United States Coast Guard

Report of the Investigation Into the Parasailing Vessel (TX5126HF), Passenger Loss of Life on August 8, 2015

MISLE Activity Number: 5211789. MISLE Case Number: 739947.

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

Commandant
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16732/IIA # 5211789
22 July 2025

LOSS OF LIFE OCCURRING ON THE UNINSPECTED PASSENGER VESSEL TX5126HF WHILE CONDUCTING PARASAILING OPERATIONS IN THE VICINITY OF PIER 19 ON THE LAGUNA MADRE, SOUTH PADRE ISLAND, TEXAS ON AUGUST 8, 2015

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

The United States Coast Guard (USCG) currently lacks regulatory authority to compel compliance with regard to parasailing operations, equipment, or parasail specific endorsements for merchant mariner credentialing. However, since 2009, the USCG has shepherded the development of consensus standards with industry stakeholders including the Water Sports Industry Association (WSIA).

In January 2012, the USCG requested that parasailing stakeholders and WSIA develop voluntary standards for the parasailing industry using the American Society for Testing and Materials (ASTM) consensus standards process. A subcommittee was formally established in the fall of 2012, and the first ASTM standards were published in April 2013.

The ASTM *Standard Practices for Parasailing* continue to be reviewed and have undergone multiple revisions over the past twelve years, the most recent version being F3099-23. The parasail industry has taken extensive action towards improving operational safety. Key elements of the standard are: Weather Monitoring and Limits, Equipment, Towline Care, Operations, Crew Requirements, Emergency Procedures, and Patron Responsibility. The USCG continues to monitor the industry's implementation of the ASTM standards and evaluate their effectiveness. This is completed through USCG presence at annual parasailing conferences and engagement with the WSIA and by periodically providing casualty data to measure ASTM standard effectiveness.

Since 2009, the USCG has issued multiple Marine Safety Alerts (MSAs) and Marine Safety Information Bulletins (MSIBs) to the public, which are specific to the parasailing industry and include the following:

- 2009: Safety Alert 06-09: 'Parasailing Incidents'
- 2011: Safety Alert 05-11: 'Parasailing: Know your Ropes'

- 2012: The Commandant released message (R 1918512 Jan 12) regarding commercial parasailing vessel safety and included the "Commercial Parasailing Vessel Safety Guidance," which prescribes how outreach to parasail operators should be conducted by USCG units.
- 2013: Safety Alert 07-13: 'Parasailing Operations - Know Your Ropes (2)'
- 2014: Safety Alert 05-14: 'Overheating of Parasailing Vessel Hydraulic System'
- 2015: MSIB 003-15: 'Parasailing - Flight Safety and Rules'
- 2015: Safety Alert 07-15: 'Prevent Parasail Accidents: Follow ASTM Standards and Follow Manufacturer Instructions!'
- 2018: Safety Alert 12-18: 'Hazards of Parasail and Watersport Passenger Transfers'
- 2019: MSIB 002-19: 'Parasailing - Navigation Rules and Flight Safety'

A hazardous condition is any condition that may adversely affect the safety of any vessel, bridge, structure, or shore area or the environmental quality of any port, harbor, or navigable waterway of the United States. In July 2015, the USCG issued Navigation and Vessel Inspection Circular (NVIC) 1-15, "Title 46, Code of Federal Regulations (CFR), Part 4 Marine Casualty Reporting Procedures Guide with Associated Standard Interpretations." NVIC 1-15 clarifies that parasailing accidents not reaching reportable marine casualty thresholds in 46 CFR § 4.05-1 would still constitute a hazardous condition as defined in 33 CFR § 160.202 and meet the subsequent reporting requirement of hazardous conditions as defined in 33 CFR §160.216.

In 2015, USCG Training Center Yorktown added a parasail casualty scenario to the Investigating Officer Course curriculum. This scenario offers USCG Investigating Officers the opportunity to consider the unique investigation considerations associated with parasail operations.

Since this incident occurred in August of 2015, parasailing fatalities and injuries have significantly declined. The USCG will continue to monitor parasailing safety and continue collaborative efforts with stakeholders to improve safety.

Through safety initiatives in public education and outreach, established ASTM standards, and continued partnership with WSIA and ASTM representatives, I am confident that the intent of the following recommendations have been addressed as is evidenced through the downward trends in parasailing related casualties. The closure of this investigation will allow the USCG to share its findings and any third-party safety recommendations with our parasailing industry partners to further strengthen safety measures within the industry.

ACTION ON RECOMMENDATIONS

Recommendation 1: Recommend to the Commandant of the USCG to seek a legislative change request to change the definition of small passenger vessel (SPV) under 46 United States Code (USC) 2101 (35) to include a parasailing vessel that carries at least one passenger for hire.

> **Action:** I do not concur with this recommendation. The investigation's findings indicated that the primary causal factor in this marine casualty was master and crew negligence. The greatest risk for parasailing vessels and passengers is operational in nature. Because operational risks are not already addressed in existing regulations, the risks would need to be mitigated through regulation. Therefore, a legislative change proposal (LCP) adding all parasailing vessels to the definition of a SPV, including those

regulated under Title 46 CFR, Subchapter C, would likely also require implementing regulations to ensure safe parasailing operations.

The recommendations to implement regulations for parasailing operations are suggested in Safety Recommendations 2 and 3 of this investigation. However, these regulations would have unintended consequences for 46 CFR Subchapter C and T parasailing vessels, particularly affecting uninspected vessels under Subchapter C. Two of these unintended consequences are:

1. The Parasail Safety Council estimates there are 630 active parasail vessels, of which 290 currently maintain a valid Certificate of Inspection (COI). The proposed LCP would require each of the approximately 340 uninspected vessels to obtain a valid COI prior to engaging in parasailing operations. Prior to being issued a COI, each vessel would have to demonstrate that it meets the relevant sections of Subchapter T, including standards for construction, stability, watertight integrity, lifesaving, fire protection, electrical systems, engineering, and navigation. The resulting compliance ramifications would likely force many operators out of business.
2. 46 CFR Subchapter B outlines more stringent requirements for a SPV master's endorsement than for operators of uninspected passenger vessels. Therefore, requiring Operator of Uninspected Passenger Vessel (OUPV) licensed mariners currently operating parasailing vessels to meet these higher standards could unnecessarily disqualify many experienced operators.

Even if the LCP was successfully codified, adding parasail vessels currently regulated under Subchapter C to the definition of SPVs (Title 46 USC 2101) would most likely not have the desired benefit and would prove to be overly burdensome for a large percentage of the parasailing industry. Specifically, the change would not address the primary causal factor in this incident, which was the negligence of the master and crew.

However, the USCG recognizes the inherent risks of parasailing due to past incidents. As a result, the USCG released MSIB #02-19, Parasailing – Navigation Rules and Flight Safety and MSA #07-13, Parasailing Operations – Know Your Ropes. To help prevent future parasailing incidents, the USCG will conduct a review of the historical guidance to parasailing operators to determine if the existing publications need to be updated and/or reissued.

Recommendation 2: Recommend to the Commandant of the USCG to seek a regulatory rulemaking to incorporate the aforementioned LCP into existing SPV regulations, Title 46, CFR, Subchapter T, in order to safely govern commercial parasailing.

Action: I do not concur with this recommendation. The findings for this investigation do not support pursuing an LCP at this time.

Recommendation 3: Recommend to the Commandant of the USCG incorporate ASTM F3099-14 into existing SPV regulations, Title 46, CFR, Subchapter T, in order to safely govern commercial parasailing conducted from vessels that are currently within the USCG's jurisdictional boundaries. ASTM F3099-14 should be incorporated by reference as it has been developed in concert with the parasailing community, has established a baseline for safe parasailing operations, and has been found to be effective at reducing parasailing casualties.

These regulations would compel parasail owners and operators across the country to operate at an acceptable level of safety expected by the American public.

Action: I concur with the intent of this recommendation. I do not believe the analysis in this Report of Investigation (ROI) supports this recommendation. Incorporating ASTM F3099-23 into SPV regulations, Title 46 CFR, Subchapter T will not address the causal factors of this marine casualty because the subject vessel is an "uninspected vessel" and is not regulated under Subchapter T, but instead, 46 CFR, Subchapter C.

