United States Coast Guard

Report of the Investigation into the TX5645JL COLLISION WITH TX9011JL RESULTING IN LOSS OF LIFE AND PASSENGER INJURIES AT TURTLE COVE, PORT ARANSAS, TX ON SEPTEMBER 10, 2022

MISLE Activity Number: 7556241

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

Commandant
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16732/IIA #7556241
03 September 2025

COLLISION BETWEEN THE UNINSPECTED PASSENGER VESSEL (UPV) TX5645JL AND THE UPV TX9011JL RESULTING IN INJURIES AND THE LOSS OF ONE LIFE WHILE UNDERWAY IN THE VICINITY OF THE CORPUS CHRISTI SHIP CHANNEL INNER BASIN NEAR CORPUS CHRISTI, TEXAS ON SEPTEMBER 10, 2022

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.

ACTION ON RECOMMENDATIONS

Administrative Recommendation 1: Recommend the Officer in Charge, Marine Inspections (OCMI), Sector Corpus Christi issue a Findings of Concern regarding recreational vessel navigation light placement.

> **Action**: I concur with this recommendation. On August 20, 2025, Findings of Concern 011-25: *Stay Visible with Proper Positioning of Navigation Lights* was published on the U.S. Coast Guard Office of Investigations and Casualty Analysis website located at:
>
> https://www.dco.uscg.mil/Our-Organization/Assistant-Commandant-for-Prevention-Policy-CG-5P/Inspections-Compliance-CG-5PC-/Office-of-Investigations-Casualty-Analysis/Findings-of-Concern/.

Administrative Recommendation 2: Recommend Sector Corpus Christi recognize the good Samaritans from UPV TX8790KF for their aid in the search and recovery of the Captain of UPV TX9011JL.

> **Action**: I note that the Sector Corpus Christi Officer Acting OCMI concurred with this recommendation in their endorsement and that the local unit is pursuing appropriate recognition for the good Samaritans who assisted during the emergency response to the incident.

[redacted]

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

U.S. Department of Homeland Security
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16732
Oct 17, 2024

TX5645JL COLLISION WITH TX9011JL RESULTING IN LOSS OF LIFE AND PASSENGER INJURIES AT TURTLE COVE, PORT ARANSAS TX ON SEPTEMBER 10, 2022

**ENDORSEMENT BY THE COMMANDER,
EIGHTH COAST GUARD DISTRICT**

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

COMMENTS ON THE REPORT

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

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

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

U.S. Department of Homeland Security

United States Coast Guard

Commander
United States Coast Guard
Sector Corpus Christi

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16732
June 3, 2024

TX5645JL COLLISION WITH TX9011JL RESULTING IN LOSS OF LIFE AND PASSENGER INJURIES AT TURTLE COVE, PORT ARANSAS, TX ON SEPTEMBER 10, 2022

ENDORSEMENT BY THE OFFICER IN CHARGE, MARINE INSPECTION

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

COMMENTS ON THE REPORT

1. I extend my deepest condolences to the family and friends of Gary Cooper. It is my earnest hope that this investigation will contribute to preventing future tragedies in the realm of uninspected passenger vessel operations.

2. The investigation and report contain valuable information which can be used to address the chain of events that resulted in loss of life, and to prevent similar incidents from occurring in the future.

ENDORSEMENT/ACTION ON RECOMMENDATIONS

Administrative Recommendation 1: Recommend the Officer in Charge, Marine Inspections, Sector Corpus Christi issue a Finding of Concern regarding recreational vessel navigation light placement.

> **Endorsement:** Concur. The proper placement of navigation lights on recreational vessels is critical for ensuring the safety of all mariners by enhancing visibility and preventing collisions, particularly in low-light conditions. This measure will help raise awareness among recreational boaters and dealers about the importance or correct navigation light placement, ultimately contributing to safer waterways.
>
> **Action**: Chief of Prevention has taken for action.

Administrative Recommendation 2: Recommend Sector Corpus Christi recognize the Good Samaritans from UPV 3 for their aid in search and recovery of Captain 2.

> **Endorsement:** Concur. Their selfless and courageous actions significantly contributed to our mission, demonstrating the vital role that community members can play in maritime

safety and rescue efforts. Acknowledging their efforts honors their bravery and compassion.

Action: Chief of Prevention has taken for action.

Administrative Recommendation 3: Recommend this investigation be closed.

Endorsement: Concur. This investigation should be closed.

