UNITED STATES COAST GUARD

REPORT OF THE INVESTIGATION INTO THE

LOSS OF LIFE FROM THE COMMERCIAL FISHING VESSEL NC3250BW IN CEDAR ISLAND BAY ON AUGUST 20, 2024

MISLE ACTIVITY NUMBER: 7987052

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

Commandant
United States Coast Guard

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16732/IIA #7987052
24 October 2025

FALL OVERBOARD AND SUBSEQUENT LOSS OF ONE LIFE FROM THE COMMERICAL FISHING VESSEL NC3250BW WHILE TRANSITING IN CEDAR ISLAND BAY SOUTH OF HOG ISLAND, NORTH CAROLINA ON AUGUST 20, 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.

[redacted]

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

U.S. Department of Homeland Security

United States Coast Guard

Commander
United States Coast Guard
East District

431 Crawford St.
Portsmouth, VA 23704
Staff Symbol: (dp)

16732
October 22, 2025

LOSS OF LIFE FROM THE COMMERCIAL FISHING VESSEL NC3250BW IN CEDAR ISLAND BAY ON AUGUST 20, 2024.

ENDORSEMENT BY THE COMMANDER, COAST GUARD EAST 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.

ENDORSEMENT ON RECOMMENDATIONS

Administrative Recommendation 2. Recommend this investigation be closed.

Endorsement: Concur. The Coast Guard East District agrees with the analysis and conclusions of the Investigating Officer and the endorsement of the Officer in Charge, Marine Inspection. No further action is required by the Coast Guard.

[redacted]

MATTHEW J. MESKUN
Captain, U.S. Coast Guard
Chief, Prevention Division

Enclosures: (1) Endorsement by the Officer in Charge, Marine Inspection
(2) Executive Summary
(3) Investigating Officer's Report

U.S. Department of Homeland Security
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16732
30 Sep 2025

LOSS OF LIFE FROM THE COMMERCIAL FISHING VESSEL NC3250BW IN CEDAR ISLAND BAY ON AUGUST 20, 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.

COMMENTS ON THE REPORT

1. The loss of the fisherman was a tragic and preventable accident. I offer my sincere condolences to the family and friends of the fisherman who lost his life.

[redacted]

TIMOTHY J. LIST
Captain, U.S. Coast Guard
Officer in Charge, Marine Inspection

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

U.S. Department of Homeland Security
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Marine Safety Detachment Fort Macon
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16732
30 Sep 2025

LOSS OF LIFE FROM THE COMMERCIAL FISHING VESSEL NC3250BW IN CEDAR ISLAND BAY ON AUGUST 20, 2024

EXECUTIVE SUMMARY

On August 20, 2024, at approximately 0830 Eastern Daylight Time (EDT), the 22-foot North Carolina-registered commercial fishing vessel NC3250BW departed Cedar Island, NC, with its owner/operator onboard for a planned blue crab fishing voyage in Cedar Island Bay. The operator, a seasoned commercial fisherman with over 44 years of experience, had owned and registered the vessel since 1998. NC3250BW was specifically designed for crabbing and equipped with a 140 hp outboard engine. The vessel's steering system consisted of pulleys and lines, enabling the single outboard engine to be steered from the bow with a wooden tiller. A 'pot puller' was mounted to the starboard side of the vessel to route lines from crab traps and facilitate their retrieval.

At approximately 1100 EDT, local fishermen observed the operator dropping off crab at the dock of a fish house in Cedar Island, NC. The exact time the operator departed the dock to resume fishing remains unknown. Witness 1 (W1), while operating a personal vessel, sighted NC3250BW transiting toward Cedar Island Bay at approximately 1130 EDT, as W1 was returning to the fish house in Cedar Island. At that time, NC3250BW was approximately one-quarter mile from W1's position, and no anomalies were noted. Two hours later, while en route back to Harkers Island, NC, W1 sighted NC3250BW again in Cedar Island Bay, unmanned and circling approximately one mile offshore. The vessel's clutch was engaged forward and the wooden tiller fixed hard to starboard. W1 boarded the vessel, stopped its movement, and inspected its onboard equipment, identifying crab pots labeled with the operator's last name, whom he knew. W1 contacted a family member, who subsequently notified 911. On-scene conditions included calm seas, clear skies, 5-10 knot winds, and a water depth of 5-6 feet.