Moreover, the requirements of the ASTM standard would far exceed the existing requirements of Subchapter C vessels with respect to marine engineering, credentialing, training, crew manning, etc. Furthermore, the incorporation of this ASTM standard would likely not have prevented this marine casualty.

The investigation determined that the primary cause of the casualty was the master's negligence. Specifically, the master allowed the victim, who had a blood alcohol content (BAC) of 0.303%, to parasail. The victim's BAC was nearly 4 times the Texas legal limit for alcohol intoxication (0.08%) and as a result, the victim should not have been allowed to parasail in that extreme state of intoxication. I note that another passenger on the vessel informed the master and crew about the victim's intoxicated state on two occasions prior to the victim going airborne. The passenger's warnings were subsequently ignored by the vessel's master and crew.

Because of the clear negligence of the master, this casualty does not justify the potential unintended consequences that would accompany a rulemaking to incorporate ASTM F3099-23 into Subchapter T, including but not limited to:

1. The manning requirements for Subchapters C and T vessels do not align with the manning requirements as outlined in ASTM F3099-23.
2. ASTM F3099-23 requires the master to complete a minimum of 500 parasailing flight rotations and the deckhand to complete 50 flight rotations. However, compliance with those new requirements for credentialing and inspection for certification purposes would presumably need to be monitored by the USCG. However, parasailing flight rotations are outside of USCG's area of expertise.

Recommendation 4: Recommend to the Commandant of the USCG that after enacting regulations for inspection of commercial parasailing vessels, the USCG should establish a merchant mariner credential endorsement that requires parasail operators to demonstrate their ability to conduct proper parasail operations. The ASTM steering committee and the ASTM F3099-14 standard may be used to establish this requirement.

Action: I do not concur with the recommendation to establish credentials or endorsements specifically for parasailing operations or separate individual regulations for parasailing to cover these vessel operations. While merchant mariner credentials are issued to individuals meeting the qualifications for vessel operations, they do not extend to all recreational or commercial activities that a credentialed mariner might undertake, including activities such as parasailing, waterskiing, or other similar activities. Adding credentialing endorsements for additional activities like parasailing would significantly expand mariner credentialing beyond the safety and security of individual vessel

operations. The following points from the ROI reinforce why a requirement for an additional parasailing credential endorsement would not have prevented this incident.

1. The ROI indicates that existing ASTM standards were not followed by the master or deckhand of the TX5126HF and this directly contributed to the fall of the passenger from her parasailing harness. ASTM standards were not followed despite the company co-owner signing the insurance policy in 2015 that stated, "The insured warrants that it has reviewed and is familiar with all ASTM Commercial Parasail Guidelines and agrees to adhere to them, including any amendments to and current versions of the standards. The insured further warrants that it regularly reviews the standards with all crew members."
2. The ROI did not cite evidence or documentation to demonstrate how the death of the passenger could have been prevented if there was an established merchant mariner endorsement for parasail operators, and it failed to demonstrate how this would have influenced the crew to follow existing standards, which they had already been made aware of through ASTM.
3. There is a wide variety of dangerous equipment operated by mariners including forklifts, welding, and cutting tools, cargo elevators, and cranes as examples, which do not require a merchant mariner credential endorsement. Mariners are covered by other regulatory agencies such as the Occupational Safety and Health Administration (OSHA) and should be held to the use of industry best practices (such as ASTM) and guidance when using non-standard dangerous equipment onboard vessels.

The USCG is not in a position to regulate or inspect all of the additional activities associated with vessel operations. However, in an advanced notice of proposed rulemaking, the USCG proposed a regulation that, if implemented, would require SPV and OUPV owners and operators to address the risks related to parasailing operations in a safety management system (SMS). The use of an SMS has also been noted and suggested in previous USCG investigations into parasailing incidents. An SMS is a better mechanism to cover a wide variety of vessel activities instead of developing specific regulations for each of them. In addition, under an SMS, mariner training for parasailing equipment operations and maintenance for individual manufacturers, adopting national standards, particular vessel handling capabilities, and operational and navigation concerns could be addressed including operational restrictions related to weather conditions and flight parameters. This approach would meet the optional safety needs without developing an individual endorsement for a merchant mariner credential and allow USCG inspections to maintain additional oversight of parasailing operations and other vessel activities within their Officer in Charge, Marine Inspection zone.

Recommendation 5: Recommend to the state of Texas, in lieu of federal regulations, to adopt and put into effect an act similar to the state of Florida's "White-Miskell Act" for parasail operations to include the requirement for parasail operators to adhere to ASTM F3099-14 standard.

Action: A copy of this ROI and its accompanying safety recommendations will be sent to the Texas Parks and Wildlife Department for the Boating Law Administrator's consideration.

Recommendation 6: Recommend to Sector Corpus Christi Inspections Division to continue education and conduct outreach in order to promote parasail safety at least once a year. The ideal timeframe would be prior to Spring Break, which is the beginning of the operating season for most parasailing operators at South Padre Island and Port Aransas. These efforts should include discussions on published USCG MSIBs, MSA, and the most current industry version of ASTM F3099-14. Also, the discussion should include outcomes of parasailing marine casualty investigations and subsequent enforcement proceedings. These engagements should take place with all levels of management and operation at a parasailing company, but should primarily focus on the masters and crew of the parasailing vessels. Outreach should be done when conducting SPV inspections and dockside walks.

> **Action:** I note that Sector Corpus Christi concurred with this recommendation and that their marine inspectors are conducting the recommended outreach efforts.

Recommendation 7: Recommend to the ASTM steering committee to amend ASTM F3099-14, section 6.3 "Emergency Procedures" to require verbal briefings of parasailing emergency procedures prior to parasailing flight. Verbal briefings would ensure that passengers have the crew's undivided attention in order to facilitate the full understanding of what actions should be taken in emergency situations. It also would remind the passengers that although they are participating in an enjoyable recreational activity, that there are inherent risks associated with parasailing and to be cognizant to the possibility of an emergency occurring during any given flight.

Recommendation 8: In addition to verbal briefings, the ASTM steering committee should consider incorporating a more direct form of communication between the parasail canopy and flight monitor on the parasail vessel, like a two-way radio, into the required equipment section 5.2 of ASTM F3099-14. This would eliminate any doubt as to whether or not an issue was occurring aloft, and would enable rapid response of the crew if necessary.

Recommendation 9: Recommend to the ASTM steering committee to amend ASTM F3099-14, section 7, "Crew Requirements" to mandate "flight monitoring" as a part of the Masters' responsibilities in section 7.3 and the Deckhands' responsibilities in section 7.4. Flight monitoring should be defined as a consistent watch on the parasail canopy during parasail flight, conducted by at least one of the crew members on board a parasail vessel. Having an active watch for flight monitoring will help to identify and mitigate any issues that may arise while passengers are aloft. The watch will also enable a quick response of the crew if necessary.

> **Action:** I concur with the intent of Recommendations 7 through 9. A copy of this ROI and its accompanying safety recommendations will be sent to ASTM for their consideration.

Administrative Recommendation 1: Recommend to Commander, Sector Corpus Christi to refer this case to the Department of Justice for potential criminal prosecution of the captain and deckhand of the TX5l26HF under the Seaman's Manslaughter Act (18 USC 1115) for negligence for failing to follow ASTM standards in way of donning and use of parasail harness, not heeding intoxication and falling warnings, and inability to recover passenger from the water, which contributed to the death of the passenger.

> **Action:** I note that Sector Corpus Christi referred this case to the Department of Justice for potential criminal enforcement. However, the referral was declined.

Administrative Recommendation 2: Recommend to Commander, Sector Corpus Christi to initiate Suspension and Revocation proceedings under Title 46 USC 7703 against the master of the TX5126HF for alleged misconduct and negligence for failing to follow ASTM standards in way of donning and use of parasail harness, not heeding intoxication and falling warnings, and inability to recover passenger from the water, which contributed to the death of the passenger.

> **Action:** I note that Sector Corpus Christi did not pursue an administrative enforcement case against the involved master in this case and that the statute of limitations to file a suspension and revocation complaint has lapsed.

Administrative Recommendation 3: Recommend to Commander, Sector Corpus Christi to formally recognize both good Samaritans who attempted to save the life of the passenger in this incident.

