UNITED STATES COAST GUARD

REPORT OF THE INVESTIGATION INTO THE DEATH ONBOARD THE RECREATIONAL VESSEL LINEDOUT (HIN: JDJ5V303J223) IN THE GULF OF MEXICO ON MARCH 12, 2024

MISLE Activity Number: 7879209

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

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16732/IIA #7879209
12 September 2025

ALLISION OF THE RECREATIONAL FISHING VESSEL LINEDOUT (HULL IDENTIFICATION NUMBER: JDJ5V303J223) WITH FIXED PLATFORM SS-087B RESULTING IN THE LOSS OF ONE LIFE WHILE UNDERWAY NEAR SOUTH MARSH ISLAND BLOCK 69 IN THE GULF OF AMERICA ON MARCH 12, 2024

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 recommendation, are approved subject to the following comments. This marine casualty investigation is closed.

ACTION ON RECOMMENDATION

Recommendation 1: Recommend United States Coast Guard's (USCG) Heartland District (CGD-H) (formally the Eighth District) Private Aids to Navigation (PATON) Office conduct an analysis of their PATON regulatory and enforcement authority involving owners of discrepant aids and identify resources needed to properly oversee the approval, verification, and enforcement of PATON equipment. As it stands, the CGD-H PATON Office is not staffed with enough personnel to verify if PATON equipment is installed in accordance with the Title 33 Code of Federal Regulations (CFR) Part 66 nor does the office have the resources to verify if the equipment is operating as intended.

> **Action**: This recommendation was issued to the CGD-H. CGD-H concurred with the intent and recognized the need to strengthen oversight of PATON within its area of responsibility (AOR) to ensure maritime safety and the integrity of the Marine Transportation System. PATON are authorized by the USCG in accordance with U.S. law and are to be maintained by and at the expense of the responsible party. This incident involving a vessel allision with an unlit PATON, resulting in a tragic loss of life, underscores the need to address vulnerabilities within the current PATON management framework. The high density of PATON within CGD-H's AOR overwhelms existing capacity for verification by USCG assets. Thus, the CGD-H PATON Office has assessed that PATON oversight is largely reactive and dependent on discrepancy reports submitted through Local Notices to Mariners, which are primarily based on owner self-reporting as outlined in 33 CFR § 64.11. The USCG *Aids to Navigation Administration Manual* (COMDTINST M16500.7A) requires either inspection by the USCG or self-verification by the owner, who then provides a written report to the USCG. Self-verification periods range from 1-, 3-, and 5-year intervals depending on the "class" of the aid.

Recognizing current resource limitations, the CGD-H will strategically focus on strengthening the accountability of PATON owners, specifically to continue to promote accurate and timely self-reporting and leverage enforcement options. The CGD-H Waterways Management Branch will release a yearly Marine Safety Information Bulletin highlighting the legal responsibilities and enforcement implications outlined in 33 CFR § 67.40-25. In parallel, the CGD-H will continue to assess existing data, foster collaborative partnerships with stakeholders, evaluate emerging technology such as drones to guide future resource allocation efforts and also address enforcement potential for future cases at the appropriate level. In addition, the CGD-H will provide opportunities for Auxiliarists to complete Personnel Qualification Standards (PQS) for "ATON Verifier", effectively amplifying inspection capacity and ensuring alignment with the CGD-H's Auxiliary Branch regarding PQS standards. While CGD-H's commitment to improving PATON oversight remains strong, it is important to emphasize that solutions need to be scalable, cost-effective, sustainable, and reflective of the constraints of CGD-H's current operational environment.

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

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16732

DEATH ONBOARD THE RECREATIONAL VESSEL LINEDOUT (HIN: JDJ5V303J223) IN THE GULF OF MEXICO ON MARCH 12, 2024

ENDORSEMENT BY THE COMMANDER, COAST GUARD HEARTLAND DISTRICT

COMMENTS ON THE REPORT

1. The loss of life in this marine casualty was a tragic, yet preventable accident. I offer my sincerest condolences to the family and friends of the passenger who lost his life.