A search for the operator commenced, involving the U.S. Coast Guard helicopter CG 6018 and local mariners. At approximately 1450 EDT, a local fisherman discovered the operator unresponsive in the water. CG 6018 airlifted the operator, who remained unresponsive throughout the transit to Marine Corps Air Station Cherry Point in Cherry Point, NC. Upon landing, Emergency Medical Services (EMS) assessed the operator and documented the presence of signs consistent with death at approximately 1527 EDT. The operator's body was subsequently transported to Carolina East Medical Center in New Bern, NC.

The investigation revealed that NC3250BW was not equipped with life jackets, and the operator was found in the water without one, wearing jeans and no shirt. An autopsy determined the cause

of death was accidental drowning and identified medical conditions, including hypertensive and atherosclerotic cardiovascular disease and acute ethanol intoxication. Toxicology results confirmed a blood ethanol concentration of 150 mg/dL (0.15% BAC), indicative of significant impairment.

As a result of this investigation, the Coast Guard has determined that the operator fell overboard into Cedar Island Bay, which constitutes the initiating event for this casualty. This was followed by drowning, resulting in the operator's death. The causal factors that contributed to this casualty include: (1) operator’s acute ethanol intoxication during fishing operations, (2) operator isolation and lack of immediate assistance, and (3) lack of personal flotation device.

U.S. Department of Homeland Security
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30 Sep 2025

LOSS OF LIFE FROM THE COMMERCIAL FISHING VESSEL NC3250BW IN CEDAR ISLAND BAY ON AUGUST 20, 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. There were no parties-in-interest designated for this investigation.

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 Eastern Standard Time (EDT) using a 24-hour format and are approximate.

2. Vessel Involved in the Incident

Figure 1: Photograph of Commercial Fishing Vessel NC3250BW. Photo sourced from USCG Investigating Officer.

Official Name:	NC3250BW
Identification Number:	KWL98310C090 (HIN)
Flag:	United States
Vessel Class/Type/Sub-Type	Fish Catching Vessel
Build Year:	1990
Length:	22’
Main/Primary Propulsion: (Configuration/System Type, Ahead Horse Power)	Gasoline, outboard 140hp
Owner / Operator:	Christopher Farrel Goodwin [redacted]

3. Deceased, Missing, and/or Injured Persons

Relationship to Vessel	Sex	Age	Status
Owner / Operator	Male	57	Deceased

4. Findings of Fact

4.1. The Incident:

4.1.1. On August 20, 2024, NC3250BW departed from Cedar Island, NC, for fishing operations in Cedar Island Bay with its owner/operator onboard.

4.1.2. The operator had over 44 years of experience conducting commercial fishing operations and navigating the local waters, including Cedar Island Bay.

4.1.3. At 1100, the operator of NC3250BW was observed by other local fishermen at the dock of a fish house, located at 2720 Cedar Island Road in Cedar Island, NC, while dropping off crab.

Figure 2: Screenshot of the fish house dock on Cedar Island Road, captured from Google Maps.

4.1.4. At 1130, Witness 1 (W1), while operating a personal vessel, observed NC3250BW transiting toward Cedar Island Bay as W1 was en route to the fish house in Cedar Island.

4.1.5. NC3250BW was transiting approximately one-quarter mile from W1's position, and no anomalies were noted.

4.1.6. The operator of NC3250BW was under the influence of alcohol, a condition subsequently confirmed by the toxicology report.