[redacted]

M. A. CINTRON
Captain, U.S. Coast Guard
Acting Officer in Charge, Marine Inspection

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

Commander
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16732
May 30, 2024

TX5645JL COLLISION WITH TX9011JL RESULTING IN LOSS OF LIFE AND PASSENGER INJURIES AT TURTLE COVE, PORT ARANSAS, TX ON SEPTEMBER 10, 2022

EXECUTIVE SUMMARY

On Saturday, September 10, 2022, an uninspected passenger vessel (UPV), UPV 1, operated by USCG credentialed mariner Captain 1, launched from Conn Brown Harbor Point Park in Aransas Pass, TX. Captain 1 was enroute to pick up charter guests from Roberts Point Park in Port Aransas, TX. The weather was clear with calm water conditions. UPV 2, also operated by a USCG credentialed mariner, Captain 2, departed Island Moorings in Port Aransas, TX, with 3 passengers. Both vessels displayed navigational lights. UPV 1 was traveling eastbound in the Aransas Channel and turned at the Inner Basin to cross the Corpus Christi Ship Channel toward the Port Aransas Marina. Simultaneously, UPV 2 was eastbound in the Corpus Christi Ship Channel toward Inner Basin. UPV 1's port bow collided with UPV 2's port beam. The collision ejected Captain 2 from UPV 2.

A Good Samaritan vessel, UPV 3, was following UPV 2 and witnessed the collision. UPV 3 immediately initiated search and recovery operations. Captain 2 was found face down in the water shortly after the collision. The Good Samaritans recovered Captain 2 and performed CPR while transporting him to meet Emergency Medical Services. Captain 2 was pronounced dead after arriving to Fisherman's Wharf. Captain 2 and one passenger were transported to Bay Area Hospital in Corpus Christi, TX.

USCG Station Port Aransas administered a breathalyzer test on Captain 1, which showed 0.00% BAC. Captain 1 completed drug testing 51 hours after the incident, with negative results. A post-mortem toxicological screen on Captain 2 for alcohol and drugs also returned negative results.

Through its investigation, the Coast Guard determined the initiating event to be the collision between UPV 1 and UPV 2. The subsequent events were the ejection of Captain 2 into the water, injuries sustained by Passenger and Captain 2, the initial flooding of UPV 2, and death of Captain 2. Causal factors contributing to this casualty were: (1) Failure of Captain 1 to keep proper look-out and maintain situational awareness, (2) Captain 1 unsafe speed for prevailing conditions, (3) Failure of Captain 1 to act as a give-way vessel, (4) Inability of Captain 2 to take action to avoid collision, (5) Improper navigational light configuration, (6) Inadequate warning sound, (7) No reasonable defense for Captain 2 ejection from UPV 2, (8) No reasonable defense for Captain 2 or Passenger injuries, (9) No reasonable defense to prevent flooding to UPV 2, (10) Failure of Captain 2 to wear a Personal Floatation Device.

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

Commander
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Sector Corpus Christi

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16732
May 30, 2024

TX5645JL COLLISION WITH TX9011JL RESULTING IN LOSS OF LIFE AND PASSENGER INJURIES AT TURTLE COVE, PORT ARANSAS, TX ON SEPTEMBER 10, 2022

INVESTIGATING OFFICER'S REPORT

1. Preliminary Statement

1.1. This marine casualty investigation was conducted and this report was submitted in accordance with Title 46, Code of Federal Regulations (CFR), Subpart 4.07, and under the authority of Title 46, United States Code (USC) Chapter 63.

1.2. Royston, Rayzor, Vickery & Williams, L.L.P. and Bandas Law Firm, P.C. representing the deceased was designated a party-in-interest in this investigation. No other 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 involving this investigation. The Port Aransas Police Department (PAPD) and Texas Parks and Wildlife Department (TPWD) assisted the Coast Guard investigator with initial casualty scene response. No other persons or organizations assisted in this investigation.

1.4. All times listed in this report are in Central Daylight Time using a 24-hour format, and are approximate.

2. Vessel Involved in the Incident

Figure 1. UPV 1 post-accident at Fisherman's Wharf in Port Aransas, TX (September 10, 2022/USCG)

Official Name:	TX5645JL
Identification Number:	TX5645JL
Flag:	United States
Vessel Class/Type/Sub-Type:	Passenger Ship/Charter Fishing Vessel/General (6 or Fewer, Gross Tonnage<100)
Build Year:	2020
Gross Tonnage:	Unknown
Length:	23.4 feet
Beam/Width:	8.8 feet
Draft/Depth:	Unknown
Main/Primary Propulsion System:	Gasoline Engine, Gasoline Outboard, 250 HP
Owner:	Captain 1 Rockport, Texas/US
Operator:	Captain 1 Rockport, Texas/US

Figure 2. UPV 2 post-accident at Fisherman's Wharf in Port Aransas, TX (September 10, 2022/USCG)

Official Name:	TX9011JL
Identification Number:	TX9011JL
Flag:	United States
Vessel Class/Type/Sub-Type:	Passenger Ship/Charter Fishing Vessel/General (6 or Fewer, Gross Tonnage<100)
Build Year:	2000
Gross Tonnage:	Unknown
Length:	23.7 feet
Beam/Width:	8.4 feet
Draft/Depth:	Unknown

Main/Primary Propulsion System:	Gasoline Engine, Gasoline Outboard, 250 HP
Owner:	Captain 2 Corpus Christi, Texas/US
Operator:	Captain 2 Corpus Christi, Texas/US

3. Deceased, Missing, and/or Injured Persons

Relationship to Vessel	Sex	Age	Status
Captain 2	Male	69	Deceased
Passenger 1	Male	57	Injured
Passenger 2	Male	52	Injured
Passenger 3	Male	56	Injured

4. Findings of Fact

4.1. The Incident:

4.1.1. On September 10, 2022, at 0610, Captain 1 launched UPV 1 from Conn Brown Harbor and departed to pick-up passengers-for-hire, Passengers 4 and 5, for a chartered fishing trip from Roberts Point Park in Port Aransas, TX, 20 to 25 minutes away. Passengers 4 and 5 were scheduled for a 0630 pick-up.