2. The record and the report of the investigation convened for the subject casualty have been reviewed by my office with a clarification of section 5.8. In this section, the Investigator assessed that Passenger 1's positioning adjacent to the console (rather than astern of the operator) could have prevented ejection. This office agrees with that assessment. This office considers this fact as a subjective decision by Passenger 1 and the operator rather than a safety or design fault of the vessel. It is noted that handrails were also assessed by the investigator as a factor in the ejection. Handrails on the T-Top support structure while standing adjacent to the console were not mentioned, nor was it mentioned that there is designed seating forward of the console which also would have resulted in ejection. The vessel, as documented, was transiting at a speed of approximately 29 knots when it collided with an 80-foot concrete structure. While the act of holding a handrail would provide a degree of stability under normal operating conditions or during minor course corrections, the forces generated during a high-speed allision with a solid object of that size would likely exceed the capacity of an individual to maintain a secure hold. The deceleration forces involved would have been immense, although not calculated in this case. While handrail usage is a prudent safety measure under normal circumstances, it is unlikely to be an effective countermeasure in such an extreme allision scenario.

3. Additionally, in section 6.1.1.1 (conclusions) it is important to note that the investigative team was not able to visually validate the non-functioning Private Aid to Navigation (PATON). The record and the report, including the findings of fact and recommendations are approved subject to the following comments. It is recommended that this marine casualty investigation be closed.

4. 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.

ENDORSEMENT ON RECOMMENDATIONS

Safety Recommendation 1: Recommend Coast Guard Heartland District's (CGDH) Private Aids to Navigation (PATON) Office conduct an analysis of their PATON regulatory and enforcement authority involving owners of discrepant aids and identify resources needed to properly oversee the approval, verification, and enforcement of PATON equipment. As it stands, the CGDH PATON Office is not staffed with enough personnel to verify if PATON equipment is installed in accordance with 33 Code of Federal Regulations Part 66, nor does the office have the resources to verify if the equipment is operating as intended.

Endorsement 1: I concur with the intent of the safety recommendation and recognize the need to strengthen oversight of Private Aids to Navigation (PATON) within our Area of Responsibility (AOR) to ensure maritime safety and the integrity of the Marine Transportation System. PATON are authorized by U.S. Coast Guard in accordance with law and are to be maintained by and at the expense of the responsible party. This incident involving a vessel allision with an unlit PATON, resulting in a tragic loss of life, underscores the need to address vulnerabilities within the current PATON management framework. The high density of PATON within our AOR overwhelms our existing capacity for organic Coast Guard verification. This office assesses that PATON oversight is largely reactive and dependent on discrepancy reports submitted through Local Notices to Mariners (LNMs) which are primarily based on owner self-reporting as outlined in 33 CFR § 64.11. The Coast Guard Aids to Navigation Administration Manual (COMDTINST M16500.7A) requires either inspection by the Coast Guard or self-verification by the owner, who provides a written report to the Coast Guard. Self-verification periods range from 1-, 3-, and 5-year intervals depending on the "class" of aid.

Actions: Recognizing current resource limitations, the Heartland District will strategically focus on strengthening the accountability of Private Aid to Navigation (PATON) owners, specifically to continue to promote accurate and timely self-reporting and leverage enforcement options. District Waterways (dw) will release a yearly Marine Safety Information Bulletin highlighting the legal responsibilities and enforcement implications outlined in 33 CFR § 67.40-25. In parallel, the Heartland District will continue to assess existing data, foster collaborative partnerships with stakeholders, evaluate emerging technology such as drones to guide future resource allocation efforts and also address enforcement potential for future cases at the appropriate level. In addition, the Heartland District will provide opportunities for Auxiliarists to complete Personnel Qualification Standards (PQS) for "ATON Verifier", effectively amplifying inspection capacity and ensuring alignment with the Heartland's Auxiliary Branch (dpa) regarding PQS standards. While our commitment to improving PATON oversight remains strong, we emphasize the

importance of implementing solutions that are scalable, cost-effective, sustainable, and reflective of the constraints of our current operational environment.

[redacted]

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

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United States Coast Guard

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16732
December 02, 2024

DEATH ONBOARD THE RECREATIONAL VESSEL LINEDOUT (HIN: JDJ5V303J223) IN THE GULF OF MEXICO ON MARCH 12, 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 subject to the following comments. It is recommended that this marine casualty investigation be closed.

COMMENTS ON THE REPORT

1. The loss of life in this marine casualty was a tragic yet preventable accident. I offer my sincerest condolences to the family and friends of the passenger who lost his life because of this incident.

