UNITED STATES COAST GUARD

REPORT OF THE INVESTIGATION INTO THE CHARTER VESSEL TOO SHORT (O.N. 1224367) LOSS OF LIFE IN WHITEHALL BAY NEAR ANNAPOLIS, MD ON JUNE 16, 2024

MISLE ACTIVITY NUMBER: 7943023

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

Commandant
United States Coast Guard

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16732/IIA #7943023
28 October 2025

LOSS OF ONE LIFE FROM THE CHARTER VESSEL TOO SHORT (O.N. 1224367) IN WHITEHALL BAY, NEAR ANNAPOLIS, MARYLAND ON JUNE 16, 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

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16732
October 16, 2025

CHARTER VESSEL TOO SHORT (O.N. 1224367) LOSS OF LIFE IN WHITEHALL BAY NEAR ANNAPOLIS, MD ON JUNE 16, 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 1. Recommend no enforcement action for the violations identified in paragraph 6.2. and 6.4. above due to the accidental nature of the drowning. The vessel's regulatory compliance was rectified after this marine casualty.

Endorsement: Concur.

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

United States Coast Guard

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16732
June 16, 2025

CHARTER VESSEL TOO SHORT (O.N. 1224367) LOSS OF LIFE IN WHITEHALL BAY NEAR ANNAPOLIS, MD ON JUNE 16, 2024

ENDORSEMENT BY THE OFFICER IN CHARGE, MARINE INSPECTION

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

ENDORSEMENT ON RECOMMENDATIONS

Administrative Recommendation 1. Recommend no enforcement action for the violations identified in paragraph 6.2. and 6.4 due to the accidental nature of the drowning. The vessel's regulatory compliance was rectified after this marine casualty.

Endorsement: Concur – I agree with not pursuing enforcement for the violations identified.

Administrative Recommendation 2. It is recommended that this investigation be closed.

Endorsement: Concur – I agree with the analysis and conclusions of the Investigating Officer. No further action is required by the Coast Guard.

[redacted]

PATRICK C. BURKETT
Captain, U.S. Coast Guard
Officer in Charge, Marine Inspection

U.S. Department of Homeland Security
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16732
October 16, 2024

CHARTER VESSEL TOO SHORT (O.N. 1224367) LOSS OF LIFE IN WHITEHALL BAY NEAR ANNAPOLIS, MD ON JUNE 16, 2024

EXECUTIVE SUMMARY

On June 16, 2024, at approximately 1420, the charter vessel TOO SHORT (O.N. 1224367) departed Annapolis Harbor Marina in Annapolis, MD, for a four-hour day cruise. The charter party included 12 passengers-for-hire and a three-person crew, consisting of a master and two crew members. At approximately 1530, the vessel reached its intended location of Whitehall Bay, where the vessel anchored, and the passengers began engaging in recreational activities in the water.

After approximately two hours of in-water activity, Passenger 1 attempted to retrieve a drifting football thrown by another passenger when he began struggling to stay above the surface of the water. Two crewmembers from the TOO SHORT jumped into the water to rescue the distressed individual, but Passenger 1 sank below the surface before they could reach him.

Emergency responders from Anne Arundel Fire Department's (AAFD) fire boats 5 and 36 located the unresponsive Passenger 1 approximately 56 minutes later and immediately initiated cardiopulmonary resuscitation (CPR) aboard fire boat 36. Passenger 1 was transported to the Maryland Department of Transportation Authority (MDTA) pier in Mezick Pond where Anne Arundel County's (AACO) Critical Incident Services (CIS) and the coroner were waiting. Passenger 1 was then transported via Mid-Atlantic Transport services to the University of Maryland Hospital in Baltimore, MD, where he was later pronounced deceased. A subsequent medical autopsy performed by the State of Maryland's Office of the Chief Medical Examiner (OCME) revealed that Passenger 1 had ingested a significant amount of water, and the cause of death was determined to be accidental drowning.

Through its investigation, the Coast Guard determined the initiating event for this marine casualty was the drowning of the passenger. The causal factors that contributed to this casualty include: (1) Lack of established procedures to enforce lifejacket donning for swimmers, (2) Lack of protocols to effectively monitor swimming times, (3) Failure of communication efforts between the master and Passenger 1, (4) Lack of established alcohol consumption policies or limitations, (5) Lack of established emergency procedures for distressed passengers in the water, and (6) Failure of owner to comply with established small passenger vessel regulations.

