UNITED STATES COAST GUARD

REPORT OF THE INVESTIGATION

INTO THE

LOSS OF LIFE ON BOARD THE PASSENGER VESSEL GOL MAKER (O.N. 1065056) IN THE GULF OF MEXICO ON NOVEMBER 26, 2022

MISLE ACTIVITY NUMBER: 7666561

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

Commandant
United States Coast Guard

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16732/IIA #7666561
January 8, 2025

THE LOSS OF LIFE ON BOARD THE PASSENGER VESSEL GOL MAKER (O.N. 1065056) IN THE GULF OF MEXICO ON NOVEMBER 26, 2022

ACTION BY THE COMMANDANT

The record and the report of the investigation convened for the subject casualty have been reviewed by the Office of Investigations & Casualty Analysis (CG-INV). The record and the report, including the findings of fact, analysis, conclusions, and recommendations are approved. This marine casualty investigation is closed.

[redacted]

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

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16732
NOV 4 2024

LOSS OF LIFE ON BOARD THE PASSENGER VESSEL GOL MAKER (O.N. 1065056) IN THE GULF OF MEXICO ON NOVEMBER 26, 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 mariner was a tragic and preventable accident. I offer my sincere condolences to the family and friends of the mariner who lost his life.

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

[redacted]
A. H. MOORE, JR.
Captain, U.S. Coast Guard
Chief of Prevention
Eighth Coast Guard District
By Direction

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

Commanding Officer
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Marine Safety Unit Houma

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16732
October 11, 2023

LOSS OF LIFE ON BOARD THE PASSENGER VESSEL GOL MAKER (O.N. 1065056) IN THE GULF OF MEXICO ON NOVEMBER 26, 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 subject to the following comments. It is recommended that this marine casualty investigation be closed.

ENDORSEMENT/ACTION ON RECOMMENDATIONS

Administrative Recommendation 1. Recommend the Officer in Charge, Marine Inspection (OCMI) conduct more thorough man overboard drills with a more realistic simulation of crewmember weight during statutory inspections, particularly on small passenger vessels.

Action: Concur – The Marine Safety Unit Houma Inspections Division will conduct an internal review of current drill observation procedures and provide me with a recommendation moving forward on how our inspectors will conduct and observe more realistic man overboard drills during vessel inspections. Marine Safety Unit Houma will also continue to conduct outreach with our local industries, stressing the importance of training crews to conduct drills as if there were an actual emergency.

Administrative Recommendation 2. Recommend this investigation be closed.

Endorsement: Concur – recommend this investigation be closed.

[redacted]

L. T. O'BRIEN
Captain, U.S. Coast Guard
Officer in Charge, Marine Inspection
Houma, Louisiana

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

U.S. Department of Homeland Security
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16732
10 Oct 2023

LOSS OF LIFE ON BOARD THE PASSENGER VESSEL GOL MAKER (O.N. 1065056) IN THE GULF OF MEXICO ON NOVEMBER 26, 2022

EXECUTIVE SUMMARY

On November 26, 2022 at approximately 0955 hours, the GOL MAKER was underway towards the offshore platform South Marsh Island 99A (SMI 99A) preparing to moor to the platform. Deckhand 1 was on the aft deck preparing for the mooring operation and was wearing a work vest. The safety chain and stanchion arrangement at the stern of the vessel was removed to allow Deckhand 1 access to the starboard aft bitt. Seas were approximately 4-6 feet, wind speed was estimated between 20-25 knots, and it was overcast with rain with weather conditions continuing to deteriorate.

At approximately 1000, while standing in the vicinity of the GOL MAKER's starboard aft bitt, Deckhand 1 threw a mooring line towards SMI 99A, lost his balance, and fell into the water. The master of the vessel saw Deckhand 1 fall into the water and immediately sounded the man overboard alarm on the vessel's sound system and via radio to platform SMI 99A and the Coast Guard. Personnel from the platform launched a life float that Deckhand 1 was able to swim to. He held on to the life float while the Relief Captain and Deckhand 2 readied the rescue platform on the port side of the GOL MAKER. As the vessel was attempting to position itself for recovery, personnel witnessed Deckhand 1 let go of the life float and stopped moving while positioned face down in the water. The Relief Captain was able to grab ahold of Deckhand 1 during one recovery attempt but could not lift him onboard and was unable to hold on. As Deckhand 1 drifted away, the work vest slipped off his body.

A Coast Guard helicopter and airplane were launched and eventually located Deckhand 1. The Coast Guard assets guided the GOL LIGHTNING, another vessel aiding in the search, to recover the body.