> **Action:** I note that Sector Corpus Cristi attempted to recognize the good Samaritans who assisted the victim during the incident. However, the intended recipients declined the recognition.

[redacted]

R. C. COMPHER
Captain, U.S. Coast Guard
Director of Inspections & Compliance (CG-5PC)

U.S. Department of Homeland Security

United States Coast Guard

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DEC 04 2023

LOSS OF LIFE ABOARD THE TX5126HF ON 08/08/2015

**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 subject to the following comments. It is recommended that this marine casualty investigation be closed.

COMMENTS ON THE REPORT

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

2. The investigation and report contain valuable information which can be used to address the preventable chain of events that caused this marine casualty, and to prevent similar incidents from occurring in the future.

ENDORSEMENT ON RECOMMENDATIONS

Safety Recommendation 1: Recommend to the Commandant of the Coast Guard to seek a legislative change request to change the definition of small passenger vessel (SPV) under 46 United States Code (USC) 2101 (35) to include a parasailing vessel that carries at least one passenger for hire.

Endorsement: I do not concur with this recommendation. Current parasail operations fall clearly and appropriately within the definition of 'Uninspected Passenger Vessel' as defined by 46 USC 2101 (53). Redefining parasail vessels as Small Passenger vessels (SPV) per title 46 USC 2101 would be overly burdensome and detrimental to these commercial operations. A far majority of parasail vessels would never be able to achieve certification as an SPV and forcing such would decimate the industry. Furthermore, in reviewing the accompanied Report of Investigation (ROI), it is clear the most notable casual factors resulting in the

passenger's demise are related to human error (ill-fitted or incorrectly fitting the harness, passenger extreme intoxication, etc.) rather than regulatory oversight.

Safety Recommendation 2: Recommend to the Commandant of the Coast Guard to seek a regulatory rulemaking to incorporate the aforementioned legislative change into existing Small Passenger Vessel regulations, Title 46, Code of Federal Regulations (CFR), Subchapter T, in order to safely govern commercial parasailing.

Endorsement: I do not concur with this recommendation. Similarly, to my non-endorsement of Safety Recommendation 1, requiring inspection for certification of parasail vessels to the standards of Subchapter 'T' would be overburdensome, costly and unnecessarily decimate the parasail industry.

Safety Recommendation 3: Recommend to the Commandant of the Coast Guard incorporate ASTM F3099-14) into existing Small Passenger Vessel regulations, Title 46, Code of Federal Regulations (CFR), Subchapter T, in order to safely govern commercial parasailing conducted from vessels that are currently within the Coast Guard's jurisdictional boundaries. ASTM F3099-14 should be incorporated by reference as it has been developed in concert with the parasailing community, has established a baseline for safe parasailing operations, and has been found to be effective at reducing parasailing casualties. These regulations would compel parasail owners and operators across the country to operate at an acceptable level of safety expected by the American public.

Endorsement: Though I understand the intent, I do not concur with this recommendation. The Coast Guard relies on multiple professional oversight and guidance publications as a primary or alternative means of safety measures where it lacks the expertise. In this instance, other ASTM standards are already incorporated by reference to bolster existing marine safety regulations on inspected vessels. Since parasail vessel are not currently inspected vessels, incorporating the ASTM F3099-19 standard by reference would be a moot point and unenforceable.

Safety Recommendation 4: Recommend to the Commandant of the Coast Guard that after enacting regulations for inspection of commercial parasailing vessels, the Coast Guard should establish a merchant mariner credential endorsement that requires parasail operators to demonstrate their ability to conduct proper parasail operations. The ASTM steering committee and the ASTM F3099-14 standard may be used to establish this requirement.

Endorsement: I do not concur with this recommendation. Under existing regulations, masters of small passenger vessels who conduct parasailing operations are required to hold a Coast Guard Merchant Mariner Credential (MMC) with either an Operator of Uninspected Passenger Vessel or a Master endorsement. Regulations in 46 CFR 15.405 states that each credentialed officer must become familiar with the relevant characteristics of a vessel prior to assuming duties. On parasailing vessels, that would include items related to their operations. In lieu of a specific endorsement, the Coast Guard continues to encourage all owners and operators to implement the voluntary standard from ASTM F3099 which was established in September 2014 and updated in March 2019. A section of ASTM F3099 includes voluntary standards for parasailing crew member training and proficiency. As such, no further action is recommended for the Commandant (CG-5P).

Safety Recommendation 5: Recommend to the state of Texas, in lieu of federal regulations, to adopt and put into effect an act similar to the state of Florida's "White-Miskell Act" for parasail operations to include the requirement for parasail operators adhere to ASTM F3099-14 standard.

Endorsement: I concur with the intent of this recommendation. The "White-Miskell Act" was put into place to increase parasailing safety in the state of Florida. The Act ensures the ASTM F3009-19 standard is complied with, as well as ensuring operators obtain and maintain insurance policies and possess current and valid merchant mariner credentials issued by the Coast Guard. The state of Texas may find similar results if they adopt a similar act. It is recommended the Commandant (CG-5P) consider sharing this report with Texas lawmakers for their consideration in whether to pursue their own version of the "White-Miskell Act" to reduce the occurrence of parasailing accidents in their state.

Safety Recommendation 6: Recommend to Sector Corpus Christi Inspections Division to continue education and conduct outreach in order to promote parasail safety at least once a year. The ideal timeframe would be prior to Spring Break which is the beginning of the operating season for most parasailing operators at South Padre Island and Port Aransas. These efforts should include discussions on published Coast Guard MSIBs, Safety Alerts, and the most current industry version of ASTM F3099-14. Also, the discussion should include outcomes of parasailing marine casualty investigations and subsequent enforcement proceedings. These engagements should take place with all levels of management and operation at a parasailing company but should primarily focus on the masters and crew of the parasailing vessels. Outreach should be done when conducting small passenger vessel inspections and dockside walks.

Endorsement: I concur with this recommendation. Education and outreach promoting the safety of parasailing operations can increase awareness and the possible adoption of parasailing safe work practices including the current ASTM Standards F3099-19. As such, this recommendation will be referred to the Captain of the Port, Sector Corpus Christi, for review and action.

Safety Recommendation 7: Recommend to the ASTM steering committee to amend ASTM F3099-14, section 6.3 "Emergency Procedures" to require verbal briefings of parasailing emergency procedures prior to parasailing flight. Verbal briefings would ensure that passengers have the crew's undivided attention in order to facilitate the full understanding of what actions should be taken in emergency situations. It also would remind the passengers that although they are participating in an enjoyable recreational activity, that there are inherent risks associated with parasailing and to be cognizant to the possibility of an emergency occurring during any given flight.

Endorsement: I concur with the intent of this recommendation. The requirement of a verbal briefing prior to flight may have ensured the passengers involved in this incident knew how to effectively communicate distress to the vessel crew. It is recommended that the Commandant (CG-5P) consider sharing this report with the ASTM steering committee for their consideration in revising the emergency procedures section of ASTM F3099-19.

Safety Recommendation 8: In addition to verbal briefings, the ASTM steering committee should consider incorporating a more direct form of communication between the parasail canopy and flight monitor on the parasail vessel, like a two-way radio, into the required equipment

section 5.2 of ASTM F3099-14. This would eliminate any doubt as to whether or not an issue was occurring aloft and would enable rapid response of the crew if necessary.

Endorsement: I do not concur with this recommendation. As mentioned in Endorsement 7, a verbal briefing to ensure everyone is aware of proper signals to use in the event of distress could have prevented this incident from occurring. A two-way radio, attached to the parasailing equipment, could become a hazard during flight. This hazard could increase the number of minor injuries, even in an otherwise uneventful flight, and therefore is not recommended. As such, no further action by the Commandant (CG-5P) is required.

Safety Recommendation 9: Recommend to the ASTM steering committee to amend ASTM F3099-14, section 7, "Crew Requirements" to mandate "flight monitoring" as a part of the Masters' responsibilities in section 7.3 and the Deckhands' responsibilities in section 7.4. Flight monitoring should be defined as a consistent watch on the parasail canopy during parasail flight, conducted by at least one of the crew members on board a parasail vessel. Having an active watch for flight monitoring will help to identify and mitigate any issues that may arise while passengers are aloft. The watch will also enable a quick response of the crew if necessary.