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

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16732
October 16, 2024

CHARTER VESSEL TOO SHORT (O.N. 1224367) LOSS OF LIFE IN WHITEHALL BAY NEAR ANNAPOLIS, MD ON JUNE 16, 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. No 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 pertaining to this investigation. Maryland Natural Resources Police (MNRP), Anne Arundel Fire Department (AAFD), Maryland State Police Aviation Command (SYSCOM), and Anne Arundel County's (AACO) Critical Incident Services (CIS) responded on scene. MNRP conducted an internal after-action incident report, NRP-24-00649, and provided a copy to the Coast Guard upon completion. No other individuals or organizations assisted in this investigation.

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

2. Vessel Involved in the Incident

Official Name:	TOO SHORT
Identification Number:	1224367 – Official Number (US)
Flag:	United States
Vessel Class/Type/Sub-Type	Recreational/General/Catamaran
Build Year:	2009
Gross Tonnage:	37 GT
Length:	46.3 feet
Beam/Width:	24.8 feet
Draft/Depth:	4 feet
Main/Primary Propulsion: (Configuration/System Type, Ahead Horsepower)	Twin Inboard Diesel Engines (250 Ahead/Astern HP)
Owner:	Windsong Charters, LLC

	Boca Raton, FL USA
Operator:	[redacted], Windsong Charters, LLC Boca Raton, FL USA

Figure 1. Photograph of TOO SHORT post-incident tied to mooring ball no. 1 in Spa Creek, Annapolis, MD on 18Jun2024. The photo was taken by the lead U.S. Coast Guard Investigating Officer.

3. Deceased, Missing, and/or Injured Persons

Relationship to Vessel	Sex	Age	Status
Passenger 1	Male	32	Deceased

4. Findings of Fact

4.1 The Incident:

4.1.1. On June 16, 2024, at 1420, the three-person crew of TOO SHORT, comprising the Master, Crewmember 1 (CM1), and Crewmember 2 (CM2), departed Annapolis Harbor Marina with 12 passengers for a four-hour day trip to Whitehall Bay. Prior to departure, the Master and crew conducted a passenger safety briefing, covering the locations of life jackets and fire extinguishers, guidelines for safe movement aboard the vessel while underway, and a reminder to drink responsibly.

4.1.2. At 1530, TOO SHORT arrived at Whitehall Bay and anchored in approximately 12 feet of water. The observed weather conditions in Whitehall Bay, Annapolis, included southeast winds at two to four knots, seas of less than one foot, air and water temperatures of 77 degrees Fahrenheit, and clear skies. The crew made the aft deck accessible, allowing passengers to enter and exit the water freely. TOO SHORT was equipped with a swimming platform and an approximate eight-foot line secured to a floating Bote dock in the water. Additionally, the vessel offered paddleboards and floating tubes, providing passengers with options to enjoy the water at their own leisure and comfort level.

Figure 2. Red Circles note the departure and arrival points from Annapolis Harbor Marina, MD, to Whitehall Bay.

Figure 3. An overall view of the Bote floating dock platform utilized by the swimming passengers. On the day of the incident, the platform was in the water, as opposed to on the deck of the vessel.

4.1.3. From 1530 to 1630, the Master observed several passengers, including Passenger 1, consuming canned alcoholic beverages brought onboard the vessel. However, the Master did not observe any concerns regarding the swimming abilities for any of the passengers or their overall level of alcohol consumption.

4.1.4. At 1700, Passenger 1 and another swimmer began tossing a football back and forth in the water.

4.1.5. At 1715, CM1 instructed all passengers in the water to return to the vessel in preparation for departure from Whitehall Bay. CM1 then proceeded below deck to the vessel's salon, while CM2 began loading the paddleboards back onto the vessel in preparation for weighing the anchor.

4.1.6. At 1715, Passenger 1, who had been in the water for nearly two hours with intermittent breaks on the Bote floating dock, began to swim approximately 50 feet from TOO SHORT to retrieve a football that was drifting away. The Master observed Passenger 1's actions and shouted for him to abandon the football, advising that it could be retrieved later. Despite this, Passenger 1 continued swimming toward the football and soon began struggling to stay afloat. The other passenger in the water called out for help, alerting the crew and other passengers on board.

