UNITED STATES COAST GUARD

REPORT OF THE INVESTIGATION

INTO THE

LOUISE S (O.N. 513659) AND RECREATIONAL KAYAK COLLISION WITH LOSS OF LIFE NEAR OHIO RIVER MILE 247 ON JUNE 27, 2024

MISLE ACTIVITY NUMBER: 7946954

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

Commandant
United States Coast Guard

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16732/IIA #7946954
11 April 2025

COLLISION BETWEEN THE INSPECTED TOWING VESSEL LOUISE S (O.N. 513659) AND AN UNREGISTERED KAYAK, RESULTING IN THE LOSS OF ONE LIFE IN THE VICINITY OF MILE 247 ON THE OHIO RIVER NEAR HARTFORD, WEST VIRGINIA ON JUNE 27, 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)

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LOUISE S (O.N. 513659) AND RECREATIONAL KAYAK COLLISION WITH LOSS OF LIFE NEAR OHIO RIVER MILE 247 ON JUNE 27, 2024

ENDORSEMENT BY THE COMMANDER, EIGHTH COAST GUARD DISTRICT

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

COMMENTS ON THE REPORT

1. The loss of the kayaker was a tragic and preventable accident. I offer my sincere condolences to the family and friends of the decedent.

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
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By Direction

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16732
20 November 2024

LOUISE S (O.N. 513659) AND RECREATIONAL KAYAK COLLISION WITH LOSS OF LIFE NEAR OHIO RIVER MILE 247 ON JUNE 27, 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]

C. C. WEISER
Commander, U.S. Coast Guard
Officer in Charge, Marine Inspection
By Direction

Enclosure: Investigating Officer's Report

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

Commanding Officer
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16732
08 November 2024

LOUISE S (O.N. 513659) AND RECREATIONAL KAYAK COLLISION WITH LOSS OF LIFE NEAR OHIO RIVER MILE 247 ON JUNE 27, 2024

EXECUTIVE SUMMARY

On June 27, 2024, at approximately 1330 hours, the operator of a recreational kayak vessel departed his primary residence and traveled to a nearby public boat ramp in Hartford, WV to launch his watercraft. At approximately 1515 hours, the LOUISE S departed Gavin Plant, Chesire, OH, towing (pushing-ahead) fifteen empty hopper barges with eight crew, consisting of one master, one pilot, four deckhands, one engineer, and one ride-along master. The LOUISE S was scheduled to transit to Wheeling, WV, conduct an onload of coal, and return to Gavin Plant.

At approximately 1730 hours, the LOUISE S was transiting upbound Ohio River near mile marker 249 and a scheduled watch relief was initiated for the bridge and deck watch stations. Near the vicinity of Ohio River mile marker 247, the recreational kayaker was operating near the middle of the channel. Approximately fifteen minutes following the initiated watch relief aboard the LOUISE S, nearby witnesses along the riverbank and aboard a recreational vessel made multiple unsuccessful attempts to gain the kayakers attention and give warning of the LOUISE S approaching his position. At approximately 1748 hours, the LOUISE S, unaware of the kayak forward of their position, collided with the kayak. At some point following the collision, the operator of the kayak fell into the water and traveled below the entire length of the tow. Approximately two minutes following the collision, the nearby recreation vessel located and recovered the unresponsive person from the water. The kayaker was transported to awaiting emergency medical services at a nearby public boat ramp and pronounced deceased. The fatality was due to drowning. Following the Coast Guard's notification to the LOUISE S regarding the collision, at approximately 1751 hours, the Master safely moored the towing vessel near mile marker 241.

Through its investigation, the Coast Guard determined the initiating event to be the collision of the LOUISE S and the recreational kayak, subsequently the kayak operator fell into the water and drowned. Causal factors contributing to this casualty were: 1) Failure of the kayaker to maintain situational awareness, 2) Inability to effectively communicate, 3) Inadequate position for towing vessel lookout, 4) Lack of personal floatation device, and 5) Once the collision occurred, there is no defense that would have prevented the kayaker from entering the water.

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LOUISE S (O.N. 513659) AND RECREATIONAL KAYAK COLLISION WITH LOSS OF LIFE NEAR OHIO RIVER MILE 247 ON JUNE 27, 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. The Investigating Office designated the owner LOUISE S at the time of incident, following receipt of request, as a party-in-interest in this investigation. No other 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. Due to this incident involving a loss of life, the Coast Guard Investigative Service (CGIS) was notified and agreed to provide technical assistance as required. West Virginia Department of Natural Resources, West Virginia State Police, and Mason County West Virginia Sheriff's Office responded to the incident and assisted in the investigation.