ENDORSEMENT ON RECOMMENDATIONS

Safety Recommendation 1. Recommend Coast Guard's Eighth District (D8) Private Aids to Navigation (PATON) Office conduct an analysis of their PATON regulatory and enforcement authority involving owners of discrepant aids and identify resources needed to properly oversee the approval, verification, and enforcement of PATON equipment. As it stands, the D8 PATON Office is neither staffed with enough personnel to verify if PATON equipment is installed in accordance with the 33 Code of Federal Regulations Part 66 nor does the office have sufficient resources to verify if the equipment is operating as intended.

Endorsement: Concur. While there is a significant number of PATON equipment located within the District 8 area of responsibility, the current level of Coast Guard oversight and enforcement to ensure PATON equipment is operational is inadequate and adds to the risk to mariners and the marine transportation system. This particular marine casualty clearly highlights the importance of operable aid to navigation equipment and could have been prevented had the Coast Guard had the resources and/or programs in place necessary to verify and enforce the 33 CFR Part 66 regulations. While the addition of more resources in the form of personnel and funding is ideal, these resources are not always available. Alternatively, seeking ways to maximize efficiencies such as augmenting verification of PATON equipment with the use of USCG Auxiliary assets, drone technology and tasking of

ATC Mobile training flights with verification of PATON as a subset mission could improve the execution of the PATON mission. The Coast Guard needs to establish a clearer path forward to address how these risks can be best mitigated.

Administrative Recommendation 1. Recommend this investigation be closed.

Endorsement: Concur – recommend this investigation be closed.

[redacted]

J. S. FRANZ
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16732
October 4, 2024

DEATH ONBOARD THE RECREATIONAL VESSEL LINEDOUT (HIN: JDJ5V303J223) IN THE GULF OF MEXICO ON MARCH 12, 2024

EXECUTIVE SUMMARY

On March 12, 2024, a 3-member fishing team was competing in the Louisiana Tuna and Wahoo Classic, a 3-day fishing tournament being held in the Gulf of Mexico. The recreational fishing vessel, LINEDOUT, was a 34’ Contender center console built in 2021, which was owned by the operator of the vessel. At approximately 0430 the 3-member team departed Coco Marina, located in Cocodrie, Louisiana, and headed towards South Marsh Island block 69 where they planned to spend the day fishing. During the transit, the Operator was seated behind the console, with Passenger 1 standing on the left side of the console and Passenger 2 standing on the right side of the console, both acting as lookouts. Once the vessel was in open waters, the Operator activated the auto pilot to follow a track line the Operator had previously programed into the chart plotter and brought the vessel to a cruising speed of 29 knots. During the transit, the Operator began switching between the systems of the navigational equipment due to a malfunctioning radar. At that time, Passenger 2 became frustrated with the Operator’s actions and moved to the stern of the vessel and sat down in a bean bag chair. At approximately 0630, the vessel struck the unlit, unmanned, platform Ship Shoal 87B (SS-87B). Passenger 1 was ejected from the vessel into the water. The Operator sustained head and face lacerations from impacting the console and Passenger 2 slammed into the back of the Operator’s seat and sustained a broken shoulder. At that time, Passenger 2 secured the LINEDOUT to the platform and began making distress calls via VHF radio channel 16. Two Good Samaritan vessels in the area responded to the distress calls and administered first aid to the Operator and Passenger 2. U.S. Coast Guard Sector New Orleans dispatched a MH-60 helicopter to the scene which transited both members to a New Orleans hospital for treatment. Also dispatched were assets from U.S. Coast Guard Station Grand Isle and an 87’ Coast Guard cutter to commence a search for the missing passenger. After 38 hours of searching, Passenger 1 was not located and presumed deceased.

As a result of its investigation, the Coast Guard determined that the initiating event was the vessel’s allision with the SS-87B platform. Subsequent events included Passenger 1 being ejected from the vessel, injuries to both the Operator and Passenger 2, and the presumed death of Passenger 1. The casual factors identified as contributing to this marine casualty were: 1) The Coast Guard’s limited regulatory authority and resources, 2) Failure to properly operate navigation equipment, 3) Platform owner’s failure to maintain the required PATON equipment, 4) Operator’s familiarity with the area caused complacency, 5) Operator distracted by navigation equipment. 6) Inoperable PATON equipment on platform Ship Shoal 87B, 7) Malfunctioning navigation equipment, 8) Lack of use of handrails, 9) Operator's excessive speed, and 10) Passenger 1’s failure to wear a personal flotation device.