4.1.7. At 1720, several of the passengers observed Passenger 1 sink below the water’s surface. CM2 and the Master immediately jumped into the water to attempt rescue of Passenger 1. CM1 observed other passengers trying to assist with the rescue by throwing life jackets into the water. Despite all efforts, the crew and passengers were unable to locate Passenger 1 in the murky water.

4.1.8. At 1721, the Master shouted back to TOO SHORT, instructing CM1 to request emergency assistance and launch the dinghy so the Master could return to the vessel and don diving equipment to search for Passenger 1. CM1 proceeded to launch the dinghy from standby position in the water from the stern of the vessel. A passenger aboard TOO SHORT called 911 for emergency assistance.

4.1.9. At 1725, the Master and CM2 returned to TOO SHORT in the dinghy. The Master donned scuba diving equipment and went back out to the last known location of Passenger 1 to search underwater. The Master continued diving until reaching the bottom at approximately 12 feet of depth but was unsuccessful in locating Passenger 1 due to the limited visibility in the murky water.

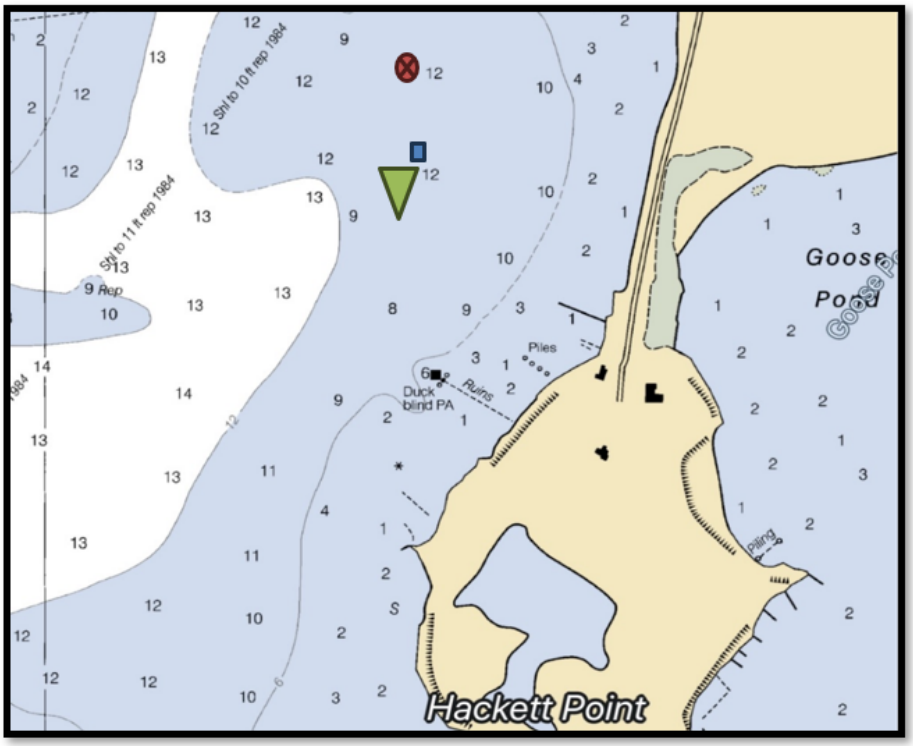

Figure 4. An image showing the charted water depths in Whitehall Bay. A depth of 12 feet was indicated where the TOO SHORT was anchored when the incident occurred. The approximate location of TOO SHORT is represented by the green triangle; the Bote floating platform is the blue square, and approximate drowning location is indicated by the red and black circle.

4.1.10. At 1730, emergency responders from MNRP rescue boat 883, AAFD fire boats 5 and 36, and SYSCOM helicopter Trooper 2 arrived on the scene and began their search for Passenger 1 utilizing search patterns, sonar, and divers.

4.1.11. At 1731, CM2 used VHF Channel 16 to contact the Coast Guard, hailing a "Mayday" for a person in the water. Coast Guard Sector Maryland-NCR issued an Urgent Marine Information Broadcast for a person in the water over Channel 16. Coast Guard Station Annapolis launched a rescue boat, call sign CG29463, to assist in the search with an estimated 20 minutes to arrival on scene. A Coast Guard Auxiliary unit, CG23569, was responding with an estimated 5 minutes to Whitehall Bay to assist with the search.