Through its investigation, the Coast Guard determined the initiating event to be Deckhand 1 falling overboard. Subsequently, Deckhand 1 drowned after multiple attempts to conduct a man overboard rescue. Causal factors contributing to this casualty were: 1) Ineffective aft railing arrangement on the GOL MAKER, 2) Normalized line handling at aft bitts due to backing vessel in, 3) Crew often worked beyond physical safety measures, 4) Limited risks addressed in deck operation procedures, 5) Inadequate Personal Protective Equipment, 6) Deckhand 1's limited experience with lifesaving appliances, 7) Inadequate man overboard drills, 8) Positive Drug Result for Deckhand 1.

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

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10 Oct 2023

LOSS OF LIFE ON BOARD THE PASSENGER VESSEL GOL MAKER (O.N. 1065056) IN THE GULF OF MEXICO ON NOVEMBER 26, 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, Subpart 4.07, and under the authority of Title 46, United States Code, Chapter 63.

1.2. No organizations or individuals were designated a party-in-interest in accordance with 46 Code of Federal Regulations (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 Central Standard Time using a 24-hour format and are approximate.

2. Vessels Involved in the Incident

Figure 1. GOL MAKER, date unknown. Source: Rec Marine Logistics.

Official Name:	GOL MAKER
Identification Number:	O.N. 1065056
Flag:	United States
Vessel Class/Type/Sub-Type	Passenger Ship/Crew Boat
Build Year:	2013
Gross Tonnage:	99 GRT
Length:	130.4 feet
Beam/Width:	27 feet
Draft/Depth:	11.75 feet
Main/Primary Propulsion:	Diesel Reduction, 3800 HP
Owner:	CANDY MAKER LLC Morgan City, LA, United States
Operator:	REC MARINE LOGISTICS Raceland, LA, United States

3. Record of Deceased, Missing, and Injured

Relationship to Vessel	Sex	Age	Status
Deckhand 1	M	44	Deceased

4. Findings of Fact

4.1. The Incident:

4.1.1. The GOL MAKER was on contract with Cox Operating to transport workers between offshore oil platforms in the Gulf of Mexico.

4.1.2. At approximately 0955, the master and Deckhand 1 on the GOL MAKER were preparing to moor the vessel to platform SMI 99A in the Gulf of Mexico, approximately 64 miles south of Vermillion Bay.

4.1.3. The weather conditions were 4-6 foot seas, winds were between 20-25 knots, and there was light to moderate rain. According to National Weather Service reports, conditions were forecasted to continue deteriorating throughout the day in the Gulf of Mexico.

Figure 2. South Marsh Island Platform 99A. Date unknown. Source: Cox Operating.

4.1.4. Deckhand 1 was wearing a work vest and was positioned on the aft deck of the GOL MAKER on the starboard quarter of the vessel. He was beyond the railing arrangement at the aft most bitt on the starboard side.

4.1.5. Deckhand 1 attempted to cast a mooring line onto platform SMI 99A's vessel landing bitt while standing at the starboard quarter of the vessel.

4.1.6. Deckhand 1 held on to the line with his left hand after he had cast it to the platform. The thrown portion of the line missed the platform, its weight pulled Deckhand 1 off balance, and he fell off the GOL MAKER and into the water.

4.1.7. The master witnessed Deckhand 1 fall into the water and called to platform SMI 99A on Ch. 68 that there was a man overboard, radioed on Channel 16 of the man overboard, and initiated the vessel's Digital Select Calling feature on the GOL MAKER's radio equipment. The master also sounded the general alarm on the vessel to alert the other two crewmembers onboard the GOL MAKER.

4.1.8. Personnel on SMI 99A launched a 12-person life float in response to receiving the man overboard call, and the relief captain and Deckhand 2 of the GOL MAKER began preparing the vessel's rescue platform on the port side.

4.1.9. Deckhand 1 was able to swim to the life float and grab ahold of it. While holding on to the life float, he attempted to climb into the life float and the device flipped over. He was able to regain control of the life float and was responsive to calls from crewmembers on the GOL MAKER.

4.1.10. After several minutes of holding onto the life float, Deckhand 1 was observed slipping from the life float and appearing to lose consciousness.

4.1.11. Deckhand 1 remained face down in the water for approximately one minute until the GOL MAKER was close enough for the Relief Captain, who was positioned on the vessel's rescue platform, to grab ahold of Deckhand 1. The Relief Captain was unable to pull Deckhand 1 on to the GOL MAKER and lost grip of Deckhand 1, causing him to drift away from the vessel.