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16732
October 4, 2024

DEATH ONBOARD THE RECREATIONAL VESSEL LINEDOUT (HIN: JDJ5V303J223) IN THE GULF OF MEXICO ON MARCH 12, 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, Subpart 4.07, and under the authority of Title 46, United States Code, Chapter 63.

1.2. The Ship Shoal 87B (SS-87B) platform owner, Sanare Energy Partners, was designated as a Party-In-Interest (PII) on March 20, 2024, in accordance with 46 Code of Federal Regulations (CFR) Subsection 4.03-10. All PII were represented by legal counsel.

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. Vessel Involved in the Incident

Figure 1. Recreational vessel LINEDOUT, date unknown. Source Instagram.

Official Name:	LINEDOUT
Identification Number:	HIN: JDJ5V303J223
Flag:	United States
Vessel Class/Type/Sub-Type:	Recreational Vessel
Build Year:	2021
Gross Tonnage:	N/A 6,600 LBs
Length:	34’
Beam/Width:	9’ 10”
Draft/Depth:	22”
Main/Primary Propulsion:	3-300 Mercury Outboards
Owner:	LINEDOUT Pro Fishing LLC
Operator:	[redacted]

3. Record of Deceased, Missing, and Injured

Relationship to Vessel	Sex	Age	Status
Passenger 1	Male	41	Missing

4. Findings of Fact

4.1. The Incident:

4.1.1. On March 12, 2024, at approximately 0430, The recreational vessel LINEDOUT (HIN: JDJ5V303J223), departed Coco Marina in Cocodrie, LA. The vessel was transiting towards South Marsh Island Block 69 with three persons onboard: The Operator, Passenger 1 and Passenger 2. The members were participating in the Louisiana Tuna and Wahoo Classic Fishing Tournament. They were on day two of the three-day tournament.

4.1.2. Once in open water, the Operator brought the vessel up to 29 kts and placed it on autopilot on a pre-programmed track line.

4.1.3. The Operator of the vessel was positioned behind the console operating the vessel, Passenger 1 was standing on the port side of the console, with Passenger 2 on the starboard side. Passengers 1 and 2 were acting as lookouts.

4.1.4. While underway, the Operator was consistently switching back and forth between the chart plotter and radar screens because the radar was not functioning correctly. Passenger 2 described the Operator’s distraction by the inoperable equipment as similar to "texting while driving".

4.1.5. At this time Passenger 2 became frustrated with the Operator's actions and moved to the stern of the vessel and sat down on a bean-bag chair.

Figure 2 LINEDOUT and Platform Ship Shoal 87B. Taken March 12, 2024. Source Coast Guard.