4.1.2. At 0612, UPV 2 departed Island Moorings Marina with Captain 2 operating and three passengers-for-hire, Passengers 1, 2, and 3, onboard a chartered fishing trip.

4.1.3. At 0623, UPV 2 passed the Port Aransas Ferry Terminal, exhibiting a visible all-around light and sidelights, heading east in the Corpus Christi Channel (Figure 3).

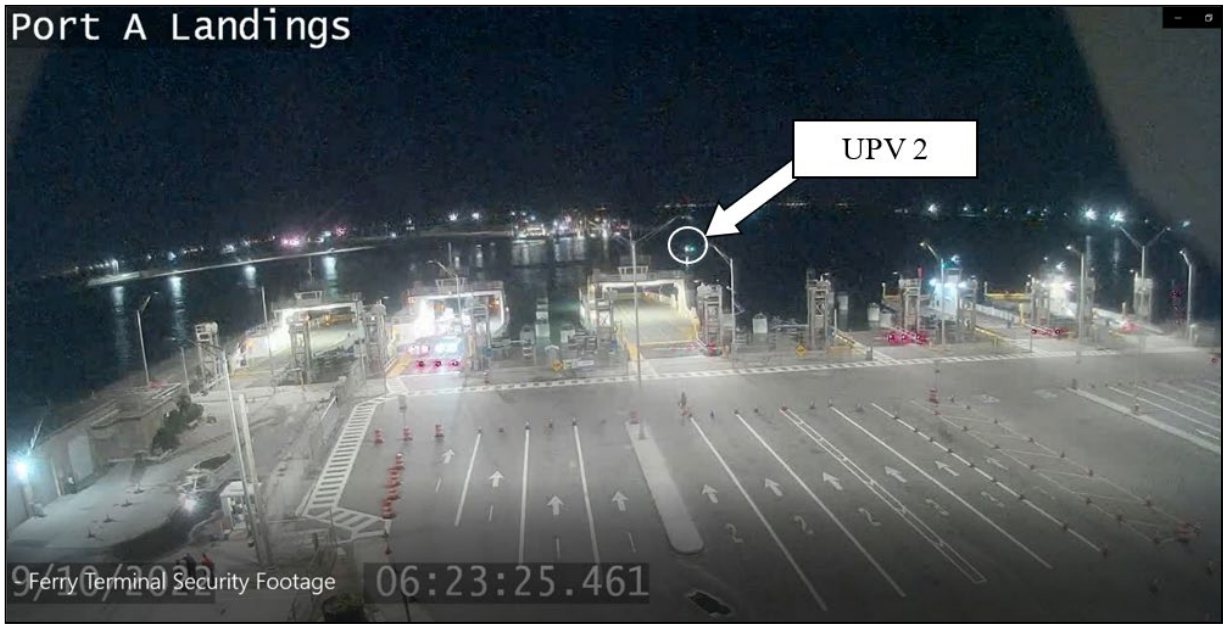

Figure 3. UPV 2 eastbound Corpus Christi Channel with visible navigation lights. (September 10, 2022, Port Aransas Ferry Security)

4.1.4. At 0625, UPV 1 departed the Aransas Pass Channel and began crossing Corpus Christi Channel Cut A, toward the flashing green lighted beacon "3", the entrance to Port Aransas Marina.

4.1.5. At 0626, UPV 2 passed the Port Aransas Marina entrance, heading east. A Good Samaritan vessel, UPV 3, proceeded to follow from approximately 100-200 yards behind.

4.1.6. At 0626, Captain 2 yelled and waved his arms toward UPV 1 to alert of collision risk. UPV 1 was estimated to be going approximately 50 mph by UPV 2 Passengers and UPV 3 witnesses.

4.1.7. At 0626, the starboard bow of UPV 1 collided with the port beam of UPV 2 and struck Captain 2, ejecting Captain 2 and his leaning post into the water, and striking Passenger 1 on his left leg. UPV 1's engine did stop immediately due to kill switch activation.