4.1.7. At some point between 1140 and 1330, the operator went overboard, and no witnesses were present.

4.1.8. At 1330, after refueling at the fish house, W1 sighted the same crab boat (NC3250BW) in Cedar Island Bay while returning to Harkers Island, NC.

4.1.9. NC3250BW was found unmanned, with its clutch engaged in forward gear and the helm fixed hard to starboard, causing it to circle in Cedar Island Bay.

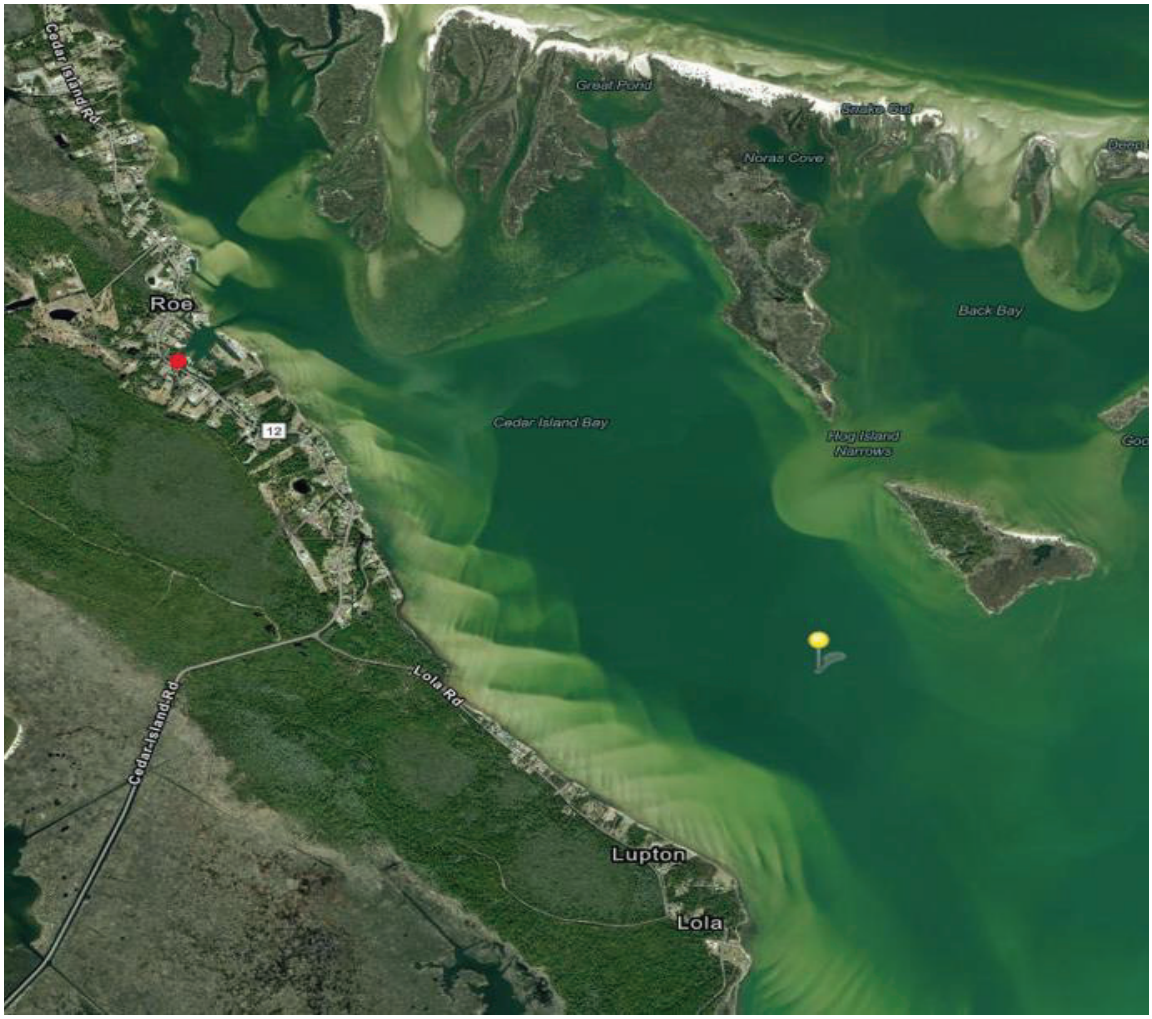

Figure 3: Satellite image of Cedar Island Bay from MISLE GIS Map Point Picker. The yellow pin marks the approximately location where NC3250BW was found making circles, while the red dot indicates the location of the fish house.