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

2. Vessels Involved in the Incident

Official Name:	LOUISE S
Identification Number:	Official Number: 513659
Flag:	United States
Vessel Class/Type/Sub-Type	Towing Vessel – Linehaul
Build Year:	1966
Gross Tonnage:	539 GT
Length:	141 feet
Beam/Width:	36 feet
Draft/Depth:	9 feet

Main/Primary Propulsion: (Configuration/System Type, Ahead Horsepower)	Diesel reduction/twin screwed, 4500 HP
Owner:	Campbell Transportation Company, Inc. Houston, Pennsylvania/USA
Operator:	Campbell Transportation Company, Inc. Houston, Pennsylvania/USA

Figure 1. Photo of LOUISE S taken October 5, 2021, courtesy of Campell Transportation Company, Inc. Facebook site.

Official Name:	UNNAMED KAYAK
Identification Number:	W_HAYES
Flag:	United States
Vessel Class/Type/Sub-Type	Recreational/Kayak
Build Year:	Unknown
Model:	Unknown
Length:	Unknown
Beam/Width:	Unknown
Manufacturer:	Unknown
Main/Primary Propulsion: (Configuration/System Type, Ahead Horsepower)	None
Owner/Operator:	[redacted] Middleport, Ohio/USA

3. Deceased, Missing, and/or Injured Persons

Relationship to Vessel	Age	Status
Kayak Operator	51	Deceased

4. Findings of Fact

4.1. The Incident:

4.1.1. On June 27, 2024, at 1330, the operator of the recreational kayak departed his primary residence and transited in his personal vehicle to a public boat ramp to launch his kayak.

4.1.2. At 1500, the LOUISE S was moored at Gavin Plant Ohio River mile marker 258, Chesire, Ohio.

4.1.3. At 1515, the LOUISE S completed their offload procedures and proceeded back underway, heading up river to Wheeling, WV. The LOUISE S was towing (pushing-ahead) fifteen empty barges in a 3x5 configuration. The tow length was approximately 1000 feet.

4.1.4. At 1700, the daily record of climatological observations documented at the nearest NOAA weather station in Parkersburg, WV, observed weather conditions for the day: clear skies, clear visibility, river current approximately was .5 mph.

4.1.5. At 1730, all watch stations aboard the LOUISE S initiated duty watch relief rotation as scheduled. Watch stations included the bridge and deck watch. The bridge watch relief process was approximately 30 minutes, with the Master, Pilot, and an additional licensed Master present on the bridge during the entirety of the watch relief.

4.1.6. At 1745, the LOUISE S was transiting upbound Ohio River near river mile marker 246.

4.1.7. At 1747, a recreational pontoon boat operator operating in the vicinity of Ohio River mile marker 247, noticed LOUISE S and her accompanying tow heading in the direction of the recreational kayaker. The pontoon operator and passengers aboard the pontoon boat attempted to gain the attention of the kayaker, by yelling and waving of arms, to warn of approaching vessel and tow. Moments before collision occurred, the pontoon operator was able to successfully gain the kayaker's attention, but it appeared the kayaker remained unaware of the imminent danger and his own proximity to the vessel and tow.

4.1.8. At 1748, the inspected towing vessel LOUISE S and the recreational kayak collided. The kayaker fell into the water.

4.1.9. At 1750, the kayaker was located and recovered by the nearby recreational pontoon boat operator and accompanying passengers aboard his vessel. During the recovery process, the kayaker was not wearing a personal floatation device (life jacket). He was found unresponsive and had sustained multiple life-threatening injuries.

Cardiopulmonary resuscitation (CPR) was not performed by any person aboard the recreational pontoon boat.

4.1.10. Following an emergency phone call to 911 from an on-scene witness, U.S. Coast Guard contacted the LOUISE S via radio, VHF-FM channel 16, to inform the Master of the collision. Unaware the casualty occurred, the crew of the LOUISE S made necessary preparations and moored the vessel to a mooring cell near Ohio River mile marker 241 right descending bank.

4.1.11. At 1807, emergency medical services arrived on-scene for the injured kayaker. The kayaker was found to have succumbed to his injuries and pronounced dead. A medical autopsy later determined drowning was the cause of the death.

4.1.12. The entire crew aboard the LOUISE S, to include the Master, completed post-casualty drug and alcohol testing in accordance with 46 CFR Subpart 4.06. All alcohol and drug test results were negative.

4.2. Additional/Supporting Information:

4.2.1. Campbell Transportation Company, Inc. (CTC) of Houston, PA, was owned by the Stephaich family since the early 1970's. CTC operates eleven line-haul towing vessels on the Allegheny, Monongahela, and Ohio rivers, as well as nine harbor vessels on the upper Ohio River and twenty line-haul vessels in the Gulf region.