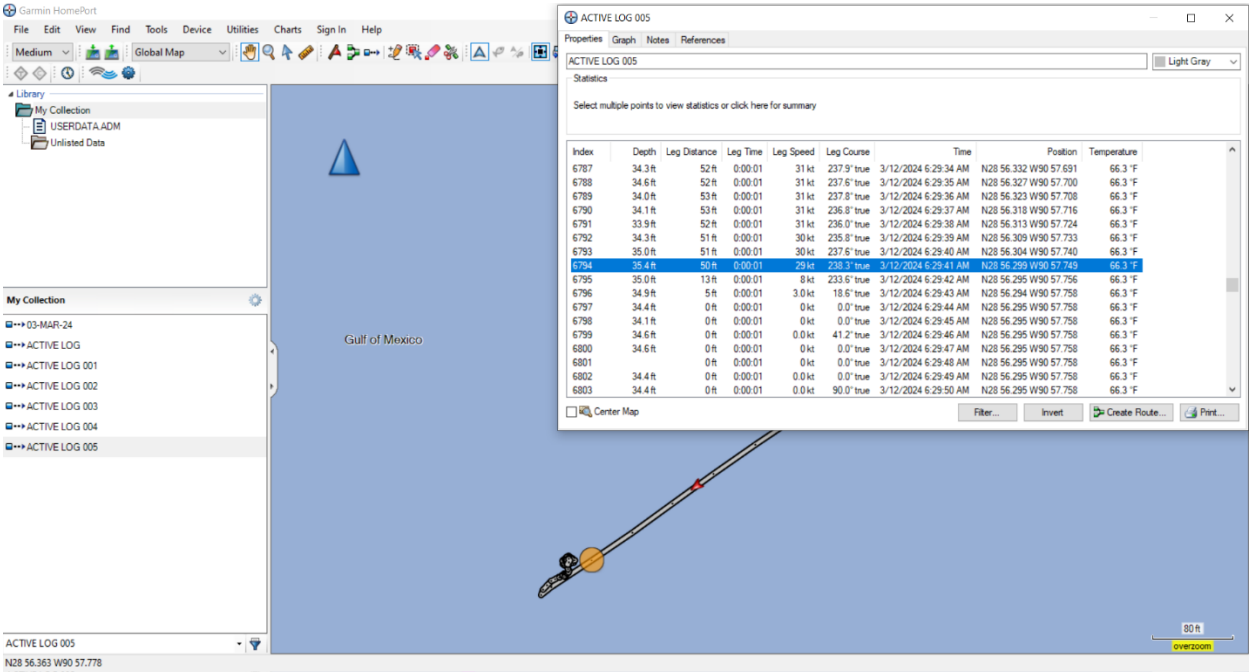

Figure 3. GPS data showing moment of impact speed. Retrieved March 27,2024. Source LINEDOUT GPS.

4.1.6. At approximately 0630, the vessel LINEDOUT allided with the SS-87B platform at the speed of approximately 29 knots.

4.1.7. Passenger 1 was ejected from the vessel on impact. The Operator sustained severe injuries to the face and head and Passenger 2 sustained a broken shoulder. Neither Passenger 2 nor the Operator saw Passenger 1 after impact.

Figure 4. LINEDOUT bow damage from impact, Taken March 12, 2024. Source US Coast Guard.

4.1.8. The vessel LINEDOUT sustained extensive damage to the bow.

4.1.9. Passenger 2 secured the vessel to a leg of the platform and hailed the Coast Guard on VHF channel 16.

4.1.10. At approximately 0640, Coast Guard Sector New Orleans dispatched a station asset, a MH-60 Helo, and an 87’ cutter for search and rescue efforts.

4.1.11. A Good Samaritan vessel in the area also responded to the distress call and embarked both the Operator and Passenger 2 and began rendering first aid treatment.

4.1.12. At approximately 0920, the Coast Guard MH-60 helicopter recovered the Operator and Passenger 2 from the Good Samaritan vessel to transition them to the University Medical Trauma Center in New Orleans, LA.

4.1.13. On March 14, 2024, the Coast Guard’s search and rescue efforts for the missing passenger ceased, and Passenger 1 was presumed deceased.

4.2. **Additional/Supporting Information:**

4.2.1. The LINEDOUT, was a 34’ center console recreational vessel with a fiberglass hull, built by Contender in 2021.

4.2.2. Sunrise on March 12, 2024, was at approximately 0713, almost 45 minutes after the LINEDOUT’s allision with the platform.

4.2.3. The Operator of the LINDEDOUT was a lifelong fisherman with over 20 years of boating experience in the area of the incident.

4.2.4. Personal onboard the LINDEDOUT were not wearing personal floatation devices (PFD) at the time of the incident nor were they required to by regulation.