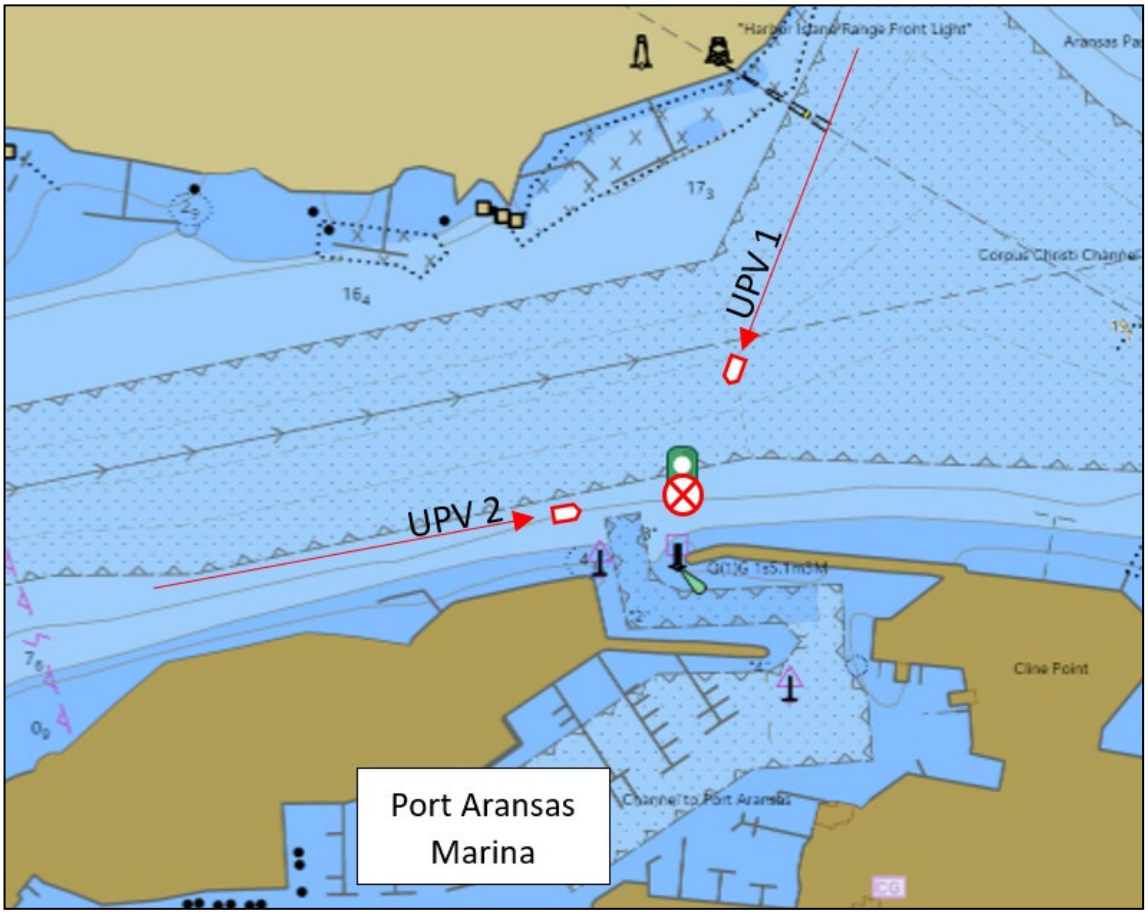

Figure 4. Diagram of UPV 1 and UPV 2 with approximate collision position developed by USCG.

4.1.8. At 0627, while reaching 911, UPV 3 that was following UPV 2 at the time of the collision found Captain 2 in the water floating facedown, unconcious, with no Personal Floatation Device on. All four persons aboard UPV 3 brought Captain 2 onto their vessel and began performing CPR.