4.1.10. W1 boarded and stopped NC3250BW, and during an inspection of the onboard equipment, observed that the crab pots were labeled with the operator's last name. This led W1 to identify the vessel as belonging to the operator, a known individual.

4.1.11. W1 then contacted a family member, who subsequently notified 911.

4.1.12. At 1405, Carteret County 911 notified USCG Sector North Carolina Command Center of an unmanned crab boat in the vicinity of Cedar Island Bay.

4.1.13. At 1415, the Coast Guard MH-60 Jayhawk helicopter (CG 6018) was diverted to search for the missing operator.

4.1.14. At 1435, CG 6018 arrived on scene and commenced search patterns.

4.1.15. At 1450, CG 6018 was alerted by a Good Samaritan to an unresponsive person in the water at position 34-57.416N / 076-16.385W.

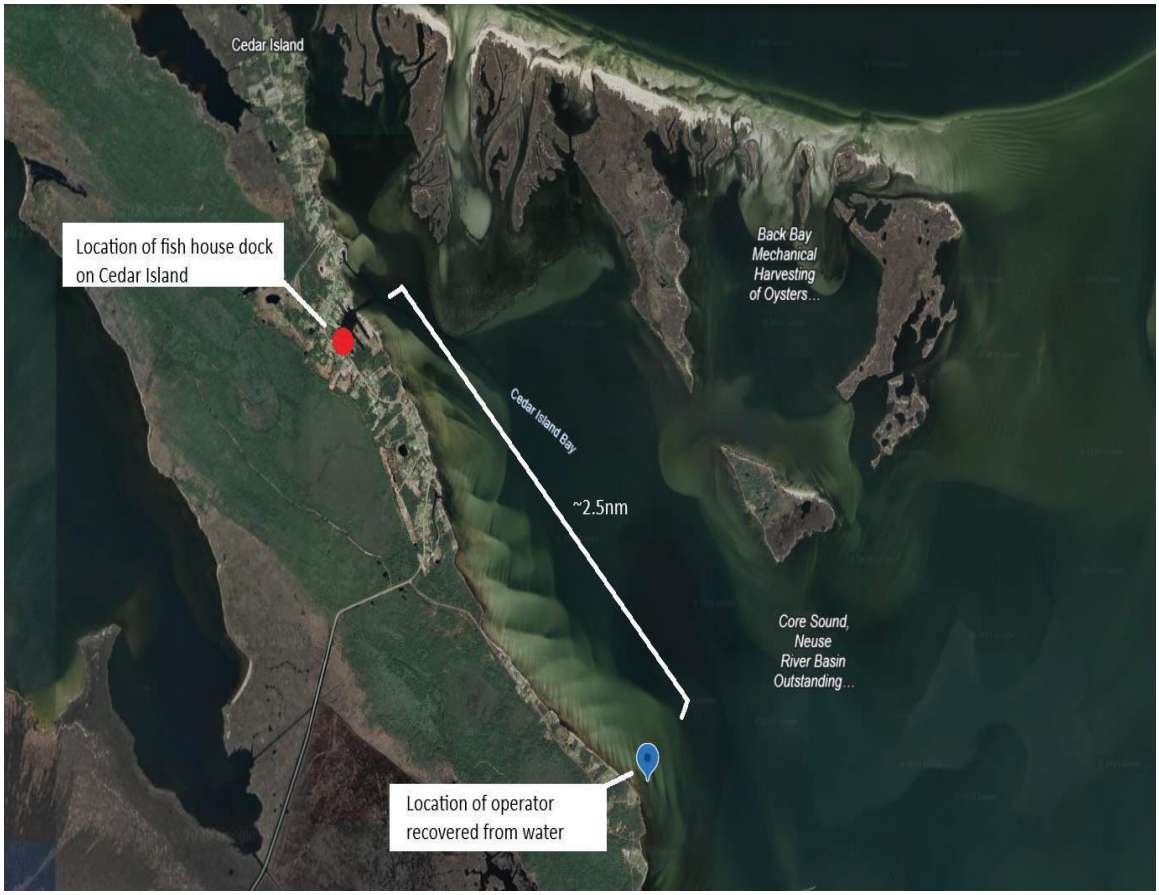

Figure 4: Satellite image of Cedar Island Bay showing the approximate location of the unresponsive operator marked by a blue dot, in relation to the fish house and its estimated distance, captured from Google Maps.

4.1.16. At 1456, CG 6018 deployed a rescue swimmer, and the unresponsive operator was hoisted and transported to Marine Corps Air Station Cherry Point for rendezvous with Emergency Medical Services (EMS).

4.1.17. At 1527, EMS assessed the operator and documented the presence of signs consistent with death.

4.1.18. On August 23, 2024, the Medical Examiner determined the operator's cause of death as drowning and the manner of death as an accidental.

4.1.19. On September 11, 2024, the operator's toxicology report indicated a blood alcohol content (BAC) 0.15% (150mg/dL).

4.2. Additional/Supporting Information:

4.2.1. The 22-foot, fiberglass-hull, downeaster-style commercial fishing vessel, registration # NC3250BW, has been registered to its owner/operator since 1998. It is equipped with a single outboard engine and modified for crabbing with a forward remote steering station and a starboard-mounted crab pot puller. NC3250BW was modified to steer its single gasoline outboard engine from the bow using a system of pulleys, lines and a wooden tiller.

