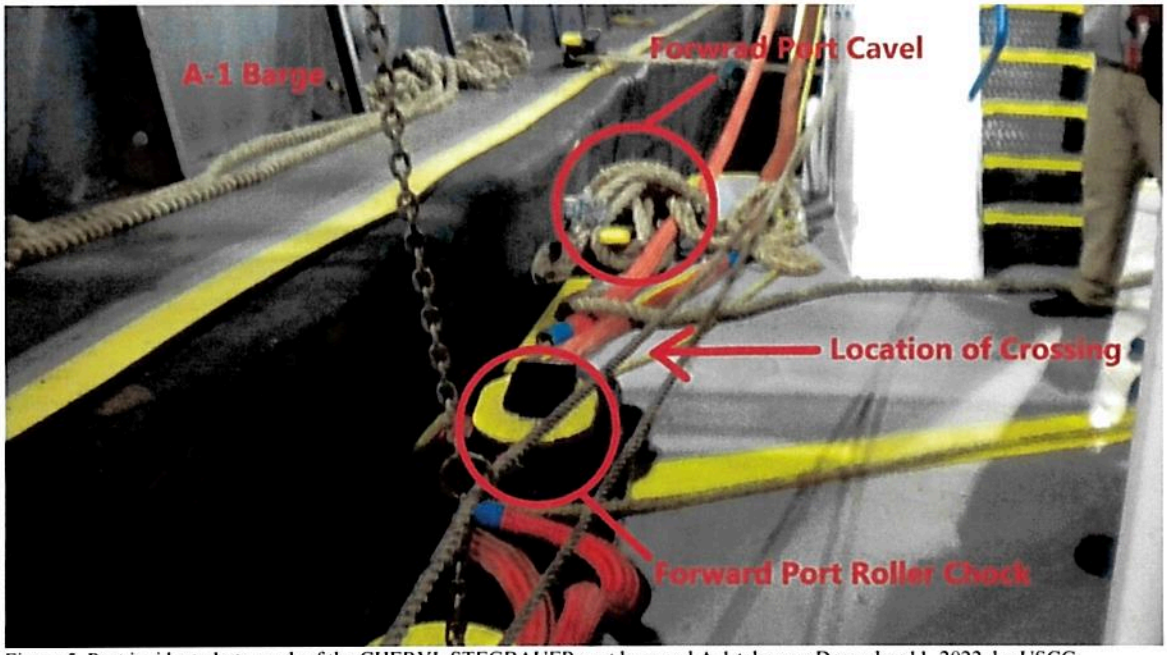

Figure 5. Post incident photograph of the CHERYL STEGBAUER port bow and A-1 taken on December 11, 2022, by USCG.

4.2.9. This mooring arrangement with a slacked single working line from the bow of the CHERYL STEGBAUER to the A-1 allowed for an angled gap between the vessels as pictured in Figure 6. This gap varied as the approximate 4 feet of slack in the working line allowed the CHERYL STEGBAUER to drift about while alongside the A-1.