4.1.9. At 0628, Captain 1 on UPV 1 pulled alongside UPV 3 and assisted in rendering CPR (Figure 5).

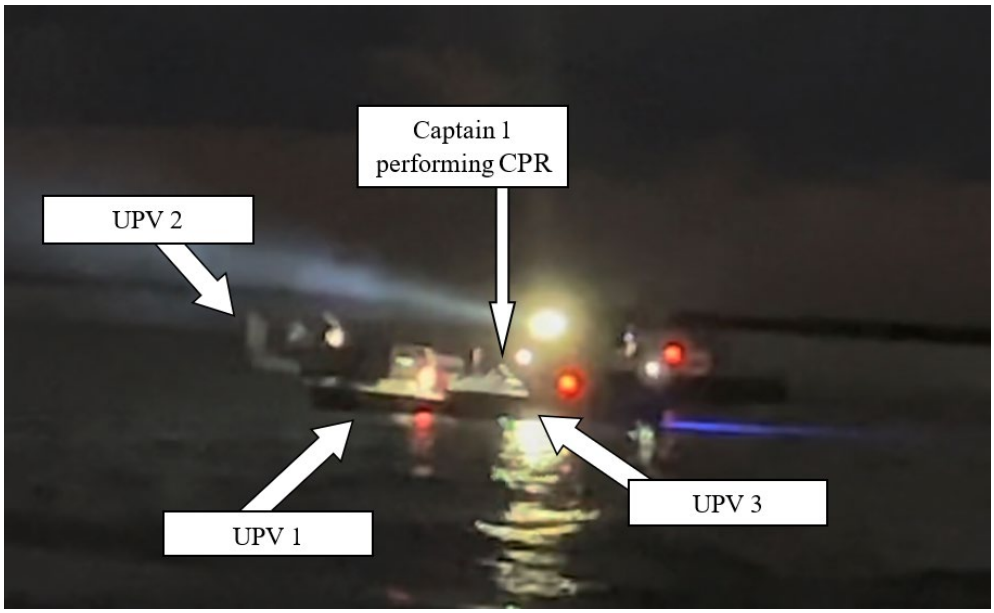

Figure 5. Screenshot from video provided by Passenger 4 awaiting Captain 1 pick-up, taken from Roberts Point Park at 0633 (September 10, 2022 / Passenger 4)

4.1.10. At 0635, UPV 3 headed to Fisherman's Wharf as directed by 911 dispatch to meet Emergency Medical Services (EMS), CPR was conducted until EMS took over.

4.1.11. UPV 1 followed the UPV 3 and moored at Fisherman's Wharf. UPV 2 was towed by another Good Samaritan vessel to Fisherman's Wharf and moored across from UPV 1 awaiting law enforcement arrival.

4.1.12. At 0638, emergency medical services (EMS) arrived at Fisherman's Wharf.

4.1.13. At 0703, EMS departed Fisherman's Wharf for Bay Area Hospital with Passenger 1 onboard. Passenger 1 suffered multiple abrasions and contusion of soft tissue to his left leg and was prescribed pain medication. He also suffered from psychological impacts.

4.1.14. At 0716, Captain 2 was pronounced deceased on scene by the Medical Examiner.

4.1.15. Passengers 2 and 3 did not require immediate hospital care. It was later found that Passenger 2 had fiberglass embedded in his hand and suffered a broken hand from holding the T-top at the time of impact. Passenger 3 experienced psychological impacts and shoulder pain.

4.1.16. The Captain 1 was subject to mandatory chemical testing for evidence of drug and alcohol use in accordance with 46 CFR Subpart 4.06. USCG Station Port Aransas administered a breathalyzer test on Captain 1 at 0835, results were 0.00% BAC. Captain 1 completed drug testing 51 hours after the serious marine incident, results were negative.

4.1.17. A post-mortem toxicological screen for alcohol and a panel of drugs was conducted on Captain 2 and all results were negative.

4.1.18. An autopsy conducted on Captain 2 identified the cause of death as multiple blunt force injuries and drowning.

4.2. Additional/Supporting Information:

Vessel Operators

4.2.1. The Navigation Rules outlined in 33 CFR Parts 83 through 90 apply to all vessels upon the inland waters of the United States.

4.2.2. Captain 1 was the owner and operator of UPV 1. Captain 1 was the holder of USCG Merchant Mariner Credential (MMC) as an OUPV – Operator of Uninspected Passenger Vessels as defined in 46 USC 2101 (42)(B) Upon Inland Waters. Captain 1 received his first MMC issuance on March 9, 2018 an had been guiding for 4.5 years.

4.2.3. Captain 1 completed his OUPV course at the Sea Academy in Aransas Pass, TX on February 2, 2018. Captain 1 was not enrolled in a Consortium or Third Party Administrator (C/TPA) and was not subject to random drug test as required by 46 CFR 16.230.

4.2.4. Captain 2 was the owner and operator of UPV 2. Captain 2 was the holder of USCG MMC as an OUPV – Operator of Uninspected Passenger Vessels as defined in 46 USC 2101 (42)(B) Upon Near Coastal Waters Not More than 100 Miles Offshore. Captain 2 received his first MMC issuance on January 22, 1992.

4.2.5. Captain 2 had been operating vessels in the Port Aransas area for over 40 years. Captain 2 had been enrolled in C/TPAs and subject to random drug tests in accordance with 46 CFR 16.230 since February 4, 1993.

Weather and Visibility

4.2.6. On September 10, 2022, at NOAA Buoy Station RTAT2 in Port Aransas, TX, winds were recorded at an average of 4.8 knots, with gusts reaching up to 7.4 knots from the southeast. The air temperature stood at 82°F, while the water temperature measured 85.6°F. Concurrently, there was an estimated 1.0 knot flood northwest current, coinciding with the forecasted high tide at 0835.

4.2.7. At the time of the incident, the skies were clear with some clouds and calm conditions, offering good visibility. Sunrise was scheduled for 0711 on September 10, 2022. Astronomical twilight commenced at 0552, followed by nautical twilight at 0620 and civil twilight at 0648.

Navigational Lighting

4.2.8. UPV 1 was a custom 23.4-foot 2021 Haynie 23 SC model, driven by a single Mercury 250HP outboard engine. It featured an approximately 3.5-foot-wide center console equipped with a tinted shield. UPV 1 had one all-around white light installed on the stern motor (Figure 6) and two sidelights installed on the center console prior to vessel purchase. Figure 1 depicts the location of the motor in relation to the center console. The all-around white light was obscured by the center console and operator location at angular sectors greater than six degrees. All navigational lights were

energized at the time of collision.