4.2.2. The LOUISE S holds a current Certificate of Inspection, issued by the U.S. Coast Guard on January 25, 2021. The last annual survey was conducted on December 08, 2023. The inspection was completed by the vessel's Third Party Organization, Towing Vessel Inspection Bureau. The report detailed one non-conforming condition (missing signage near emergency fuel shut-off) and subsequent corrective action.

4.2.3. The master of the LOUISE S, a licensed master of towing vessels upon the Western Rivers, had fifteen years' experience operating as master of the LOUISE S and similar towing vessels owned and operated by CTC.

4.2.4. The pilot of the LOUISE S, a licensed master of towing vessels upon the Western Rivers, had six years' experience operating as the pilot of the LOUISE S and similar towing vessels owned and operated by CTC. He had an additional twelve years' experience as a licensed pilot of towing vessels upon the Western Rivers.

4.2.5. CTC company policy (VOP-011) states that before relieving the watch, pilothouse personnel coming on watch must take time to learn what is happening and make risk-based decisions on several factors, to include commercial and recreational vessel traffic movement in the area. No significant commercial or recreational traffic density was recorded near Ohio River mile marker 247 around the time of the marine casualty.

4.2.6. CTC company policy (VOP-009) states, regarding lookout duties performed, that vessel Pilot's on watch shall take precautions to appointing a person to perform look-out duties. CTC company policy (ORG-005) stated the Pilot on watch can use a steersman as a lookout, but noted a proper lookout can be the Master or Pilot on watch (only). Company policy also stated the Pilot on watch must maintain a proper lookout (i.e. a

clear, unobstructed view from the steering station) at all times, support can be achieved by using an extra lookout in situations to include operating in areas congested with recreational boats.

4.2.7. The immediate family of the decedent stated he was previously diagnosed with loss of hearing to the point of deafness. Additionally, the family also reported he was diagnosed with [redacted], to include [redacted], both of which were managed under the care of a physician.

4.2.8. U.S. Senate report No. 96-979, dated September 22, 1980, provides additional clarification to the U.S. Coast Guard Navigational Rules of the Road. Specifically, the Senate report identifies those towing vessels with an unobstructed all-round view from the steering station may permit the watch officer to serve as the vessel's designated lookout. The intent of Rule 5 (Lookout) is not to require additional personnel positioned forward on a vessel to act as a lookout, if such act is not required to enhance safety.

4.2.9. U.S. Senate report, previously mentioned in 4.2.8, identifies the confines and constraints of narrow channels or fairways upon the Western Rivers, and the relative inability of larger vessels to maneuver as quickly as small vessels. As such, Rule 9 (b) (Inland), found within the U.S. Coast Guard Navigational Rules of the Road requires vessels of less than 20 meters in length to navigate in such a manner so to not impede the passage of a vessel which can safely navigate only within a narrow channel or fairway.

4.2.10. Ohio Department of Natural Resources (OhioDNR.gov – Boating Hazards on the Ohio River) provides annual statistics regarding commercial traffic along the Ohio River. Additionally, Ohio DNR offers safety advice and best practices to vessel operators transiting near towing vessels and barges.

5. Analysis

5.1. *Failure of the kayaker to maintain operational awareness.*

The operator of the recreational kayak failed to maintain a sufficient level of awareness relating to his proximity and position to surrounding vessel traffic. As mentioned in 4.2.10, Ohio DNR provides guidance and best practices to operators of recreational vessels transiting on the Ohio River. The Ohio River serves as a main shipping lane for commercial traffic and averages more than 150 million tons of cargo annually. Towing vessels pushing barges have limited navigational abilities due to their size, weight, and are often restricted to the shipping lane within the marked channel. A towing vessel pushing-ahead a loaded configuration of barges can take up to two miles to stop their forward momentum. If the kayak operator maintained a consistent lookout and awareness of surrounding vessel traffic, it could have afforded early detection of an approaching vessel and given him the opportunity to transit outside of the navigable channel and avoid collision.

5.2. *Inability to effectively communicate.*

Initial witness reports following the collision, and subsequent statements provided to responding investigators from the descendant's family, provided details to investigators regarding the kayak operator's previously diagnosed loss of hearing (deaf). U.S. Coast Guard Navigation Rule and Regulations Handbook, last amended June 12, 2023, requires every vessel operating upon inland navigable waterways to, always, maintain a proper look-out by sight and hearing to make a full appraisal of their situation and of any risk of collision. Multiple witness accounts from responding good Samaritans stated that upon eventually gaining the attention of the kayaker, without placing their own vessel in danger or proximity to the tow, the kayaker's demeanor appeared uninterested and unconcerned to the alerts, as if he was completely unaware of the approaching vessel. The kayak was never recovered following the collision. It is unknown if the operator was carrying any alternate forms of signaling or communication device. Given the descendant's significant reduced ability to hear, it is reasonable to assume if he could have been able to hear the alerts of distress signals offered by numerous bystanders in the vicinity of the collision, or maintained a greater level of situational awareness, he could have detected the approaching tow near his position and may have had enough time to transit outside of the towing vessel's path.