4.1.12. At 1826, emergency responders from AAFD fire boat 36 located Passenger 1 under the surface of the water via a diver after confirming a sonar hit by AAFD fire boat 5 and began recovery efforts of Passenger 1 from the water.

4.1.13. At 1830, emergency responders with AAFD fire boat 36 recovered unresponsive Passenger 1 from the water and commenced cardiopulmonary resuscitation revival efforts. Despite their revival attempts, Passenger 1 remained unresponsive. The individual was transported to the Maryland Department of Transportation Authority pier in Mezick Pond to meet with AACO CIS and the coroner. Passenger 1 was then transferred via Mid-Atlantic Transport services to the University of Maryland Hospital in Baltimore, MD, where he was pronounced deceased.

4.1.14. At 1900, TOO SHORT weighed the anchor and proceeded back to Annapolis Harbor to offload the remaining passengers.

4.1.15. At 1945, TOO SHORT offloaded the passengers at the Annapolis Harbor Marina docks and then moored to mooring ball number 1 in Spa Creek, Annapolis, MD.

4.1.16. On June 17, 2024, at 1442, the Master, CM1, and CM2, who were directly involved in the incident, underwent chemical testing for evidence of drug in accordance with 46 CFR Subpart 4.06. The drug test results were negative for all crew members. Alcohol testing strips were not available on the vessel and the responding MNRP officers did not determine a reasonable suspicion to conduct alcohol testing of the crew, therefore, alcohol testing of the crew was not conducted.

4.1.17. On September 16, 2024, a subsequent medical autopsy by the State of Maryland's Office of the Chief Medical Examiner (OCME) determined the cause of death to be drowning, with the manner of death ruled as accidental. The post-mortem toxicology report revealed an ethanol concentration of 0.08 percent in the deceased's bloodstream and 0.11 percent in the urine, confirming the Master's account of all passengers who were partaking in drinking, were drinking responsibly. Drug testing returned negative results.

4.2. Additional/Supporting Information:

4.2.1. Whitehall Bay, Maryland was located east of Annapolis Maryland, a high maritime tourist destination. Although Whitehall Bay was not designated as a Maryland State Park swim area, it was common practice for recreational vessels to anchor and allow passengers to swim in the water.

4.2.2. The vessel, TOO SHORT, was a 46.3-foot foreign-built uninspected catamaran used primarily for day charters offering sailing and swimming excursions. During the winter months, it was operated from Boca Raton, FL, and from approximately June to September, it operated from Annapolis, MD. The vessel held a valid Certificate of Documentation (COD) with a recreational endorsement only. TOO SHORT did not hold a Certificate of Inspection; 46 CFR Subchapter T requires all vessels of less than 100 gross tons carrying more than six passengers, including at least one for hire, to be inspected by the Coast Guard.

4.2.3. TOO SHORT was chartered with crew provided, offering services for up to 12 passengers-for-hire via GETMYBOAT.com. The owner of WINDSONG CHARTERS LLC was appointed as the Master of the charter and the owner specified the crew. Coast Guard Navigation and Vessel Inspection Circular number 7-94, Guidance on the Passenger Vessel Safety Act of 1993, specifies that vessels chartered with the crew provided or specified by the owner are subject to inspection as small passenger vessels.

4.2.4. WINDSONG CHARTERS LLC owned and operated TOO SHORT since January 2024. The company owner primarily engaged in bareboat chartering services but additionally utilized TOO SHORT as his alternate home of residence. The vessel typically moored to mooring ball number 1 in Spa Creek of Annapolis, Maryland.

4.2.5. WINDSONG CHARTERS LLC did not have any established policies or procedures for swimming excursions involving passengers aboard TOO SHORT. There were no written guidelines for safely entering or exiting the water, or for using hand signals to signal distress while swimming. Additionally, there were no protocols in place

to ensure that crewmembers maintained visual contact with passengers in the water, nor were there any outlined responsibilities for the Master regarding passenger safety in the water. It was routine for passengers to enter the water during charter excursions.

4.2.6. WINDSONG CHARTERS LLC had no written instructions mandating the use of life jackets while passengers were swimming, nor was there a requirement for crewmembers to assess the swimming abilities of passengers before allowing them to enter the water.