4.1.12. The crew of the GOL MAKER made another attempt to recover Deckhand 1 but could not successfully recover him. Deckhand 1 was reportedly unresponsive during the rescue attempts, and the work vest he was wearing slipped off Deckhand 1's body during the second attempt.

4.1.13. The rain increased and the GOL MAKER lost sight of Deckhand 1.

4.1.14. The autopsy report indicated the cause of death of Deckhand 1 was drowning.

4.1.15. The GOL MAKER was in communication with the Coast Guard via the platform and was instructed to stay with the flotsam and provide coordinates. The GOL MAKER notified shoreside personnel and the GOL LIGHTNING, another Rec Marine Logistics crew boat also in the area, made efforts to assist in locating the crewmember.

4.1.16. A Coast Guard MH-60 helicopter from Air Station New Orleans arrived on scene at approximately 1340 and a Coast Guard HC-144 airplane from Air Station Mobile arrived on scene at 1345. The HC-144 successfully located the body of Deckhand 1 at approximately 1430 and vectored in the MH-60 and GOL LIGHTNING to the location of the body.

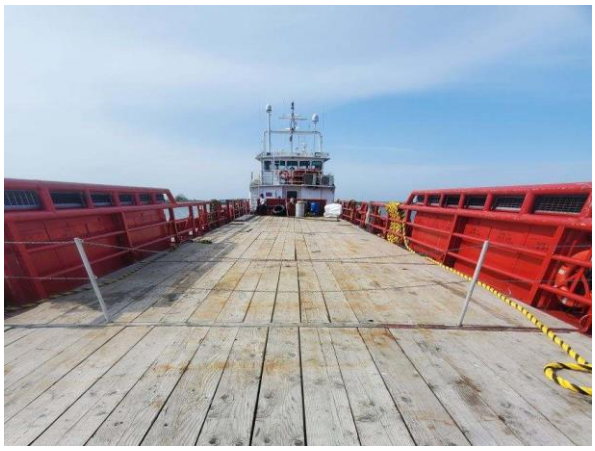
4.1.17. At approximately 1530, the GOL LIGHTNING retrieved the body of Deckhand 1 from the Gulf of Mexico due to it being a larger vessel than the GOL MAKER and a more stable platform for recovery. Both the GOL MAKER and GOL LIGHTNING then proceeded to port.

4.2. Additional/Supporting Information:

4.2.1. The GOL MAKER is an aluminum hulled, 130.4-foot crew boat certificated under 46 CFR Subchapter T and was delivered May 28, 1998. The vessel is operated by Rec Marine Logistics. At the time of the incident, there were four crew members on board.

4.2.2. Deckhand 1 had been employed by Rec Marine Logistics since June 30, 2022, and had been working as a deckhand for 5 months with the company.

4.2.3. The GOL MAKER has been in service and operating as a certificated crew boat since 1998 with a gap in service between 2015 and 2020. In the requirements for certificated small passenger vessels, 46 CFR §177.900(e) states: "*Where the principal business of the vessel requires the discharge of persons or cargo in a seaway, such as on pilot boats and dive boats, the cognizant OCMI may accept alternatives to the rails required in paragraphs (d)(1), (2), and (3) of this section for those areas of a deck where passengers or cargo are discharged and for which removable rails, lifelines, or chains would hinder discharge operations."* The OCMI of both Marine Safety Unit Morgan City and Marine Safety Unit Houma had identified no issues with the railing arrangement throughout the course of the vessel's service.



Figures 3 & 4. GOL MAKER Aft chain and stanchion arrangement looking forward and aft. Source: Rec Marine Logistics.

4.2.4. At the time of the mooring evolution on the GOL MAKER, the aft chain arrangement was down, as it would have prevented Deckhand 1 from egressing to the forward portion of the vessel in case of an emergency. There is no bulwark or chain that protects personnel from falling in the vicinity of the aft port or starboard bitts once they go beyond the stern chain arrangement.

4.2.5. The operations manual for deck operations provided by the company covers the following: "*Safe practices and inherent dangers in handling mooring lines should be regularly discussed with line handlers. These include keeping out of bights of mooring line or getting between a line that could come under tension and a fixed object, synthetic line-snap back, preventing hands from being caught between mooring lines and bitts, a proper method for securing lines to bitts, and safe procedures for tying up to a rig*." The manual does not cover risks of falling overboard while line handling or conducting mooring operations.

4.2.6. Per 46 CFR § 160.027-2(a), "*Each life float must meet the requirements in subpart 160.010 of this chapter for a peripheral body type buoyant apparatus designed so that persons supported are only partially immersed (180 N (40 lb.) of buoyancy per person required)*". Life floats are designed to be held on to along the periphery and are not designed to support personnel within the inner ring of the lifefloat. The lifefloat deployed by SMI 99A was a Jim-Buoy 1200 series, 12 person life float.