Endorsement: I concur with this recommendation. Since the conclusion of this investigation, the ASTM steering committee has updated the standard with the publication of ATSM Standard F3099-19, published in March 2019. Sections 7.2, 7.3 and 7.4 under 'Crew requirements' have not changed regarding 'Flight Monitoring', only that 'Flight Monitoring' remains listed as required training in section 7.2. The standard puts the responsibility on the owner to "…establish a crewmember training program that includes…" 'Flight Monitoring' (section 7.2.1.6) but offers no criteria or guidance. Additional guidance of 'Flight Monitoring' would provide a benchmark for minimum safety standards. Furthermore, detailing the specific responsibility in each section of the Master and Crewmember, emphasizes the importance of flight monitoring, which is a prominent casual factor identified in several casualty investigations where improvement is necessary to increase passenger safety.

[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

Commander
United States Coast Guard
Sector / Air Station Corpus Christi

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JAN 10 2018

MEMORANDUM [redacted]

From: R. A. Hahn, CAPT
CG SECTOR / AIRSTA Corpus Christi

To: [redacted], LT

Subj: TX5126HF LOSS OF LIFE ADMINISTRATIVE RECOMMENDATIONS

Ref: (a) 46 Code of Federal Regulations, Part 4, Marine Casualties and Investigations
(b) 18 United States Code 115, Misconduct or Neglect of Ship Officers
(c) 46 United States Code 7703, Bases for Suspension or Revocation

1. On 8 Aug 2015, the TX5126HF was conducting parasailing operations in the vicinity of Pier 19, on the Laguna Madre, South Padre Island, Texas, when one of the passengers aloft fell approximately three-hundred feet from her harness into the water below. The incident resulted in the death of the passenger. In accordance with reference (a), MSD Brownsville conducted a marine casualty investigation.

2. Findings and analysis of the subject investigation yielded four administrative recommendations for the Commander, Sector/Air Station Corpus Christi.

a. Section 7.2.1: Refer the case to the Department of Justice for potential criminal prosecution of the captain and the deckhand of the TX5126HF under the Seaman's Manslaughter Act (18 USC 1115) for negligence for failing to follow ASTM standards in way of donning and use of parasail harness, not heeding intoxication and falling warning, and inability to recover passenger from the water which contributed to the death of the passenger, as per reference (b).

b. Section 7.2.2: Initiate Suspension and Revocation proceedings against the master of the TX5126HF for alleged misconduct and negligence for failing to follow ASTM standards in way of donning and use of parasail harness, not heeding intoxication and falling warning, and inability to recover passenger from the water which contributed to the death of the passenger, as per reference (c).

c. Section 7.2.3: Formally recognize both the [redacted] and [redacted] family for their actions to attempt to save the life of [redacted].

d. Section 7.2.4: Close the investigation.

3. Administrative recommendation 1 was presented to Commander, Sector/Air Station Corpus Christi for review on 11 Dec 2015 and was found to be an actionable recommendation. The recommendation was approved by the Commandant, and was successfully referred to Department of Justice. The U.S. Attorney's Office for the Southern District of Texas has not taken any action for criminal prosecution.

4. Administrative recommendation 2 was presented to Sector/Air Station Corpus Christi's Investigations Division on 10 Jan 2017 and was found to be an actionable recommendation. Sector/Air Station Corpus Christi's Investigations Division is currently in the process of conducting Suspension and Revocation against the master of the TX5126HF.

5. Administrative recommendations 3 and 4 were presented to Commander, Sector/Air Station Corpus Christi and were found to be actionable recommendations.

6. This memorandum serves as an endorsement of the administrative recommendations promulgated by MSD Brownsville and the actions taken by Commander, Sector/Air Station Corpus Christi and Sector/Air Station Corpus Christi's Investigations Division to address concerns identified during the course of the subject marine casualty investigation. Therefore, it is requested that the status of these administrative recommendations and coinciding actions taken be considered as "Concur-Acceptable Action" for the purpose of the marine casualty investigation in accordance with reference (a).

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

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16732
16 Nov 2017

MEMORANDUM

[redacted]

From: [redacted]
Investigating Officer, MSD Brownsville

To: CG SECTOR / AIRSTA Corpus Christi [redacted] 1/10/18

Subj: LOSS OF LIFE ABOARD THE TX5126HF ON 08/08/2015, INVESTIGATING OFFICER'S REPORT

Ref: (a) Title 46 United States Code, Chapter 63
(b) Title 46 Code of Federal Regulations, Part 4
(c) Marine Safety Manual Volume V, COMDINST M16000.10A

Preliminary Statement

1.1. This investigation involving the death of a passenger aboard the TX 5126HF while conducting parasailing operations, along with the submission of this report, was conducted in accordance with the references listed above. The Incident Investigation Activity Number for this investigation is 5211789.

1.2. No other persons or organizations assisted in this investigation.

1.3. Sonny's Beach Service, Inc., and all of its involved employees were designated as parties-in-interest in this investigation in accordance with 46 CFR Subsection 4.03-10. There were no other persons or organizations requesting and/or being designated a party-in-interest.

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

Executive Summary

On 08 August 2015, at approximately 1816 hours, the TX5126HF was conducting parasailing operations with six passengers on board, in the vicinity of Pier 19, on the Laguna Madre, South Padre Island, Texas. Approximately four minutes into the first flight of the parasailing trip, one of the two passengers aloft fell approximately three-hundred feet from her harness into the water below. After realizing that the passenger was no longer in the parasailing canopy, the captain immediately maneuvered the parasailing vessel in the direction of the person in the water. The deckhand and another passenger aboard the parasailing vessel jumped into the water to recover the victim. With the parasailing vessel alongside, the captain and deckhand, along with the other

passengers on board, were unable to recover the victim, who was unresponsive, over the freeboard and back onto the parasailing vessel. Approximately eight minutes later, a passing vessel was hailed down, and the Good Samaritan's were able to recover the victim onto their shallow draft vessel's flat deck. A Coast Guard small boat arrived on scene shortly thereafter, and the victim was taken ashore by the small boat crew to awaiting emergency medical services at Coast Guard Station South Padre Island.

The victim was then taken via ambulance to Valley Regional Hospital in Brownsville, Texas, where she was declared deceased. The remaining passengers on board the TX5126HF were transferred to a shuttle vessel and were returned back to shore. The TX5126HF, was returned to its moorings at Tequila Sunset on South Padre Island. There was no damage sustained to the vessel due to the incident.

Through its investigation, the Coast Guard determined that the initiating event for this casualty was the victim entering the water from a height of 300 feet from her parasailing harness. Once in the water, the captain, deckhand, and other passengers were incapable of recovering the victim without the assistance of a second vessel. The victim subsequently passed away from blunt force trauma and drowning. The casual factors that contributed to this casualty were: (1) Lack of regulatory oversight for parasailing equipment and operations, (2) An existence of complacency within the company, (3) Distress message from aloft was not received by crew of parasail vessel, (4) Intoxication of the victim, (5) The harness was donned incorrectly on the victim, (6) Parasail vessel crew's inability to recover victim from the water.

Section 2 – Vessels Involved in the Incident

Vessel Name:	TX5126HF
Vessel Identification Number:	TX5126HF
Flag:	U.S.
Vessel Class/Type/Sub-Type	"Paracraft" Passenger Ship/Parasail Vessel/General (no more than 6)
Build Year:	1994
Length:	32 Feet
Main/Primary Propulsion: (Configuration/System Type, Ahead Horse Power)	330 HP Inboard Engine

Photo of the TX5126HF at South Padre Island August 2015

Section 3 – Record of Deceased, Missing, and Injured

Name (First, MI, Last)	Sex	Relationship to Vessel	Age	Status
[redacted]	F	Passenger	46	Deceased

Section 4 – Findings of Fact

4.1. There was no federal, state, or local regulatory oversight specific to the operation, maintenance, and inspection of parasail equipment and/or training standards for parasail crewmembers in place at the time of the incident.