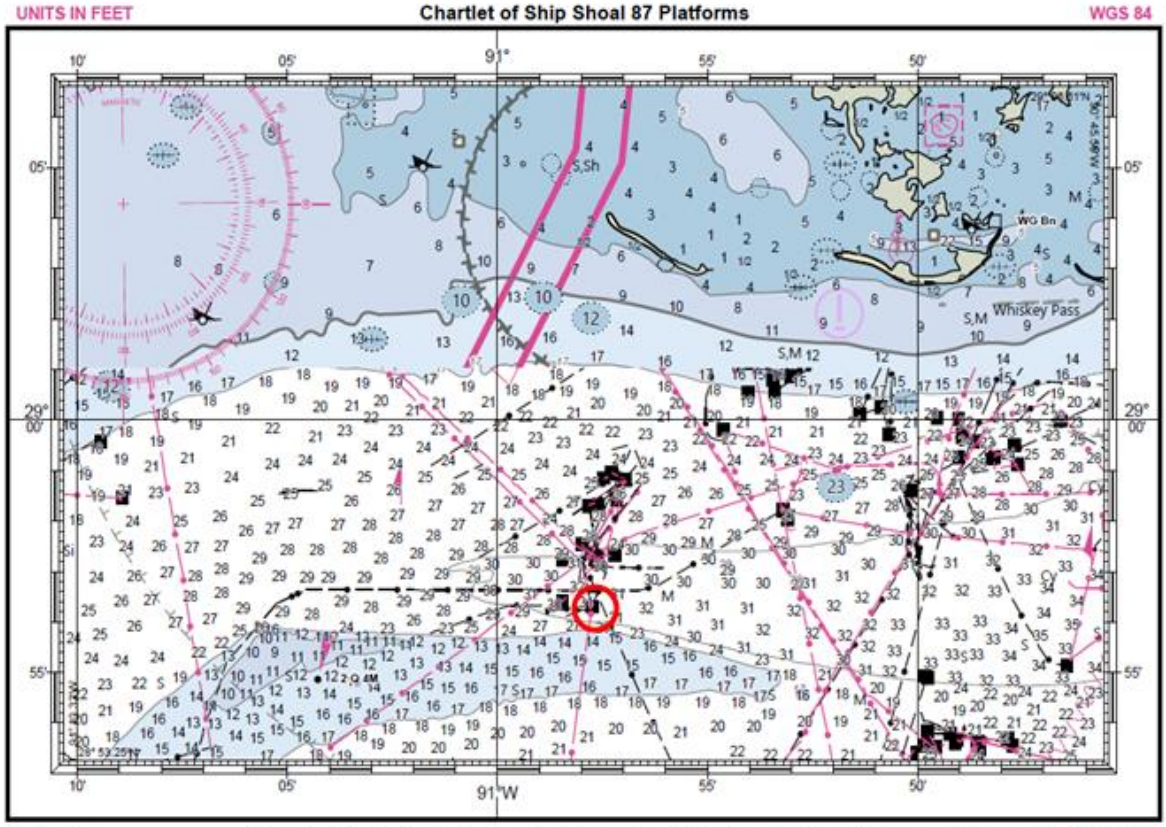

Figure 5. NOAA chart indicating charted location of Ship Shoal 87B in red. Source NOAA.

4.2.5. The Operator was driving the vessel via autopilot, following track lines previously installed. The Operator stated that he didn't see any obstructions, to include the SS-87B platform, in the path of the plotted track line. The Operator was also not sure of which scale the parameters the chart plotter was set for. As seen in Figure 5, the SS-87B platform is a charted object.

4.2.6. SS-87B was an unmanned oil field platform, located in the Gulf of Mexico Ship Shoal Block 87, and owned by Sanare Energy Partners. SS-87B received Coast Guard Private Aids to Navigation (PATON) approval in 2001. The platform was required to be marked with a light on each corner, and a half nautical mile fog signal.

4.2.7. An annual inspection of the platform's lights and fog signal was conducted by a third party on January 22, 2024. All lights and signals were listed as functional per the inspection report.

4.2.8. A Good Samaritan vessel that responded to the distress call on the morning of the incident, reported that SS-87B's lights and sound signal were not functioning when they arrived on scene. The Operator and Passenger 2 also stated after the incident that the platform was unlit at the time of the incident.

4.2.9. The Coast Guard Eighth District (D8) Private Aids to Navigation (PATON) Office maintains a database with the approvals for approximately 31,000 individual pieces of PATON equipment throughout the Coast Guard's Eighth District. The office is not adequately resourced to physically ensure PATON equipment is installed correctly or functioning as designed. Furthermore, the PATON Office does not have the regulatory authority to enforce compliance once an aid is found derelict. Annual verifications of PATON equipment are the responsibility of the equipment's owner. All discrepant aids are published in a notice to mariners until they are repaired by the owner.

5. Analysis

5.1. **The Coast Guard's limited regulatory authority and resources.** The Coast Guard D8 PATON Offices is not required to be nor is it staffed with PATON inspectors to physically verify if the PATON equipment was installed as required or operating as intended. The PATON equipment's maintenance and operation is regulated under an honor system, making it the full responsibility of the owner to comply and report inoperable equipment. However, it is typical that discrepant equipment is reported after an incident has occurred, which is counter to how the program was designed. It is logical to assume that, if the PATON office was staffed with sufficient personnel to verify the maintenance and operation of the aids, instead of relying on the reports from owners of the equipment, the Coast Guard could have ensured the proper operation and maintenance of the PATON equipment on the SS-87B platform. Furthermore, if stricter regulations were enacted in regard to holding the owners of the equipment accountable when inoperable PATON equipment is not properly reported, the owners could be more inclined to take effective corrective action and rectify the deficiencies or remove the platform all together, which could prevent similar incidents from occurring.