Figure 6. UPV 1 All-around white light close-up circled in red. Light was installed on outboard motor. (September 10, 2022/USCG)

4.2.9. UPV 2, a 23.7-foot vessel built in 2000 by Kenner, was powered by a single Suzuki 250HP outboard engine and featured a center console, T-top, and leaning post. Passenger seating was just aft of the bow on both the port and starboard sides, as well as in front of the center console. UPV 2 had one all-around white light and combined sidelights installed on the T-top above the center console (Figures 2, 7 and 8). The all-around white light was installed approximately 6-inches above the combined lantern sidelights. All navigational lights were energized at the time of collision.

Figure 7. UPV 2 all-around white light, post-accident with ruler guide. (September 13, 2022 / USCG)

Figure 8. UPV 2 prior to collision with navigation lights intact, all-around white light location shown. (Unknown / Captain 2)

Safety Equipment

4.2.10. At the time of collision, neither Captain 1, Captain 2, nor Passengers 1, Passenger 2, and Passenger 3 were wearing PFDs. There were PFDs stowed on both UPV 1 and UPV 2. There are no regulations requiring adults to wear PFDs while onboard recreational vessels.

Vessel Traffic

4.2.11. The Haynie Boat Owners Tournament was scheduled to start at sunrise on Saturday, September 10th. There was increased recreational vessel traffic from Conn Brown Harbor, Port Aransas Marina, and surrounding waters.

5. Analysis

5.1. *Failure of Captain 1 to keep proper look-out and maintain situational awareness*. During interviews, Captain 1 repeatedly stated that he "did not see" UPV 2 until the collision. He mentioned that as he rounded the Fina Docks, his attention was focused on the green flashing light indicating the Port Aransas Marina entrance as well as meeting the pick-up time for Passengers 4 and 5 of 0630. This indicated a skill-based execution error or attention failure, where Captain 1's cognitive "radar screen" was directed elsewhere, leading to his failure to maintain proper look-out and situational awareness. Additionally, UPV 2 was highly visible on Port Aransas Ferry Terminal security footage. As required by Navigation Rules 33 CFR 83.05 (Inland Rule 5), every vessel shall at all times maintain a proper look-out by sight and hearing as well as by all available means appropriate in the prevailing circumstances and conditions so as to make a full appraisal of the situation and of the risk of collision. Captain 1's attention was diverted to navigating towards the marina entrance, causing him to neglect the critical task of monitoring for other vessels. This lapse in situational awareness directly resulted in his inability to see UPV 2 in time to prevent the collision. Captain 1's failure to uphold this duty was a key factor in the incident, demonstrating how divided attention and misallocated focus can lead to catastrophic consequences. Had Captain 1 maintained a proper look-out, the collision could have been avoided.

5.2. *Captain 1 unsafe speed for prevailing conditions*. As required by Navigation Rules 33 CFR 83.06 (Inland Rule 6) every vessel shall at all times proceed at a safe speed so that she can take proper and effective action to avoid collision and be stopped within a distance appropriate to the prevailing circumstances and conditions. Factors influencing safe speed include visibility, background light, and traffic density. On the morning of September 10, 2022, Captain 1 was navigating UPV 1 across the Corpus Christi Ship Channel towards the Port Aransas Marina from the Aransas Channel. Captain 1 estimated his speed to be between 20-25 mph, which he stated was his normal operating speed for this route. Eyewitnesses estimated his speed to be approximately 50 mph; his speed could not be confirmed with the extracted GPS data. However, at the time of collision, the sun had not risen yet, and the sky was experiencing nautical twilight. Nautical twilight, as defined by the National Weather Service, "begins in the morning, or ends in the evening when the geometric center of the sun is 12 degrees below the horizon. In general, the term nautical twilight refers to sailors being able to take reliable readings via well known stars because the horizon is still visible, even under moonless conditions. Absent fog or other restrictions, outlines of terrestrial objects may still be

discernible, but detailed outdoor activities are likely curtailed without artificial illumination." This means that during nautical twilight, although outlines of objects on land may still be visible, engaging in detailed outdoor activities becomes challenging without artificial lighting. Additionally, the Haynie Owners Tournament, scheduled to start at sunrise (0711) on September 10, 2022, had increased boat traffic in the area around Turtle Cove and Port Aransas Marina. Multiple witnesses confirmed the heightened traffic density, which further necessitated a reduction in speed for crossing a channel. Captain 1 did not adjust his vessel's speed to account for the reduced visibility during nautical twilight and the increased traffic due to the tournament. Had Captain 1 reduced his speed, he might have had sufficient time and distance to see UPV 2 and avoid the collision.