4.2. Sonny's Beach Service, Inc., had been in operation since January 1986, and started parasailing operations in 1992. The company operated from a booth and dock that is co-located with "Tequila Sunset," a bar located on the Laguna Madre Bay side of the island. The company's insurance policy required adherence to American Society for Testing and Materials (ASTM) standards, along with regularly reviewing the standards with all crew members. The company and employees were not following ASTM standards and equipment manufacturer's instructions in way of the operation of parasail harnesses. The last formal company training for parasailing operations occurred in 1992 with the initial training from the parasailing equipment manufacturer, Custom Chutes, Inc. There had been no emergency training done on the parasailing vessel in recent memory, particularly no man overboard drills had been conducted.

4.3. On August 8, 2015, Ms. [redacted], the victim, and Mr. [redacted], her boyfriend, had started consuming alcohol around noon. The couple was from Castorville, Texas, and had arrived the day before the incident for a weekend vacation.

4.4. At approximately 1700 hours, Ms. [redacted] and Mr. [redacted] were dropped off at Tequila Sunset. The couple paid for the trip and signed all the necessary paperwork at the company booth. Company procedure was to have passengers read and sign a two-page, 13 bullet-point "Parasailing Pre-Board Safety Briefing," along with the company "Indemnity Agreement" and the "Waiver/Release of Liability" forms when paying for the trip at the company booth at the dock, prior to getting underway. Company staff gave no verbal briefing on what to do in the event of an emergency while passengers were aloft prior to the flight that evening.

4.5. At approximately 1710, while waiting for the shuttle vessel, Mr [redacted] stated that he and Ms. [redacted] had three or four rum and cokes apiece from the bar at Tequila Sunset.

4.6. At approximately 1730, the passengers were fitted with Type III life jackets by the shuttle vessel captain and booth staff prior to boarding the shuttle vessel at the dock.

4.7. At approximately 1745, the shuttle vessel was underway from the Tequila Sunset's dock enroute parasailing vessel, TX5126HF. Six passengers were aboard, including Ms. [redacted], Mr. [redacted] Mr. [redacted]., Mr. [redacted]., [redacted] girlfriend, Ms. [redacted], and [redacted] fiancée, Ms. [redacted]. Mr. [redacted] was the operator of the vessel.

4.8. At approximately 1747, Ms. [redacted], fell over on the shuttle vessel as it was transiting to the parasailing vessel. Shortly after her first fall, she fell over a second time almost overboard. Mr. [redacted] who was seated next to Ms. [redacted], caught her leg and prevented her from falling overboard. Mr. [redacted] voiced his concern about Ms. [redacted] intoxicated condition and her ability to parasail to Mr. [redacted] and relayed that she had fallen. Mr. [redacted] stopped the shuttle vessel, and asked Mr. [redacted] and Ms. [redacted] if they would like to reschedule for another time. Mr. [redacted] refused, and Mr. [redacted] continued the transit to the parasailing vessel.

4.9. At approximately 1805, all six passengers boarded the parasailing vessel. The operator of the vessel was Mr. [redacted], and the deckhand was Mr. [redacted]. Mr. [redacted]. told the crew of the parasailing vessel about Ms. [redacted] intoxicated condition.

4.10. At approximately 1810, Mr. [redacted] placed a parasail harness on Ms. [redacted], prior to her flight, and checked the fitting of her life jacket. The harness's waist strap was placed around her life jacket. Mr. [redacted] was placed into his harness the same way by Mr. [redacted]. There was no verbal briefing on parasail emergencies conducted by the parasailing vessel crew.

4.11. At approximately 1816, Mr. [redacted] operated the winch to launch Ms. [redacted] and Mr. [redacted] into the air.

4.12. At approximately 1818, after the two passengers reached a height of approximately 300 feet, Mr. [redacted] hat flew off his head. Mr. [redacted] maneuvered the vessel to retrieve the hat and Mr. [redacted] picked the hat up out of the water. Mr. [redacted] and Ms. [redacted] looked

up to observe Ms. [redacted] and Mr. [redacted] parasailing. The couple noted that Ms. [redacted] legs were tucked into her chest and her bottom was hanging low in an egg-like fashion. Mr. [redacted] voiced his concern to the crew about Ms. [redacted] positioning and the possibility of her falling. Mr. [redacted] said that she was ok and she wouldn't fall. Mr. [redacted] stated to Mr. [redacted] that there had been one other person previously that had parasailed from the vessel that had been "worse" or more intoxicated then Ms. [redacted].

4.13. Aloft at approximately 1818, Ms. [redacted] harness straps were down around her knees, and her life jacket was up around her neck. She was slipping out of her harness. She was holding onto her harness's straps with great effort. Mr. [redacted] tried to indicate to the crew below that Ms. [redacted] was having issues and the couple needed to return to the vessel. The vessel's crew did not respond.

4.14. At approximately 1820, Ms. [redacted] fell from her harness into the water from a height of approximately 300 feet. It was observed by both Ms [redacted] and Mr. [redacted] that Ms. [redacted] life jacket was still in the parasail harness.

4.15. At approximately 1821, after locating Ms. [redacted] in the water, Mr. [redacted] maneuvered the vessel in her direction to recover her. Approximately fifty yards away from Ms. [redacted], Mr. [redacted] and Mr. [redacted] jumped into water to retrieve her. Ms. [redacted] was face-down in the water. Mr. [redacted] returned to the vessel unable to reach Ms. [redacted]. Mr. [redacted] reached Ms. [redacted] pulled her head up out of the water, and tried to conduct CPR. The parasailing vessel maneuvered over to Mr. [redacted] and Ms. [redacted] and after multiple attempts, Mr. [redacted] and Mr. [redacted] were unable to recover or lift Ms. [redacted] onto the vessel. Mr. [redacted]. and Ms. [redacted] grabbed Ms. [redacted] arms from the side of the boat to help both Mr. [redacted] and Mr. [redacted] attempt to lift her into the boat. The four adults failed in their attempts to bring her back aboard. Mr. [redacted] notified emergency services via calling 911. Emergency services made initial notification by telephone to the U.S. Coast Guard, after receiving Mr. [redacted]s cell phone call from the parasailing vessel.

4.16. At approximately 1828, a family on a passing vessel stopped to assist and to help lift Ms. [redacted] onto the bow of their shallow-draft vessel. One of the persons on board the shallow-draft vessel, [redacted], started CPR on Ms. [redacted].

4.17. At approximately 1835, Coast Guard small boat 45750 arrived on scene and the crew transferred Ms. [redacted] to their vessel. Ms. [redacted] was transferred to emergency medical services which were waiting at USCG Station South Padre Island. EMS transferred Ms. [redacted] to Valley Regional Hospital in Brownsville, TX.

4.18. At approximately 1837, [redacted] harness was recovered by Mr. [redacted] with the waist strap still buckled. Her life jacket could not be found.

4.19. At approximately 1840, post casualty drug and alcohol testing required by 46 CFR Subpart 4.06 for both Mr. [redacted] and Mr. [redacted] was conducted. The testing revealed no indication of the presence of either illegal drugs or alcohol.

4.20. At 1942 Ms. [redacted] was pronounced decreased at Valley Regional Hospital in Brownsville, TX. Toxicology conducted post-mortem on Ms. [redacted] revealed that her blood alcohol content was at .303.

Section 5 – Analysis and Opinions

5.1. *Lack of Regulatory Oversight for Parasailing Equipment and Operations.* At the time of the incident, there were no federal, state (Texas), or local (Cameron County/South Padre Island) regulatory oversight governing the operation, maintenance and inspection of parasailing vessels and equipment, and training standards for parasailing crewmembers, as shown in section 4.1.

In September 2014, ASTM issued a comprehensive standard for parasailing, ASTM F3099-14, "Practices for Parasailing," that added sections for equipment, operations, crew proficiency and training, recordkeeping and patron responsibility. Sonny's Beach Services, Inc. and its employees were not following ASTM standards in way of the operation of parasail harnesses. Additionally, there had been no recent emergency training done on the parasailing vessel in recent memory, particularly no man overboard training had been conducted.

The standards have been followed by many parasail operators nationwide on a voluntary basis and on a mandatory basis due to some insurance requirements and/or as a condition of membership into local or national parasailing/water sports safety organizations.

Since the promulgation of ASTM F3099-14, the Coast Guard stated in their latest parasailing Public Affairs Guidance (PAG 2015), that the standards have improved the industry's safety record and parasailing marine casualties reported to the Coast Guard under 46 Code of Federal Regulations (CFR) 4.05-10 have declined.