5.2. **Failure to properly operate navigation equipment**. The vessel's navigation was set to auto pilot following a track line installed in the chart plotter by the Operator. The chart plotter was not equipped with a warning to alert the user when the track line was laid over a charted object in the water. Instead, the person installing the track line may have to zoom in to scale and personally ensure the track line avoids charted objects. The Operator in this incident did not see any charted objects obstructing the plotted track line; however, the Operator could not state what scale setting the chart plotter was set to at the time of the incident. It is logical to assume that, if the Operator would have set the chart plotter to an adequate scale, the Operator may have seen that the track line was installed over the charted platform and could have been able to alter the course of the track line preventing the casualty from occurring.

5.3. **Platform owner's failure to maintain the required PATON equipment.** Platform SS-87B was an unmanned platform which had PATON equipment installed onboard that was approved by the Coast Guard Eighth District on January 12, 2001. The owner of SS-87B provided the required annual report, dated January 22, 2024, stating that all required PATON

equipment was fully operational. However, on the day of the casualty the required PATON equipment on the platform was reported not lit and the sound signal was reported not functioning. It is reasonable to assume that, if the PATON equipment was functioning as designed, the vessel operator may have seen or heard the structure and could have been able to safely avoid the platform and possibly prevent the casualty from occurring.

5.4. **Operator's familiarity with the area caused complacency.** The Operator was an experienced vessel navigator that had been fishing in the area of the incident for approximately 20 years and was aware that platforms were in the area. It is logical to assume, that over the years of operating vessels in the same area, the Operator had become significantly comfortable with the area, which may have led to complacency and subsequent unsafe decision making such as driving the vessel at high speeds at night with a malfunctioning radar, in an area that the Operator knew contained several platforms.

5.5. **Operator distracted by navigation equipment.** While transiting at speeds up to 29 knots, the Operator was switching between navigation equipment screens on the console and not maintaining a diligent lookout for objects in the water. The continued switching between the radar and GPS navigation equipment distracted the Operator, causing him to often look down at the navigation screens instead of the area ahead of the vessel reducing his ability to operate the vessel safely. It is reasonable to assume that, if the Operator would have maintained a proper lookout by not being distracted with the electronics, the Operator may have seen the platform in enough time to navigate around the object, which could have prevented the casualty from occurring.

5.6. **Inoperable PATON equipment on platform Ship Shoal 87B.** SS-87B was equipped with the required PATON equipment consisting of four flashing lanterns (one on each corner of the platform), a ½ nautical mile sound signal with a cycle of 2 minutes, and a charging system. The system's maintenance and operation were the responsibility of the owner, who is required to make available to the Coast Guard's PATON Office an annual report, showing all systems are fully functional. Sanare Energy Partners provided the most recent required annual report, dated January 22, 2024, stating that all required PATON equipment was fully operational. However, on the day of the casualty multiple witnesses from vessels that responded to the incident and personnel onboard the LINEDOUT, reported that neither the visual nor audible signals on the platform were functioning. Equipment normally required to help prevent the casualties like from occurring was in place, but due to the lack of additional oversight by the company the equipment was not operational. It is logical to assume, that if the company's installed PATON equipment, that is required to be always operational, was functioning as designed on March 12, 2024, the vessel operator may have seen the structure and would have been able to safely avoid the platform and possibly prevent the casualty from occurring.

5.7. **Malfunctioning navigation equipment.** The LINEDOUT was equipped with a radar, which is designed to detect objects near the vessel while navigating. However, at the time of the incident the radar was not functioning properly. It is logical to assume that giving the size of the steel platform, if the radar was operating properly and the Operator had the radar set to the correct settings (i.e. scale), the radar would have detected the platform in the path of the

vessel and alerted the Operator of the structure which may have allowed the Operator to navigate the vessel to avoid the casualty.