Figure 5: Photograph of the operating area in the bow of NC3250BW. The oval highlights the tiller handle used for steering from the forward position of vessel. Photo sourced from the USCG Investigating Officer.

4.2.2. Crabbing operations onboard NC3250BW typically involved the use of a handheld catch hook to retrieve trap lines, which were then fed into a pot puller. The pot puller utilized the vessel's propulsion to lift traps from the water, a process that often required the operator to lean against or over the starboard gunwale. No evidence of malfunction or tampering was found on the pot puller or any other vessel equipment that would account for the operator's entry into the water. Notably, the catch hook was missing from the vessel.

Figure 6: Photograph of operating area of NC3250BW. The circle highlights the "pot puller" mounted on the starboard gunwale. Photo sourced from the USCG Investigating Officer.

4.2.3. No life jackets were found onboard the vessel during the investigation. Family members stated the operator habitually did not wear a life jacket and typically fished wearing oilskins over regular clothing.

4.2.4. On August 20, 2024, at 1310, on-scene weather conditions, corroborated by witness accounts and historical data, included 5-10 knot winds, calm seas, clear (10 mile) visibility and an approximate water depth of 5-6 feet.

4.2.5. The operator's medical conditions included hypertensive and atherosclerotic cardiovascular disease, specifically nephrosclerosis, 50% atherosclerotic luminal stenosis of the left main coronary artery, and mild, complex, ulcerated atheromas carpeting the aorta.

4.2.6. NC3250BW was a state-registered commercial fishing vessel that was exempt from the requirement to undergo a Coast Guard dockside safety examination. This exemption was in accordance with 46 CFR Part 28, as the vessel operated within three nautical miles of the U.S. baseline and carried no more than 16 individuals on board. Furthermore, the vessel had never opted to undergo a voluntary Coast Guard dockside safety examination.