Despite the standards having been shown to work, their adherence remains strictly voluntary (except for insurance requirements and membership to safety organizations), which counters their overall effectiveness.

As shown in section 4.2., this case has demonstrated that even stipulations imposed by insurance companies requiring adherence to the standards are not enough to compel the compliance of ASTM standard.

A check of Sonny's Beach Services' records revealed that the company co-owner signed the company's water sport insurance policy in April of 2015 that stated: "The insured warrants that it has reviewed and is familiar with all ASTM Commercial Parasail Guidelines and agrees to adhere to them, including any amendments to and current versions of the standards. The insured further warrants that it regularly reviews the standards with all crew members." Despite the company co-owner acknowledging familiarity with ASTM standards, and that the standards would be reviewed with all crew members, the standards were not fully followed by the company, as evidenced by the incident, particularly in way of donning parasail harnesses, crew training, and patron responsibilities.

It is the opinion of the investigator that had the standards been compulsory in this case, Ms. [redacted] death may have been prevented.

This investigation concludes that in order for ASTM standards to be most effective in ultimately reducing parasailing casualties; they cannot be relied on to be followed on a voluntary basis, or as a stipulation of insurance coverage. Incorporation by reference of the standards as regulatory requirements by a governing body, i.e.: federal, state, or local government would compel all parasail operators to operate at an acceptable level of safety expected by the American public and would prevent further injuries/fatalities from occurring.

5.2 An Existence of Complacency within the Company. Through the interview process of the company co-owner and the parasailing vessel crew, it was evident that the company co-owner and employees had largely based their expertise as safe parasailing operators on the fact that they were the oldest parasailing company on South Padre Island, having brought parasailing to the area in 1992, and had been operating successfully and without issues since that time. These facts were brought up multiple times throughout the interviews.

It is the opinion of the investigator that the overall confidence in company methods over-time created a level of comfort that led to complacency throughout the company at all levels. This complacency may have also led to the use or continued use of methods that were not in-line with current industry standard ASTM F3099-14 and/or equipment manufacturer's specifications, as reveled by facts gathered through investigation.

5.2.1. Harness

As per section 4.10., statements made by Mr. [redacted] during his interview indicated that Mr. [redacted] and Mr. [redacted] donned both his and Ms. [redacted] parasail harness over the passenger's life jackets, contrary to the harness manufacture's specifications and ASTM F3099-14 section 6.1.3.

As per section 4.2., discussions with the company co-owner and with Mr. [redacted] and Mr. [redacted] confirm that the company routinely donned parasail harnesses over passengers' life jackets as a company practice, contrary to the harness manufacture's specifications and ASTM F3099-14 section 6.1.3.

5.2.2. Emergency Training / Man Overboard

As per section 4.2., statements made by Mr. [redacted] and Mr. [redacted] during their interviews confirm that the parasail vessel crew did not routinely conduct emergency training, particularly man overboard training, and had not in recent memory, contrary to ASTM F3099-14, Section 6.3.3.1.

5.2.3. Intoxication

As per section 4.8., statements made by the Mr. [redacted] Mr. [redacted] and Ms. [redacted] indicated that Ms. [redacted] appeared intoxicated and noted that she fell over twice on the shuttle vessel during the trip out to the parasailing vessel. Mr. [redacted] stated that Mr. [redacted]

made a comment that acknowledged the fact that he was aware that Ms. [redacted] was intoxicated, but she was still allowed to parasail, contrary to the harness manufacture's specifications and ASTM F3099-14 section 8.1.2.

As per sections 4.8., 4.9., and 4.12., discussions with Mr. [redacted] Mr. [redacted] and Ms. [redacted] revealed that Mr. [redacted] voiced his concern several times to Mr. [redacted], and then to Mr. [redacted] and Mr. [redacted] over Ms. [redacted] condition and questioned her ability to parasail. Regardless of Mr. [redacted] concern, Ms. [redacted] was allowed to parasail.

5.2.4. Falling Danger
As per section 4.12., discussions with Mr. [redacted]., Mr. [redacted]., and Ms. [redacted] revealed that Ms. [redacted] looked like she was in danger of falling several minutes into her parasail flight. Mr. [redacted] stated that he voiced his concern to the parasail vessel crew, but Ms. [redacted] was allowed to continue parasailing.

Taking into account the findings of fact that are referenced above, this investigation concludes that the company employees were complacent before and during the evening of the incident for not following ASTM standards/ equipment manufacture's specifications and for failing to heed several warnings from another passenger about Ms. [redacted] condition throughout the course of the parasailing trip. Had complacency not been a factor, Ms. [redacted] death may have been prevented.

5.3. *Distress Message from Aloft was not received by Crew of Parasail Vessel.* Discussions with Mr. [redacted]., Mr. [redacted], Ms. [redacted] and the parasail vessel crew specified that they were able to see Ms. [redacted] and Mr. [redacted] at a height of 300 feet, and that there was no indication of distress from Mr. [redacted] during his and Ms. [redacted] time aloft.

Mr. [redacted] stated during his interview that he tried to signal to Mr. [redacted] and Mr. [redacted] to stop the parasail flight after realizing that Ms. [redacted] was slipping out of her harness. After analyzing these facts, two opinions have been drawn as to why the distress message from aloft was not received by the crew of the parasail vessel:

1. Mr. [redacted] demonstrated a "reeling it in" type-motion to investigators that was contrary to what is stated on the company's written parasailing pre-board briefing form, in paragraph 13 for "hand signals to come down," which states: "Simply spread and then cross your arms several times and the crew will begin your decent back to the boat."

As per section 4.4., discussions with the company co-owner and employees indicate that company policy is for passengers to review and sign the written parasailing pre-board safety briefing form prior to leaving the dock on the shuttle boat, which covers procedures to follow if there is an emergency aloft. A review of the form shows that it states in paragraph one that a verbal briefing and /or additional information may also be provided while onboard the vessel.

Statements made by Mr. [redacted] Mr. [redacted] Ms [redacted], and Mr. [redacted] confirm that there was no verbal briefing conducted by Mr. [redacted] or Mr. [redacted] covering parasail emergency procedures prior to the parasail flight.

This investigation concludes that Mr. [redacted] miscommunication with the parasail vessel crew while aloft may have been due to his misunderstanding of the company's written parasailing emergency procedures. It is the opinion of the investigator that a verbal briefing would have made the procedures clear to all passengers prior to the flight and may have prevented Ms. [redacted] death by ending the parasail flight prior to her fall.

2. Another possible explanation as to why Mr. [redacted] indication was not received by the parasail vessel crew may have been because they were occupied during that time and thus not monitoring the parasail canopy.

Although it is not exactly known what the crew was doing at the time of Mr. [redacted] indication, his gesturing may have been done while the crew was preoccupied with picking his hat up and out of the water. Mr. [redacted] Mr. [redacted], Ms. [redacted], and the parasail vessel crew stated that Mr. [redacted] hat flew off of his head after he and Ms. [redacted] had been launched from the boat in the parasail canopy, and that the crew recovered the hat from the water.

If distraction was the cause of the crew not perceiving the distress aloft, it is the opinion of the investigator that had there been constant monitoring of the parasail canopy, Mr. [redacted] distress indication may have been observed and may have prevented Ms. [redacted] death by ending the parasail flight prior to her fall.

Furthermore, it is the opinion of the investigator that an additional safety measure that could have been put into place that may have helped in this case would have been a more direct method of communication, like a two-way radio, between the parasail canopy and the parasail vessel that could have relayed the distress when the directed company procedure of indicating had failed.

5.4. Intoxication of the Victim. Post-mortem toxicology that was conducted during Ms. [redacted] autopsy indicates that at the time of her death, Ms. [redacted] had a blood alcohol content of .303.

As per section 4.3., Mr. [redacted] and Ms. [redacted] had been drinking since around noon the day of the incident. As per section 4.5, Mr. [redacted] and Ms. [redacted] also consumed alcohol at the Tequila Sunset bar prior to their parasail flight.

Statements from Mr. [redacted] Mr. [redacted], Ms. [redacted] indicate that Ms. [redacted] exhibited behavior consistent with intoxication and loss of control of her body just before her parasail flight.