4.2.7. WINDSONG CHARTERS LLC had no formal policies in place to limit alcohol consumption aboard TOO SHORT. The Master provided general guidance to passengers, which included encouraging responsible drinking, ensuring that all alcohol consumers were of legal drinking age (21 or older), and reminding passengers that anyone behaving disruptively due to alcohol would be escorted back to shore and required to disembark the vessel.

4.2.8. The Master held a valid Merchant Mariner's Credential (MMC) for self-propelled vessels under 50 gross tons (GT), which was not required if operating TOO SHORT as a legal bareboat charter. A valid MMC was required if operating TOO SHORT as an inspected small passenger vessel. The Master was also the registered owner of WINDSONG CHARTERS LLC and had been conducting charter operations aboard TOO SHORT since August 2023.

4.2.9. CM1 was an employee aboard TOO SHORT and served as the Operating Manager for WINDSONG CHARTERS LLC, assisting with charter operations since August 2023. She did not hold a Merchant Mariner Credential (MMC), nor was one required for her position.

4.2.10. CM2 was employed aboard TOO SHORT and contributed as crew for charter operations with WINDSONG CHARTERS LLC for approximately four months. She did not hold a Merchant Mariner Credential (MMC), nor was one required for her position.

4.2.11. When Passenger 1 embarked TOO SHORT, he was five feet and seven inches in height, weighed 190 pounds, had no medical history, and was considered a good swimmer by the account of the other passengers. A subsequent medical autopsy of his heart by the OCME revealed increased fibrous and elastic tissue in and around the sinoatrial node, as described in cases of sinus node dysfunction and long QT syndrome.

4.2.12. A review of the Master's work/rest history for the 96-hour period leading up to the incident revealed no signs of impairment or any indication of an inability to perform the assigned duties as required.

5. Analysis

5.1 **Lack of established procedures to enforce lifejacket donning for swimmers**. The crew conducted a passenger safety briefing with the passengers, which detailed lifejackets locations aboard the TOO SHORT. Although Coast Guard approved lifejackets were available, they were not required to be worn for those passengers entering the water. Instead, passengers were entrusted with their own swimming abilities. Wearing of a proper Coast

Guard approved lifejacket can reduce the associated risk of drowning and could have prevented Passenger 1's death.

5.2 **Lack of protocols to effectively monitor swimming times.** TOO SHORT was primarily utilized for 4-hour long day cruise operations, to include anchoring to allow passengers to swim and utilize the various floatable items in the water. Since passengers could use these floatable items to take swimming breaks, passengers swam unattended for prolonged periods with the occasional glance over by the crew; total swimming times were not monitored or limited as there were no formal protocols for the crew to do so. In this case, Passenger 1 remained engaged in swimming activities, using the Bote inflatable dock as needed, for nearly two hours. Prolonged swimming can cause overexertion, muscle fatigue, or cramping and could have increased the risk of drowning.

5.3 **Failure of communication efforts between the master and Passenger 1**. Passenger 1 had been playing catch with a football, when the football began drifting away, resulting in Passenger 1 attempting its retrieval. The Master shouted at Passenger 1, who was approximately 50 feet from TOO SHORT at the time, urging him to leave the football. Despite the communication attempts, Passenger 1 continued to swim after the football and ultimately drowned. It is unclear whether Passenger 1 heard the Master's commands or not. Either way, had the Master's communication efforts to Passenger 1 been successful, it's possible Passenger 1 would have returned to the vessel safely and avoided distress in the water.

5.4 **Lack of established alcohol consumption policies or limitations**. A post-mortem toxicology report was conducted during the autopsy of Passenger 1 by the OCME. WINDSONG CHARTERS LLC had no formal policies to limit alcohol consumption. The Master provided general guidance during a passenger safety briefing to drink responsibly. The investigation revealed that alcohol was consumed by Passenger 1 while he was participating in swimming activities. Alcohol was detected in Passenger 1's bloodstream at a level of 0.08 percent, and in the urine at 0.11 percent. Consuming alcohol can lead to symptoms such as slowed decision-making, misjudgment, reduced reaction time, and impaired coordination. Had alcohol policies to limit consumption been established, it could have reduced the risk of Passenger 1 encountering complications while swimming.