Figure 5. Jim-Buoy life float, 1200 Series. Source: Fisheries Supply.

4.2.7. Deckhand 1 weighed 250 pounds according to the autopsy report.

4.2.8. Marine Safety Unit Houma Marine Inspectors often use spare lifejackets to conduct man overboard drills during Coast Guard Inspections.

4.2.9. A review of the GOL MAKER's logs identified adequate abandon ship and man overboard drills conducted on a monthly basis as required by 46 CFR 185.520. Man overboard drills were conducted with use of the rescue platform and harness that were used during the incident. Drill records do not specify retrieving anything from the water other than ring buoys. The last man overboard drill was conducted on November 7, 2022, and included all members of the crew on board on November 26, 2022, with the exception of Deckhand 2.

4.2.10. Chemical and alcohol testing were conducted for the Master, Relief Captain, and Deckhand 2 in accordance with the post casualty testing requirements of 46 CFR 4.06. The results for both chemical and alcohol testing of the Master, Relief Captain, and Deckhand 2 were negative.

4.2.11. Chemical testing for Deckhand 1 was conducted as part of the autopsy report. Deckhand 1 tested positive for Delta-9 THC with a result of 0.50 ng/ml.

5. Analysis

5.1. **Hazardous weather conditions for deck operations.** The heavy sea states and high wind speeds likely increased the difficulty of the vessel's mooring operation. It is reasonable to assume the master had increased difficulty in maneuvering the vessel close to the platform, which may have made it more difficult for Deckhand 1 to throw the line. Additionally, the 4-6 foot seas likely splashed over the deck and made the vessel pitch and roll, which may have increased the difficulty for Deckhand 1 to maintain his balance. If the wind and seas had been calm, it is reasonable to assume the mooring evolution would have been less difficult and the crewmember on deck may not have fallen overboard.

5.2. **Ineffective aft railing arrangement.** The aft railing arrangement provided no protection for crewmembers line handling in the vicinity of the transom of the vessel. In order to effectively moor the vessel using the aft bitts, crew members were required to pass beyond the stanchion and chain arrangement to an area of the vessel with no railing or bulwark. If there had been railing or bulwark around the deck area where the crewmember was line handling, it is reasonable to assume they may have been able to catch themselves upon slipping and prevented them from falling overboard.

5.3. **Normalized line handling at aft bitts due to backing vessel in.** The majority of the time, the vessel was docked by backing into a location, which meant that crewmembers normally made up the vessel's aft bitts first. All of the aft bitts are beyond physical safety measures to prevent falls overboard. If the vessel had approached the platform bow first, the crewmember likely would have been line handling on a portion of the deck surrounded by substantial bulwark. It is reasonable to assume that if the crewmember had been line handling within an area with railing or bulwark, they may have been able to catch themselves against vessel structure, likely preventing a fall overboard.

5.4. **Crew often worked beyond physical safety measures.** The crew of the vessel frequently conducted deck operations with the railing down and with personnel beyond the aft railing while it was in the down position. At the time of the incident, Deckhand 1 was handling mooring lines on the area of the deck with no physical barrier along the edge of the vessel. It is reasonable to assume that the crewmember felt comfortable operating beyond the physical railing and bulwark barriers because it was common practice for the crew. If this had not been a routine adaptation by the crew, Deckhand 1 may have been more wary of his position on the vessel and may have thrown the mooring line from a different location which could have prevented his fall overboard.

5.5. **Limited risks addressed in operation procedures.** The mooring and line handling section of the Deck Operations manual primarily focuses on risks associated with physical injury from lines and securing points. There is no mention of the risk of falls. If there had been a detailed section about the risks of falling overboard, particularly when line handling beyond the aft railing arrangement, it is reasonable to assume the master and crewmember may have been more cautious in their approach to the mooring operation. They may have taken precautionary measures or actions to mitigate known risks and may have prevented the fall overboard.

5.6. **Inadequate Personal Protective Equipment.** The crewmember on the aft deck was wearing an orange work vest with flotation properties as a form of personal protective equipment, but in no way could the work vest have helped prevent a fall overboard. If the crewmember had been wearing a harness that was secured to the vessel, it is reasonable to assume the crewmember would not have fallen overboard. Additionally, if there had been safety harnesses on board that were offered to the crew for use during heavy weather, the crew may have been more cognizant of the risks of falling overboard, particularly on the aft deck.