Additional testimony from Mr. [redacted] Mr. [redacted] Ms. [redacted] indicates that Ms. [redacted] was not sitting upright in her harness during the parasail flight as compared to [redacted] (sitting

upright as in a swing), and that her legs were tucked into her chest and her bottom was hanging low in an egg-like fashion.

Taking into account the findings above, this investigation concludes that Ms. [redacted] loss of control of her body due to her level of intoxication contributed to her inability to maintain a safe position in her harness during her parasail flight, which led to her slipping through her life jacket and out of the harness between the back pad and seat pad as further demonstrated in section 5.5. Had intoxication not been a factor, Ms. [redacted] death may have been prevented.

5.5. *The Harness was Donned Incorrectly on the Victim.* As per section 4.10., statements made by Mr. [redacted] and Mr. [redacted] confirm that Ms. [redacted] was fitted into her harness by Mr. [redacted], with the waist strap secured around her life jacket vice her waist.

Discussions with the company co-owner and with Mr. [redacted] and Mr. [redacted] confirm that the company routinely donned parasail harnesses over passengers' life jackets as a company practice. When asked by investigators how the crew ensures the harnesses are safely secured around the bodies of the passengers, both Mr. [redacted] and Mr. [redacted] stated that after harnesses are fitted, passengers routinely sit down on the vessel and wait for their turn to parasail; upon standing up for their turn, a confirmation of correct fitting would be indicated by the harness not slipping or falling off the passenger.

Statements from Mr. [redacted] confirm [redacted] positioning in her harness consistent to what was noted by Mr [redacted] Mr. [redacted] Ms [redacted] Mr. [redacted] stated that he observed Ms. [redacted] harness straps down around her knees, and her life jacket up around her neck. He noted that Ms. [redacted] made several attempts to re-position herself back into the harness, but was unable to do so. Mr. [redacted] stated that [redacted] slumping subsequently worsened until the point of her fall.

The following series of pictures were taken during the investigating officer's recreation of [redacted] fall and best helps to illustrate what witnesses observed. Ms. [redacted] was wearing a Custom Chutes' parasailing harness in size large. It was properly sized for Ms. [redacted] weight as per the "Product Owners and Maintenance Manual" version 13.1, 165 - 230lbs, and was in good condition. Upon further more detailed expert analysis, the dimensions of the harness were found to be within manufactures' specifications and no abnormalities were noted.

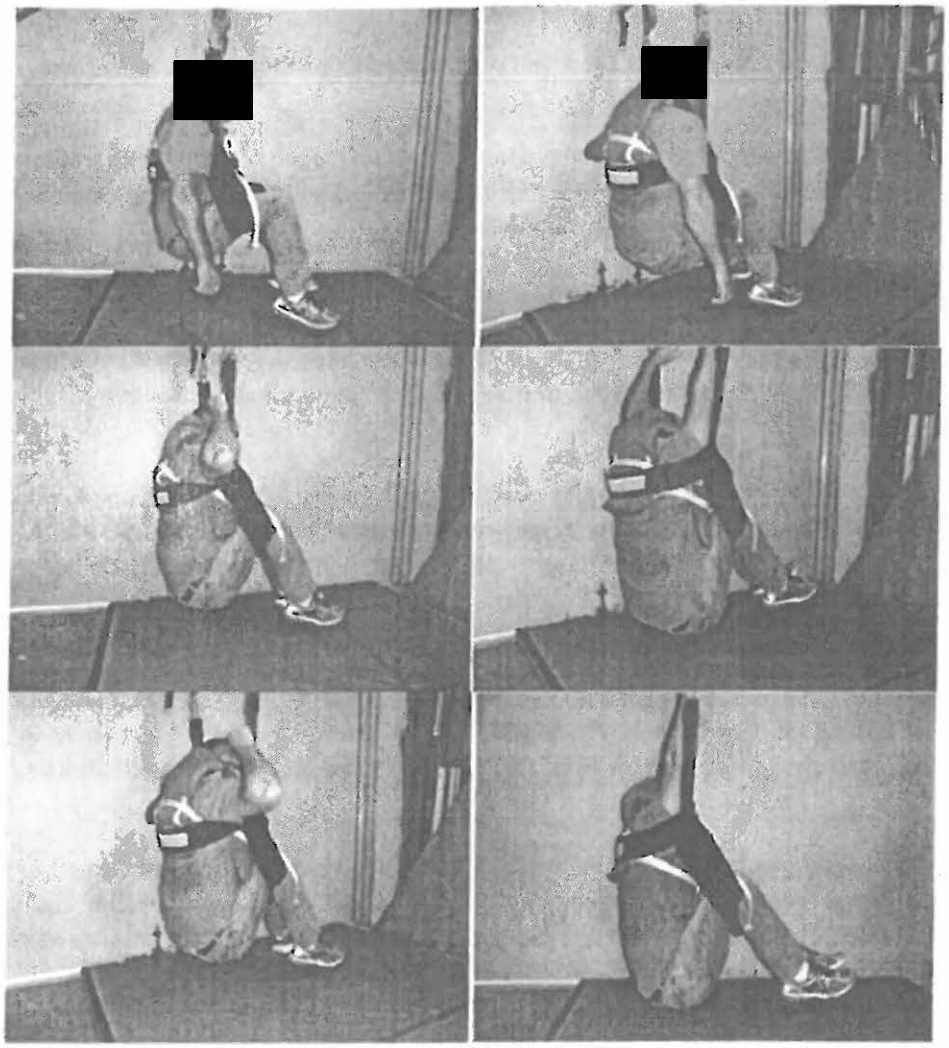
Note that Ms. [redacted] was 5 feet 8 inches tall and approximately 181 lbs. The individual used in the recreation was bigger at 6 feet 0 inches and 210 lbs.

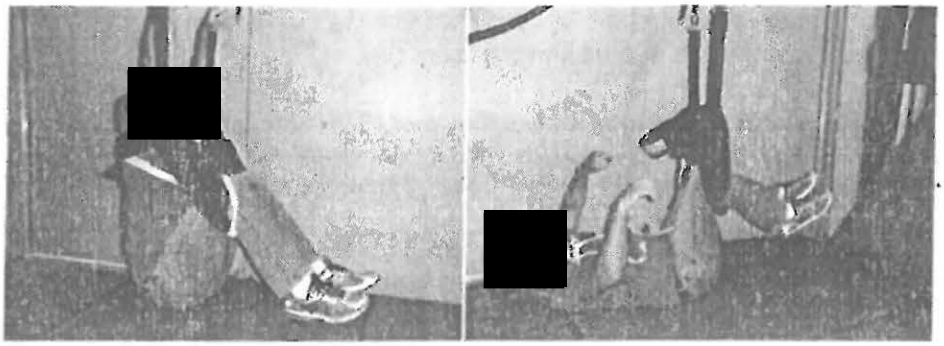
Also note that in this recreation, the passenger's life jacket stayed on the passenger after the fall. According to testimony by all witnesses, Ms. [redacted] was not wearing her life jacket after her fall and the life jacket was observed to have remained in the harness.

As per section 4.6., statements from both witnesses and company employees confirm that all passengers were fitted into their life jackets at the dock prior to embarking on the shuttle boat by

the ticket booth staff and Mr. [redacted]. Mr. [redacted] stated that the fitting of Ms. [redacted] jacket was checked again by Mr. [redacted] prior to her flight.

Although there was no information available on the size of Ms. [redacted] life jacket and the jacket itself could not be recovered for analysis, based on witness testimony it is surmised that either Ms. [redacted] was not fitted correctly into her life jacket or the jacket was too large for her, or both.





Manufacturer product information and ASTM Standards indicate that a parasail harness's waist strap must fit around the passenger's waist and not over the life jacket. The waist strap must be made tight over the waist to prevent the passenger from sliding out of the harness and keep the person correctly positioned on the seat of the harness.

Taking into account the findings above, this investigation concludes that Ms. [redacted] harness waist strap's incorrect positioning contributed to her inability to maintain a safe position while aloft and failed to prevent her from slipping out of the harness. Had the harness been properly fitted as directed by the manufacturer and ASTM Standards, Ms. [redacted] death may have been prevented.