5.5 **Lack of established emergency procedures for distressed passengers in the water**. WINDSONG CHARTERS LLC had no emergency procedures for the crew if passengers encountered distress in the water. Established policy can ascertain crew roles and responsibilities during standard and emergency situations. Additionally, a prior identification of hand signals for passengers to utilize to signal crew if experiencing distress in water could be beneficial if unable or unsuccessful in shouting for help. WINDSONG CHARTERS LLC likely believed its existing practices were adequate, as there had been no prior incidents to drive formal policy establishment. Had such procedures been established, it may have increased Passenger 1's distress detection and improved emergency response efforts.

5.6 **Failure of owner to comply with established small passenger vessel regulations.** TOO SHORT was chartered with a crew carrying over six passengers for hire, and thus, was operating as an illegal small passenger vessel (SPV). SPVs are regulated under 46 CFR Subchapter T and are subject to a Coast Guard inspection process prior to being issued a Certificate of Inspection (COI). During these inspections, federal regulations are applied by

Inspectors to determine any unique operating conditions based on a vessel's intended operation and route. Had the vessel been properly subjected to this oversight, the intended operations—such as chartering limitations or passenger activities, would have been evaluated against established policy, regulations, and laws. As an inspected vessel, man overboard procedures would have been established and passenger safety would have been evaluated by the owner, potentially identifying lookout and life jacket requirements for passengers entering the water and may have reduced risk associated with such in-water activities.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty occurred when Passenger 1 drowned. Causal factors leading to this event were:

6.1.1.1. Swimmers were not required to wear a lifejacket in the water.

6.1.1.2. The crew was not required to monitor swimming times of the passengers.

6.1.1.3. The communication efforts by the Master attempting to deter Passenger 1 from retrieving the drifting football were unsuccessful.

6.1.1.4. Passenger 1 had been consuming alcohol while partaking in physically demanding activities in the water.

6.1.1.5. Crew procedures were not established for identification of in-water passengers in distress.

6.1.1.6. The owner/operator of TOO SHORT was operating as an illegal small passenger vessel the day of incident.

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: This investigation identified evidence of acts or violations of law by a credential mariner for the following:

6.2.1. The Master failed to obtain a COI for the TOO SHORT, a vessel of less than 100 gross tons carrying more than six passengers, including at least one for hire, as required by 46 CFR 176.100(a).

6.3. Evidence of Act(s) or 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 identified that contributed to this casualty.

6.4. Evidence of Act(s) Subject to Civil Penalty: This investigation identified potential violations warranting civil penalty assessments for the following:

6.4.1. The company owner failed to obtain a COI, as required by 46 CFR 176.100(a).

6.4.2. The company owner failed to obtain a COD endorsed for Coastwise trade, as required by 46 CFR 67.7.

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 identified no matters needing new or amended U.S. law or regulation.

6.7. Unsafe Actions or Conditions that Were Not Causal Factors: This investigation revealed the following unsafe action or condition outside of the causal factors identified in paragraphs 5.1 through 5.6 above:

6.7.1. *Passenger 1 had a pre-existing medical condition*. A subsequent medical autopsy of his heart by the OCME revealed increased fibrous and elastic tissue in and around the sinoatrial node, as described in cases of sinus node dysfunction and long QT syndrome. According to the American Academy of Family Physicians (AAFP), these conditions "may result in the inability to meet physiological demands, especially during periods of physical activity" and "has a known association with sudden death during exercise, especially swimming." Due to the physical demands of swimming, Passenger 1's pre-existing heart condition could have increased the risk of drowning but was not a conclusive causal factor.

7. Actions Taken Since the Incident

7.1. On June 28, 2024, the owner/operator of TOO SHORT and WINDSONG CHARTERS LLC was issued a Captain of the Port Order by the Coast Guard, directing them to cease small passenger vessel operations.

7.2. After the issuance, the Coast Guard met with the Owner, educated them on the statutory and regulatory requirements of inspected and uninspected service. In lieu of meeting regulatory requirements, the Master/Owner decided to sell WINDSONG CHARTERS LLC and only operate the vessel as a recreational vessel.

7.3. On July 03, 2024, the Captain of the Port Order was rescinded.

8. Recommendations

8.1. Administrative Recommendations:

8.1.1. Recommend no enforcement action for the violations identified in paragraph 6.2. and 6.4 above due to the accidental nature of the drowning. The vessel's regulatory compliance was rectified after this marine casualty.

8.1.2. Recommend this investigation be closed.

[redacted]

Lieutenant, U.S. Coast Guard