5.3. *Inadequate position for towing vessel lookout.*

Company policy required the towing vessel pilot on watch to determine the necessity of additional lookouts given external factors (ex. poor weather conditions, increased recreational traffic density). The towing vessel's master deemed the bridge location to be the most prudent location for the lookout at the time of the collision and designated himself as the lookout. Designating the bridge as the primary lookout station and having the pilot on watch as the lookout is a common practice throughout the towing vessel industry and this practice aligns with both the U.S. Coast Guard's Inland Navigation Rules and Regulations Handbook, and beforementioned U.S. Senate report (4.2.8) of ensuring the vessel had a designated lookout. Investigators identified two areas of concern regarding the towing vessel's lookout: (01) Although the designated lookout positioned on the bridge was in accordance with their company's policy, the condition of the pushed tow presented a significant 750 foot blind spot forward of their 1000 foot tow of empty hopper barges (hopper barge is a type of barge commonly designed to transport commodities like coal/steel/rock/dirt). (02) The towing vessel's transit up river consisted of maneuvers around bends in the channel of the Ohio River. Prior to the collision, the pilot on watch failed to reassess the need for placing an additional lookout on the lead barge. It is reasonable to assume if the pilot on watch placed an additional lookout on the lead barge of the towed configuration, that secondary lookout could have provided early warning of recreational traffic around the channel's bend.

Figure 2. Photo of LOUISE S pilot station, taken June 27, 2024, courtesy of USCG Investigator.

5.4. *Lack of personal floatation device.*

Following the immediate recovery of the kayaker from the water, no lifejacket was found secured to his person. Investigators were unable to determine if the kayaker was wearing a lifejacket prior to getting underway or if a donned life jacket was removed prior to or immediately following his fall in the water. If the kayak operator had a properly fitted and secured lifejacket, it could have provided adequate buoyancy and may have assisted in reducing the overall time (approximately two minutes) below the waterline.

5.5. *Defense does not exist.*

Once the collision occurred, there is no defense that would have prevented the kayaker from entering the water. With no reasonable alternate system or safety gear to supplement the gear already in place, it is unlikely an alternate piece of equipment could have been used to prevent the kayaker's fall in the water following the collision.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty occurred when towing vessel collided with the kayak. Causal factors leading to this event were:

6.1.1.1. Failure of the kayak operator to maintain situational awareness of his surrounding and transiting vessel traffic.

6.1.1.2. Inability of the kayak operator to effectively communicate due to a medical disability involving loss of hearing.

6.1.1.3. Failure of the towing vessel Master to designate a secondary look-out.

6.1.2. The kayak operator's unintended water entry resulted in the next event, causing serious injuries as he impacted the steel hull of, likely, multiple barges. Causal factors leading to this event were:

6.1.2.1 There were no additional safeguards or safety system in place to stop or slow his entry into the water following the collision, nor do any safeguards exist that may have mitigated the seriousness of his injuries.

6.1.3. Following the unintended water entry, the kayak operator sustained multiple life-threatening injuries and remained below the waterline for approximately two minutes, fatally drowning as a result. Causal factors leading to this event were:

6.1.3.1 Investigators were unable to determine if the kayaker, at any point during his transit, was in possession of or wearing 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.

6.2.1. There were no potential 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.

6.3.1. There were no potential acts of misconduct, incompetence, negligence, unskillfulness, or violations of law by Coast Guard employees or any other person that contributed to this casualty.

6.4. Evidence of Act(s) Subject to Civil Penalty.

6.4.1. This investigation did not identify any potential violations of U.S. law warranting Coast Guard civil penalty actions.

6.5. Evidence of Criminal Act(s).

6.5.1. CGIS reviewed the evidence in this investigation and did not identify any potential violations of criminal law.

6.6. Need for New or Amended U.S. Law or Regulation.

6.6.1. This investigation did not identify a need to add or amend U.S. Law or Regulation.

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

6.7.1. This investigation did not identify any additional unsafe actions or conditions.

7. Actions Taken Since the Incident

7.1. Following the collision, CTC reinforced and reminded crewmembers of its existing safety training. On July 2, 2024, Captain's Call Notes, Holiday Week Weekend Navigation Safety email reminder and Navigation and Standing Safety Orders was sent to all CTC vessels.

8. Recommendations

8.1. Safety Recommendation: There were no proposed actions to add new or amend existing U.S. laws or regulations, international requirements, industry standards, or U.S. Coast Guard policies and procedures as part of this investigation.

8.1.1. Administrative Recommendations: Recommend this investigation be closed.

[redacted]
U.S. Coast Guard
Investigating Officer