5.6. Parasail Vessel Crew's Inability to Recover Victim from the Water. Statements made by Mr. [redacted] and Mr. [redacted] during their interviews confirm that the parasail vessel crew did not routinely conduct emergency training, particularly man overboard training, and had not in recent memory. As stated in paragraph 5.2., this is in contradiction to ASTM F3099-14, Section 6.3.3.1.

As per section 4.15., discussions with Mr. [redacted] Mr. [redacted] Ms. [redacted], and Mr. [redacted], including Mr. [redacted] and Mr. [redacted], confirm that the crew was unable to recover Ms. [redacted] onto the parasail vessel from the water after her fall. Ms. [redacted] was eventually recovered with the assistance of Good Samaritans who arrived on a second vessel.

In this case, the captain and deckhand were unable to overcome the vessel's freeboard to recover Ms. [redacted] from the water. A "rescue" platform, or a device commonly used to enable a crew member safely down to the water for ease of recovery of a person back into a vessel may have helped in this particular situation.

Taking into account the findings above, this investigation concludes that the parasail vessel crew was unprepared to recover Ms. [redacted] from the water. Had the crew conducted routine man over board drills as directed in ASTM Standards, the crew would have been adequately prepared for overboard emergencies and known if they required any additional equipment in order to successfully recover a victim from out of the water.

Section 6 - Conclusions:

6.1. Cause of the Casualty:

6.1.1. The initiating event for this casualty was Ms. [redacted] entering the water from a height of 300 feet after falling from her parasailing harness. Actions and conditions which caused her fall from her harness were: (1) Lack of regulatory oversight for parasailing equipment and operations, (2) An existence of complacency within the company, (3) Distress message from aloft was not received by crew of parasail vessel, (4) Intoxication of the victim, (5) The harness was donned incorrectly on the victim.

6.1.2. After falling into the water, despite the efforts of the parasailing vessel crew, its passengers, and the Good Samaritans to save her, Ms. [redacted] was declared deceased after being transported to the hospital. The casual factors contributing to her death were: (1) Parasail vessel crew's inability to recover victim from the water.

6.2. Violations of Law by Credentialed Mariners: There was evidence of misconduct and negligence on the part of a Credentialed Mariner that resulted in the loss of life that warrants enforcement action under Title 46, United States Code, Subtitle II, Part E. Evidence includes failing to follow ASTM standards in way of donning and use of parasail harness, not observing critical safety hazards (i.e. intoxication levels and fall risks) and inability to recover passenger from the water which contributed to the death of the passenger.

6.3. Violations by Members of the Coast Guard: There were no acts of misconduct, incompetence, negligence, unskillfullness, or violations by members of the coast guard that contributed to this casualty.

6.4. Violations Subjecting Parties to a Civil Penalty: There are no other violations of law identified as a result of this investigation.

6.5. Violations of Criminal Law: This investigation revealed evidence of criminal negligence on the part of the captain and deckhand of the TX5126HF that lead to the loss of life, as per 18 U.S.C. 1115. Evidence includes failing to follow ASTM standards in way of donning and use of parasail harness, not heeding intoxication and falling warning, and inability to recover passenger from the water which contributed to the death of the passenger.

6.6. Need for New or Amended Laws/Regulations: The events described in paragraphs 6.1.1. and 6.1.2. represent the potential need to amend Title 46, Code of Federal Regulations (CFR), Subchapter T, to prevent the reoccurrence of a similar casualty. The specific changes recommended are addressed in section 7 of this report.

Section 7 - Recommendations:

7.1. Safety Recommendations:

7.1.1. Recommend to the Commandant of the Coast Guard to seek a legislative change request to change the definition of small passenger vessel under 46 United States Code (USC) 2101 (35) to include a parasailing vessel that carries at least one passenger for hire.

7.1.2. Recommend to the Commandant of the Coast Guard to seek a regulatory rule making to incorporate the aforementioned legislative change into existing Small Passenger Vessel regulations, Title 46, Code of Federal Regulations (CFR), Subchapter T, in order to safely govern commercial parasailing.

7.1.3. Recommend to the Commandant of the Coast Guard incorporate ASTM F3099-14 into existing Small Passenger Vessel regulations, Title 46, Code of Federal Regulations (CFR), Subchapter T, in order to safely govern commercial parasailing conducted from vessels that are currently within the Coast Guard's jurisdictional boundaries. ASTM F3099-14 should be incorporated by reference as it has been developed in concert with the parasailing community, has established a baseline for safe parasailing operations, and has been found to be effective at reducing parasailing casualties. These regulations would compel parasail owners and operators across the country to operate at an acceptable level of safety expected by the American public.

7.1.4. Recommend to the Commandant of the Coast Guard that after enacting regulations for inspection of commercial parasailing vessels, the Coast Guard should establish a merchant mariner credential endorsement that requires parasail operators to demonstrate their ability to conduct proper parasail operations. The ASTM steering committee and the ASTM F3099-14 standard may be used to establish this requirement.

7.1.5. Recommend to the state of Texas, in lieu of federal regulations, to adopt and put into effect an act similar to the state of Florida's "White-Miskell Act" for parasail operations to include the requirement for parasail operators adhere to ASTM F3099-14 standard.

7.1.6. Recommend to Sector Corpus Christi Inspections Division to continue education and conduct outreach in order to promote parasail safety at least once a year. The ideal timeframe would be prior to Spring Break which is the beginning of the operating season for most parasailing operators at South Padre Island and Port Aransas. These efforts should include discussions on published Coast Guard MSIBs, Safety Alerts, and the most current industry version of ASTM F3099-14. Also, the discussion should include outcomes of parasailing marine casualty investigations and subsequent enforcement proceedings. These engagements should take place with all levels of management and operation at a parasailing company, but should primarily focus on the masters and crew of the parasailing vessels. Outreach should be done when conducting small passenger vessel inspections and dockside walks.

7.1.7. Recommend to the ASTM steering committee to amend ASTM F3099-14, section 6.3 "Emergency Procedures" to require verbal briefings of parasailing emergency procedures prior to parasailing flight. Verbal briefings would ensure that passengers have the crew's undivided attention in order to facilitate the full understanding of what actions should be taken in emergency situations. It also would remind the passengers that although they are participating in

an enjoyable recreational activity, that there are inherent risks associated with parasailing and to be cognizant to the possibility of an emergency occurring during any given flight.

7.1.8. In addition to verbal briefings, the ASTM steering committee should consider incorporating a more direct form of communication between the parasail canopy and flight monitor on the parasail vessel, like a two-way radio; into the required equipment section 5.2 of ASTM F3099-14. This would eliminate any doubt as to whether or not an issue was occurring aloft, and would be enable rapid response of the crew if necessary.

7.1.9. Recommend to the ASTM steering committee to amend ASTM F3099-14, section 7, "Crew Requirements" to mandate "flight monitoring" as a part of the Masters' responsibilities in section 7.3 and the Deckhands' responsibilities in section 7.4. Flight monitoring should be defined as a consistent watch on the parasail canopy during parasail flight, conducted by at least one of the crew members on board a parasail vessel. Having an active watch for flight monitoring will help to identify and mitigate any issues that may arise while passengers are aloft. The watch will also enable a quick response of the crew if necessary.

7.2. Administrative Recommendations:

7.2.1. Recommend to Commander, Sector Corpus Christi to refer this case to the Department of Justice for potential criminal prosecution of the captain and deckhand of the TX5126HF under the Seaman's Manslaughter Act (18 USC 1115) for negligence for failing to follow ASTM standards in way of donning and use of parasail harness, not heeding intoxication and falling warning, and inability to recover passenger from the water which contributed to the death of the passenger.

7.2.2. Recommend to Commander, Sector Corpus Christi to initiate Suspension and Revocation proceedings under 46 USC 7703 against the master of the TX5126HF for alleged misconduct and negligence for failing to follow ASTM standards in way of donning and use of parasail harness, not heeding intoxication and falling warning, and inability to recover passenger from the water which contributed to the death of the passenger.

7.2.3. Recommend to Commander, Sector Corpus Christi to formally recognize both the [redacted] and [redacted] family for their actions to attempt to save the life of [redacted].

7.2.4. It is recommended that this investigation be closed.

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