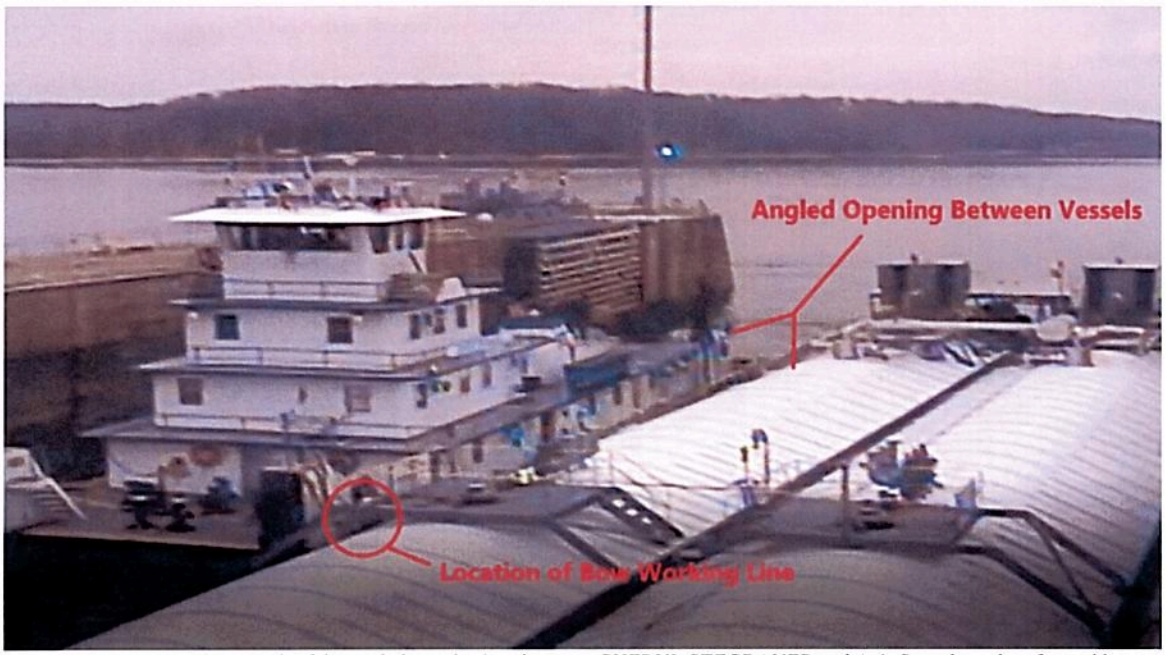

Figure 6. Pre incident photograph of the angled opening/gap between CHERYL STEGBAUER and A-1. Snapshot taken from video on December 11, 2022, by USCG.

4.2.10. The Pilot had difficulty maneuvering away from Crewmember 3 with the working line secured between the CHERYL STEGBAUER and the A-1.

5. Analysis

5.1. *Failure of the CHERYL STEGBAUER to have the proper procedure or policy for determining crew assignment for new hires.* The CHERYL STEGBAUER had no set policy or procedure for deciding how crew assignments for new hires was determined. Crewmember 2 was inexperienced. He was hired as an inexperienced deckhand and completed new hire orientation in July 2022. Crewmember 2 had only three (approximate 28 day) trips worth of experience prior to reporting aboard on November 25, 2022. The vessel Master who assigned Crewmember 3 to shadow Crewmember 2 acknowledged that he did not know Crewmember 2 well. The Master added that his experience with Crewmember 2 consisted of three trips and would have been split between him and his relief Captain. Therefore, assuming they stood the same watch, the Master had roughly six weeks total experience with Crewmember 2. During an interview, Crewmember 2 was uncertain of where the bow of the CHERYL STEGBAUER was located and did not know what the vessel's safety lines were. Without a policy or procedure in place, the discretion to make a decision of assigning a new crewmember shadow is left solely with the Master. In this case, the CHERYL STEGBAUER had no policy or procedure in place to assist the Master with new hire assignments in order to ensure a new crewmember was placed with a responsible trainer. Had the CHERYL STEGBAUER been provided guidance for the Master to follow for new hire crew shadow assignment, Crewmember 3 may not have been assigned to Crewmember 2 and the incident would not have occurred.

5.2. *Failure of Crewmember 2 to follow company policy that prohibited crossing over open water.* Crewmember 2 directed Crewman 3 to cross over the open water between the CHERYL STEGBAUER and A-1 even though he was aware of the STOP Manual Fall Overboard Prevention and Protection policy that prohibited this practice. Crewmember 2 acknowledged and was aware of this policy and failed to comply with it. He believed that the

gap was not a large gap and admitted that he had crossed over similar gaps in the past without incident. Had he not directed Crewmember 3 to do cross between the CHERYL STEGBAUER and A-1, Crewmember 3 may not have fallen overboard and the incident would not have occurred.

5.3. *Failure of Crewmember 3 to follow company policy that prohibited the crossing over open water.* Crewmember 3 decided to follow Crewmember 2's instruction to cross over the open water although he had been trained on the STOP Manual Fall Overboard Prevention and Protection policy that prohibited the crossing over open water. Crewmember 3 was inexperienced and trusted Crewmember 2's instruction and guidance. Had Crewmember 3 not followed Crewmember 2's instruction and not crossed over the open water, he may not have fallen overboard and the incident would not have occurred.

5.4. *Crewmember 3 did not know how to swim.* Crewmember 3 disclosed to some of his fellow crewmembers that he could not swim. Therefore, when Crewmember 3 fell overboard, the likelihood of surviving a fall in the water was drastically reduced. Had Crewmember 3 known how to swim, it's possible he could have swam aft, towards the wider, angled opening between the CHERYL STEGBAUER and A-1 and cleared himself from any pinch point or crushing hazard.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty occurred when Crewmember 3 fell overboard from the port bow deck of the CHERYL STEGBAUER. The causal factor leading to this event was:

6.1.1.1. Failure of the CHERYL STEGBAUER to have the proper procedure or policy for determining crew assignment for new hires.