5.3. *Failure of Captain 1 to act as a give-way vessel*. UPV 1 had UPV 2 on its starboard side, creating a crossing situation. Navigation Rules 33 CFR 83.15 (Inland Rule 15) states when two power-driven vessels are crossing to involve risk of collision, the vessel which has the other on her starboard side shall keep out of the way and shall, if the circumstances of the case admit, avoid crossing ahead of the other vessel. Captain 1, therefore, had the responsibility to keep out of UPV 2's way and, if possible, avoid crossing ahead. Captain 1's failure to adhere to this rule was a critical factor in the collision. By not taking timely and appropriate action to yield to UPV 2, Captain 1 violated the navigation regulations designed to prevent such accidents. Had Captain 1 acted appropriately as the give-way vessel, this collision could have been avoided.

5.4. *Inability of Captain 2 to take action to avoid collision*. Captain 2 was navigating UPV 2 as the stand-on vessel in a crossing situation with UPV 1, which was on UPV 1's starboard side. Navigation Rules 33 CFR 83.15 states when two power-driven vessels are crossing so as to involved risk of collision, the vessel which has the other on her starboard side shall keep out of the way and shall, if the circumstances of the case admit, avoid crossing ahead of the other vessel. Additionally, Navigation Rules 33 CFR 83.17 (Inland Rule 17) requires the stand-on vessel should maintain its course and speed but may take action to avoid a collision if it becomes clear the give-way vessel is not taking appropriate action. Passengers 1, 2, and 3 reported that Captain 2 tried yelling to warn Captain 1 of collision. From the condition of the UPV 2 throttle when investigators arrived on scene, Captain 2 attempted to increase speed for collision avoidance. According to eyewitnesses from UPV 3, by the time Captain 2 recognized UPV 1 was not maneuvering to avoid collision, there was no reasonable maneuver he could have made to prevent the collision from occurring. If Captain 2 turned to the right, he would have severely grounded on the jetty rocks and potentially ejected passengers. If he had slowed down, his passengers near the bow would have been struck. If he would have turned to the left, he would have collided head on with UPV 1.

5.5. *Improper navigational light configuration*. While reviewing photographs and witness interviews, it was evident that Captain 2 saw UPV 1 before Captain 1 saw UPV 2, but still not within an appropriate amount of time to avoid collision. As seen in Figures 1 and 6 previously in this report, it is possible that UPV 1's all-around white light was obstructed by Captain 1 and his center console. Navigation Rules 33 CFR 84.15 states all-around lights shall be so located as not to be obscured by masts, topmasts, or structures within angular sectors of more than six degrees. This obstruction could have contributed to late awareness. Additionally, as seen in Figures 2, 7 and 8, UPV 2's all-

around white light was approximately 6-inches higher than the sidelights, but visible on Port Aransas Ferry Terminal security footage. Navigation Rules 33 CFR 84.02 (Annex I) states the masthead light, or all-around light of a power-driven vessel of less than 12 meters in length shall be carried at least one meter higher than the sidelights. This vertical separation ensures visibility from all directions and reduces the chance of confusion with other light signals. The obstruction of UPV 1's all-around light and the insufficient height of UPV 2's all-around light may have hindered early detection and recognition of each vessel's presence and intentions. Had the navigational lights been configured correctly, the risk of collision could have been recognized sooner, allowing for timely and appropriate evasive actions to avoid the accident.

5.6. *Inadequate warning sound*. Passengers onboard UPV 2 reported that Captain 2 began yelling at UPV 1 just as they passed the Port Aransas Marina entrance, but Captain 1 did not hear him. During interviews, Captain 1 confirmed that he did not hear any warnings from Captain 2 and admitted that he did not make any warning sounds himself. The lack of effective auditory warnings played a crucial role in the collision. According to maritime best practices, sound signals are essential for communicating intentions and alerting other vessels to potential dangers, especially in situations where visibility might be compromised or when vessels are in close proximity. Navigation Rules 33 CFR 83.33(b) (Rule 33) require vessels of less than 12 meters in length not be obliged to carry the sound signaling appliances described in 33 CFR 83.33(a) but if not, to be provided with some other means of making an efficient sound. Captain 2's attempt to warn UPV 1 by yelling was inefficient, as human voices are often not loud enough to be heard over engine noise and environmental sounds, particularly on the water. Captain 1's failure to make any warning sounds further exacerbated the situation, as there was no auditory cue to alert Captain 2 of the imminent danger. The absence of proper warning sounds prevented effective communication between the vessels, which could have prompted timely evasive actions. Had efficient sound signals been used, the likelihood of the collision could have been significantly reduced, as both Captains would have been more aware of each other's presence and intentions in time to avoid the accident.

5.7. *No reasonable defense for Captain 2 ejection from UPV 2*. There was no reasonable defense to prevent Captain 2 from being ejected into the water once struck by UPV 1.

5.8. *No reasonable defense for Captain 2 or Passenger injuries*. There was no reasonable defense to prevent injuries from occurring to the Passengers or Captain 2 onboard UPV 2 once struck by UPV 1.