5. Analysis

5.1. **Operator's Acute Ethanol Intoxication During Fishing Operations:** The source and exact commencement time of ethanol intoxication in the operator of NC3250BW remain undetermined. However, post-mortem autopsy and toxicology reports revealed a blood ethanol

concentration of 150mg/dL, equivalent to 0.15% BAC. This level is considered high and indicative of significant intoxication.

A BAC of 0.15% is known to cause substantial physical and cognitive impairment. These effects can include diminished motor skills, impaired physical coordination and balance, reduced visual and perceptual acuity, and delayed reaction times. While the autopsy report did not indicate that the operator suffered a stroke, a BAC at this level is likely to elevate resting heart rate and blood pressure, potentially induce arrythmia, exacerbate pre-existing heart conditions, and interfere with the efficacy of medications.

This level of impairment, combined with the demands of a physically challenging maritime operation, could have significantly contributed to the operator's loss of balance, leading to his entry into the water and subsequent drowning. Had the operator not been intoxicated while conducting fishing operations, his physical coordination and stability would have been significantly improved, potentially preventing the fall overboard and the resulting fatal outcome.

5.2. **Operator Isolation and Lack of Immediate Assistance:** The operator was fishing alone in a semi-secluded area, which significantly increased the risk of a fatal outcome. Operating without companions eliminated the possibility of immediate assistance if an emergency occurred. With no witnesses present, there was no one to observe the operator entering the water or to provide timely aid. This isolation likely delayed both the discovery of the incident and the emergency response. Fishing alone in such areas presents heightened risks, including limited access to help during emergencies and difficult reconstructing events due to the absence of witnesses. Had another person fished with the operator, they could have offered flotation support, initiated rescue actions, or called for assistance, potentially preventing the accidental drowning.

5.3. **Lack of Personal Flotation Device (PFD):** The circumstances surrounding the operator's entry into the water remain unwitnessed. The operator was discovered in the water a significant, though undetermined, amount of time after going overboard from NC3250BW. It is strongly believed that the operator was not wearing a PFD at any point during the relevant timeframe, neither during operations leading up to the incident nor upon entering the water. A thorough search of the vessel, the operator's body, and the immediate vicinity revealed no PFDs present.

The absence of a PFD, combined with two critical factors, the unknown duration the operator was submerged and the operator's acute ethanol intoxication, drastically reduced the likelihood of survival. Without a PFD, the operator would have faced a significantly increased risk of drowning and exhaustion. It is highly probable that a properly fitted and donned PFD would have kept the operator afloat, maintaining the operator's head above water and substantially increasing the chances of rescue or self-rescue, even in a compromised state due to intoxication.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty was the operator of NC3250BW falling overboard. Causal factors leading to this event include:

6.1.1.1. The operator experienced acute ethanol intoxication with a BAC of 0.15%.

6.1.1.2. The operator was fishing alone in a semi-secluded area, with no witnesses present to observe the operator entering the water.

6.1.2. After falling overboard, the operator was found unresponsive in the water without a PFD.

6.1.2.1. The cause of death was determined to be accidental drowning with acute ethanol intoxication identified as a contributing factor.

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: There were no 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) of Violation(s) of Law by U.S. Coast Guard Personnel, or any other person: There were no 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: This investigation revealed that the operator was in violation of 46 USC 2302(c) for operating a vessel while under the influence of alcohol. However, as the operator is deceased, the Coast Guard has decided not to pursue a civil penalty.

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

6.6. Need for New or Amended U.S. Law or Regulation: This investigation identified no matters needing new or amended U.S. law or regulation.

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

6.7.1 There were no unsafe actions or conditions that were not casual factors identified.

7. Actions Taken Since the Incident

7.1 There were no actions taken since the incident.

8. Recommendations

8.1. Safety Recommendation:

8.1.1.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.

8.2. Administrative Recommendations:

8.2.1. Recommend this investigation be closed.

[redacted]

Lieutenant, U.S. Coast Guard
Investigating Officer