6.1.1.2. Failure of Crewmember 2 to follow company policy that prohibited the crossing over open water.

6.1.1.3. Failure of Crewmember 3 to follow company policy that prohibited the crossing over open water.

6.1.2. The subsequent event was the crushing of Crewmember 3 between the CHERYL STEGBAUER and A-1. The causal factor leading to this event was:

6.1.2.1. Crewmember 3 did not know how to swim and therefore could not swim to a safer location between the vessels.

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: As indicated below in section 6.7.1 of this report, the Pilot potentially violated 46 CFR §4.05-1, Notice of Marine Casualty. This is addressed in section 8.2.1. of this report.

6.3. Evidence of Act(s) or Violation(s) of Law by U.S. Coast Guard Personnel, or any other person: There was no evidence of any such acts or violations of law by any Coast Guard personnel or other persons.

6.4. Evidence of Act(s) Subject to Civil Penalty: There were no acts or evidence that warrant civil penalty in this investigation.

6.5. Evidence of Criminal Act(s): There were no acts or evidence of criminal activity in this investigation.

6.6. Need for New or Amended U.S. Law or Regulation: This investigation did not identify the need for any new or amended U.S. law or regulation.

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

6.7.1. On December 9, 2022, at 1400, the Pilot logged "BUMPED GROUND ON DEPARTURE" at MM 136 on the UMR in the vessel log for the CHERYL STEGBAUER. This log entry indicated a grounding occurred that was not reported to the Coast Guard. This grounding, although not a causal factor, was unsafe since the incident was not reported. Marine casualties that go unreported can prevent actions by the Coast Guard or other agencies that could prevent future incidents from occurring.

6.7.2. During the lock evolution and after un-facing the A-1 from the CHERYL STEGBAUER, Crewmember 2 left the stern line and A-1 and boarded the bow of the CHERYL STEGBAUER. He rode the vessel to its position alongside the A-1. Leaving the stern entirely unattended while aboard the CHERYL STEGBAUER was unsafe and not common practice. This was not a factor in the casualty because the un-facing evolution occurred prior to the CHERYL STEGBAUER coming alongside the A-1 barge and the deckhands crossing between the vessels.

6.7.3. After successfully bringing Crewmember 3 onboard the CHERYL STEGBAUER, nobody aboard was certified or had formal training in CPR within the previous 2 years. Additionally, nobody on deck had communications with 911 operators to receive CPR instruction. However, due to the internal injuries discovered during the coroner's examination of Crewmember 3, any lifesaving attempts would have been futile.

7. Actions Taken Since the Incident

7.1. Southern Towing Company, LLC has taken a number of actions since the incident. These actions included but were not limited to, a companywide safety stand down that covered high risk operations, vessel embarkation/disembarkation, and man overboard prevention; publication of Safety Bulletin 01-20-23 to remind personnel of hazards associated with crossing from vessel to vessel; updated man overboard training from annual to biannual; expedited the installation of closed circuit video monitoring onboard vessels; increased vessel visits by senior company personnel to evaluate safety and risk management; and audited the New Hire Orientation to find areas of improvement.

7.2. On December 20, 2022, Lock and Dam 25 implemented new operating procedures that required lock operators to initiate communications with vessel operators. These communications would affirm vessel readiness for lock gate closure, securing of vessels and raising/lowering water within the lock. Implementation of these new procedures of communicating all lock operations with vessel operators could help during emergency responses within the lock chamber.

8. Recommendations

8.1. Safety Recommendations:

8.1.1. None.

8.2. Administrative Recommendations:

8.2.1. It is recommended that this case be referred to Sector Upper Mississippi River, Marine Investigations for potential Suspension & Revocation proceedings against the Pilot for violation of 46 CFR §4.05-1, Notice of Marine Casualty for failure to report a grounding on December 09, 2022. (Administrative Recommendation 1)

8.2.2. It is recommended that the Officer in Charge, Marine Inspection of Sector Upper Mississippi River direct the Third-Party Oversight Coordinator to conduct an audit of Sabine Surveyors LTD and Southern Duval, formally known as Southern Towing Company, L.L.C. at the tie of the incident, to verify compliance with the training requirements under 46 CFR 140.515, internal surveys are being conducted appropriately, and any unsafe practices are corrected. (Administrative Recommendation 2)

[redacted]

Chief Warrant Officer
U.S. Coast Guard
Investigating Officer