5.9. *No reasonable defense to prevent flooding to UPV 2*. There was no reasonable defense to prevent UPV 2 from initial flooding once damaged by UPV 1. The structural integrity of UPV 2 was compromised; immediate flooding was unavoidable at the time of collision.

5.10. *Failure of Captain 2 to wear a Personal Floatation Device*. The Port Aransas Police Report and witness accounts confirm that Captain 2 was not wearing a Personal Floatation Device (PFD) at the time of collision and being ejected into the water. The cause of death was documented as multiple blunt force injuries and drowning. PFDs are designed to enhance survivability in the water. Specifically, a Type I PFD provides the greatest inherent buoyancy, turning most unconscious individuals from a face-down

position to a vertical and slightly backward position. A Type II PFD is designed to turn some unconscious persons from a face-down position to a safer orientation where respiration is not impeded.[1] It is not a common practice to always wear a Type I or Type II PFD onboard. Had Captain 2 been wearing a Type I or Type II PFD, his chances of survival may have significantly increased. The PFD could have helped prevent drowning by keeping his airway clear of the water, despite the blunt force injuries sustained during the collision.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty was the collision between UPV 1 and UPV 2. Causal factors contributing to this event were:

6.1.1.1. Captain 1 failed to maintain proper look-out and maintain situational awareness onboard UPV 1.

6.1.1.2. Captain 1 failed to operate UPV 1 at a safe speed for the prevailing conditions of lighting and scheduled vessel activities.

6.1.1.3. Captain 1 failed to act as a give-way vessel while in a crossing situation with UPV 2.

6.1.1.4. Captain 2 was unable to take action to avoid collision given location and time.

6.1.1.5. UPV 1 and UPV 2 navigation lights were configured incorrectly.

6.1.1.6. Inadequate warning sound from UPV 2 and no warning sound from UPV 1.

6.1.2. The first subsequent event was the ejection of Captain 2 into the water. Causal factors contributing to this event were:

6.1.2.1. There was no reasonable defense to prevent Captain 2 from entering the water after being struck.

6.1.3. The second subsequent event was the injuries sustained by Passengers onboard UPV 2. Causal factors contributing to this event were:

6.1.3.1. There was no reasonable defense to prevent injuries sustained from vessel impact.

6.1.4. The third subsequent event was the initial flooding of UPV 2. Causal factors contributing to this event were:

6.1.4.1. There was no reasonable defense to prevent initial flooding upon damage to UPV 2.

[1] Definition of PFD Types from www.uscgboating.org

6.1.5. The fourth subsequent event was the death of Captain 2. Causal factors contributing to this event were:

6.1.5.1. Captain 2 was not wearing a PFD capable of turning his head out of the water.

6.1.5.2. There was no reasonable defense to prevent blunt force injuries sustained from vessel impact.

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: The actions described in paragraphs 4.1.7 and 4.1.16 and analyzed in paragraphs 5.1, 5.2, and 5.3 above represent potential allegations of negligence, misconduct, and violation of law or regulation by Captain 1.

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 a mariner, U.S. Coast Guard Personnel, or any other persons identified as part of this investigation.

6.4. Evidence of Act(s) Subject to Civil Penalty: The actions described in paragraph 4.2.1 above represent a violation of 46 CFR 16.201 as the Captain 1 was the Owner and Operator of Artificial Action and was not enrolled in a Drug and Alcohol Program as required by 46 CFR 16.203.

6.5. Evidence of Criminal Act(s): The actions described in paragraphs 4.1.7 and 4.1.16 and analyzed in paragraphs 5.1, 5.2, and 5.3 above led to life of a person being destroyed as noted in paragraph 4.1.14 and 4.1.18. This represents potential allegations of 18 USC 1115; misconduct or neglect of ship officers.

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: There were no unsafe actions or conditions identified that were not causal factors during this investigation.

7. Actions Taken Since the Incident

7.1. The Coast Guard issued a Notice of Violation to Captain 1 for failure to be enrolled in a Drug and Alcohol Program as required by 46 CFR 16.203.

7.2. The Coast Guard initiated an administrative proceeding against Captain 1's Merchant Mariner Credential proposing Revocation for allegations of Negligence, Misconduct, and Violation of Law or Regulation.

8. Recommendations

8.1. Safety Recommendation: There were no proposed actions to add new or amend existing U.S. laws or regulations, international requirements, industry standards, or U.S. Coast Guard policies and procedures as part of this investigation.

8.2. Administrative Recommendations:

8.2.1. Recommend the Officer in Charge, Marine Inspections, Sector Corpus Christi issue a Finding of Concern regarding recreational vessel navigation light placement.

8.2.2. Recommend Sector Corpus Christi recognize the Good Samaritans from UPV 3 for their aid in search and recovery of Captain 2.

8.2.3. Recommend this investigation be closed.

Lieutenant Commander, U.S. Coast Guard
Investigating Officer