5.7. **Deckhand 1's limited experience with lifesaving appliances.** At the time of the incident, the crewmember had been employed with Rec Marine Logisitics for

approximately 5 months. According to witness statements, the crew member attempted to climb into the life float deployed by the platform. If the crewmember had known that life floats are designed for personnel to hang off the side, it is reasonable to assume that he may have only held on to the side of the life float, not lost control of it, and conserved his energy, allowing him to hold on longer.

5.8. **Inadequate man overboard drills**. Multiple Marine Safety Unit Houma marine inspectors were surveyed and explained that during Coast Guard inspections, inspectors often throw a lifejacket in the water to simulate the man overboard during drills. Furthermore, vessel records do not indicate crewmembers simulated man overboard drills with anything other than ring buoys. The crewmember that fell overboard from the vessel weighed approximately 250lbs, and the rest of the crew onboard was unable to recover the crewmember after two attempts. It is reasonable to assume that if drills had been conducted with an object weighing closer to that of the overboard crewmember, the crew may have been more prepared and possibly could have recovered the crewmember.

5.9. **Positive Drug Result for Deckhand 1.** During the autopsy report, chemical testing for Deckhand 1 was conducted and produced a non-negative test result of .5ng/ml for Delta-9 THC, the active ingredient in marijuana. In a National Institute of Justice funded study published in 2021, researchers concluded that biofluid samples were not reliable indicators of marijuana intoxication. The variable nature of a person's metabolism and the unknown frequency of Deckhand 1's marijuana use prevent the determination of whether Deckhand 1 was intoxicated and impaired at the time of the incident. The positive test result does indicate the ingestion of marijuana, but it is unclear as to what time and date the ingestion took place. Therefore, Deckhand 1's use of marijuana cannot be ruled out as a causal factor because it is possible that there was some level of impairment from marijuana consumption.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty occurred when Deckhand 1 fell overboard from the GOL MAKER. Causal factors leading to this event were:

6.1.1.1. Hazardous weather conditions throughout the Gulf of Mexico for vessel deck operations.

6.1.1.2. The approved, ineffective railing arrangement for protecting individuals operating in the vicinity of the GOL MAKER's aft bitts.

6.1.1.3. The normalized practice of backing the vessel into mooring locations and making up the aft mooring lines first.

6.1.1.4. The routine adaptation of crewmembers working beyond physical safety measures of railing and bulwark.

6.1.1.5. The lack of addressing the risks of falling overboard while line handling in the company's Deck Operations manual.

6.1.1.6. Possible impairment of Deckhand 1 due to previous consumption of marijuana.

6.1.2. Deckhand 1 falling overboard led to the subsequent event of the drowning and loss of life of Deckhand 1. Causal factors leading to this event were:

6.1.2.1. Inadequate personal protective equipment being worn by Deckhand 1.

6.1.2.2. Deckhand 1's inexperience with the functions and purpose of marine lifesaving equipment.

6.1.2.3. Inadequate man overboard drills conducted with unrealistic weight.

6.2. Evidence of Acts by any Coast Guard Credentialed Mariner Subject to Action Under 46 USC Chapter 77: This investigation did not identify any evidence of acts by any Coast Guard credentialed mariners subject to action under 46 USC Chapter 77.

6.3. Evidence of Acts or Violations of Law by U.S. Coast Guard Personnel, or any other person: 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 Acts Subject to Civil Penalty: This investigation did not identify any evidence of acts subject to civil penalty.

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

6.6. Need for New or Amended U.S. Law or Regulation: This investigation did not identify any need to create or amend any U.S. laws or regulations.

6.7. Unsafe Actions or Conditions that were not Causal Factors: This investigation did not identify any unsafe acts or conditions that were deemed not to be causal factors.

7. Actions Taken Since the Incident

7.1 No actions have been taken since the incident occurred.

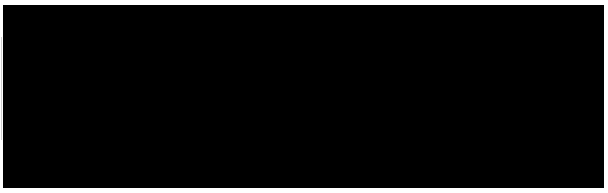
8. Recommendations

8.1. Safety Recommendations:

8.2. Administrative Recommendations:

8.2.1. Recommend the Officer in Charge, Marine Inspections (OCMI) conduct more thorough man overboard drills with a more realistic simulation of crewmember weight during statutory inspections, particularly on small passenger vessels.

8.2.2 Recommend this investigation be closed.



LTJG, U.S. Coast Guard
Investigating Officer