5.8. **Lack of use of handrails.** The 34' Contender center console is designed with three general areas for the occupants to sit or stand. The operator has a seat behind the console, there is a seat in front of the console and an area behind the operator's seat for people to stand with a rail for the passengers to hold on to while the vessel is in operation. At the time of the casualty, Passenger 1 was standing on the port side of the center console and not seated in one of the designed seating areas. Although, the vessel was not designed with a mechanical means to restrain passengers while seated or standing behind the Operator the vessel was fitted with a handrail for standing personnel to hold onto, while facilitating balance and limiting the effects of moving forces. Holding onto the handrail could have provided a safer condition for Passenger 1, instead of standing beside the console with little to no protection from the forces experienced during the impact. It is logical to assume that, if Passenger 1 was positioned behind the Operator holding on to the rail as the vessel was designed, instead of standing on the port side of the console, the rail and seat may have lessened the forward momentum and could have prevented Passenger 1 from being ejected from the vessel.

5.9. **Operator's excessive speed.** The speed of the vessel could be a factor in the severity of the injuries experienced and the Operator's inability to identify and avoid potential hazards in the path of the vessel. In accordance with International Regulations for Prevention of Collisions at Sea, 1972 (72COLREGS) Navigation Rule 6, "every vessel shall at all times proceed at a safe speed so that they can take proper and effective action to avoid collision and be stopped within a distance appropriate to the prevailing circumstances and conditions". The Operator's speed of 29 knots could be considered excessive and unsafe, considering the issues with the navigation equipment, operating at night, and his prior knowledge of platforms in the area. It cannot be ruled out, that if the vessel operator would have navigated the vessel at a reduced safer speed, the SS-87B platform may have been avoided and injuries to the persons in the vessel may have been reduced or prevented.

5.10. **Passenger 1's failure to wear a personal flotation device.** The recreational boating regulations pertaining to personal flotation devices (PFD) only require that the vessel be equipped with one PFD per person on the vessel at the time of operation and does not require an adult person to don the device. However, it is best marine practices to always don a PFD while in a vessel in case an incident does occur. It was reported that at the time of the allison, Passenger 1 was not wearing a PFD. This cannot be ruled out as a contributing factor. It is logical to assume that if Passenger 1 would have been wearing a PFD at the time of incident, the device may have created a neutral buoyancy, keeping Passenger 1 floating at the surface of the water after being ejected from the vessel and may have prevent the death from occurring or allowed for the recovery of his body.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event or this casualty occurred when the recreational vessel LINEDOUT allided with the unmanned oil field platform Ship Shoal 87B at a speed of approximately 29.5 knots. The Causal factors leading to this event were:

6.1.1.1. Oilfield platform Ship Shoal 87B's approved PATON equipment was not operational at the time of the allision.

6.1.1.2. The Coast Guard Private Aids to Navigation office's lack of regulatory authority and resources to ensure the aids are operational and ensure the companies that own the aids are maintaining the structures as required.

6.1.1.3. Ship Shoal 87B was in the path of the track line installed in the chart plotter.

6.1.1.4. The LINDEDOUT's radar was inoperable and did not detect the platform in the vessel's path.

6.1.1.5. The Operator troubleshot the malfunctioning radar while traveling at a speed of approximately 29.5 knots.

6.1.2. The allision with Ship Shoal 87B platform caused Passenger 1 to be ejected from the vessel. The causal factor leading to this event were:

6.1.2.1. Due to the design of the vessel, the LINDEDOUT did not have a practical means to restrain passengers onboard in the case an allision occurs.

6.1.3. Both the Operator and Passenger 2 sustained severe injuries during the allision. Causal factors leading to this event were:

6.1.3.1. Vessel's lack of passenger restraints combined with the Operator's excessive speed.

6.1.4. The missing passenger was not recovered and presumed deceased. Causal factors leading to this event were:

6.1.4.1. Passenger 1 failure to wear a personal flotation device at the time of the allision.

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: This investigation did not identify any evidence of acts or violations of law by U.S. Coast Guard Personnel, or any other person.

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. This investigation did not identify any evidence of acts subject to criminal law.

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.

8. Recommendations

8.1. Safety Recommendation:

8.1.1 Recommend Coast Guard's Eighth District (D8) Private Aids to Navigation (PATON) Office conduct an analysis of their PATON regulatory and enforcement authority involving owners of discrepant aids and identify resources needed to properly oversee the approval, verification, and enforcement of PATON equipment. As it stands, the D8 PATON Office is not staffed with enough personnel to verify if PATON equipment is installed in accordance with the 33 Code of Federal Regulations Part 66 nor does the office have the resources to verify if the equipment is operating as intended.

8.2. Administrative Recommendations:

8.2.1 Recommend this investigation be closed.

Chief Warrant Officer, U.S. Coast Guard
Investigating Officer