



UNITED STATES COAST GUARD

REPORT OF THE INVESTIGATION INTO THE CAPSIZING OF THE VESSEL UNA MAS (OR854ACS), IN THE PACIFIC OCEAN NEAR GOLD BEACH, OR, WITH LOSS OF LIFE, ON AUGUST 31, 2025



U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
United States Coast Guard

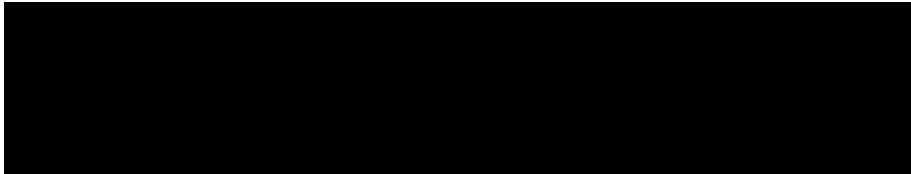
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16732/IIA # 8231938
22 June 2026

**CAPSIZING OF THE COMMERCIAL FISHING VESSEL UNA MAS (OR854ACS)
RESULTING IN THE LOSS OF TWO LIVES WHILE TRANSITING IN THE PACIFIC
OCEAN APPROXIMATELY FOUR NAUTICAL MILES WEST OF GOLD BEACH,
OREGON ON AUGUST 31, 2025**

ACTION BY THE COMMANDANT

The record and the report of investigation completed for this marine casualty have been reviewed by the Office of Investigations & Casualty Analysis. The record and the report, including the findings of fact, analyses, and conclusions are approved. This marine casualty investigation is closed.



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

U.S. Department of
Homeland Security

United States
Coast Guard



Commander
United States Coast Guard
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16732
11 June 2026

**CAPSIZING OF THE VESSEL UNA MAS (OR854ACS), IN THE PACIFIC OCEAN
NEAR GOLD BEACH, OR, WITH LOSS OF LIFE, ON AUGUST 31, 2025.**

ENDORSEMENT BY THE COMMANDER, NORTHWEST 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.

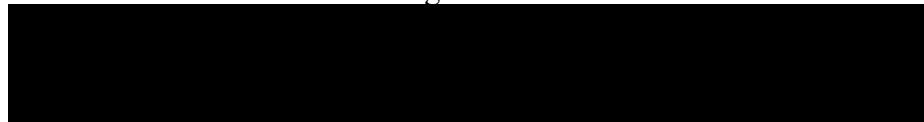
COMMENTS ON THE REPORT

1. The circumstances of this marine casualty were both tragic and potentially preventable in nature. I offer my sincerest condolences to both the family and friends of the operator and the crewmember that were lost at sea as a result of this incident.

ENDORSEMENT/ACTION ON RECOMMENDATIONS

Administrative Recommendation #1: Recommend this investigation be closed.

Endorsement: Concur. Recommend this investigation be closed.



D. A. JENSEN
Captain, U.S. Coast Guard
Chief of Prevention



16732

February 23, 2026

**CAPSIZING OF THE VESSEL UNA MAS (OR854ACS), IN THE PACIFIC OCEAN
NEAR GOLD BEACH, OR, WITH LOSS OF LIFE, ON AUGUST 31, 2025**

ENDORSEMENT BY THE OFFICER IN CHARGE, MARINE INSPECTION

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

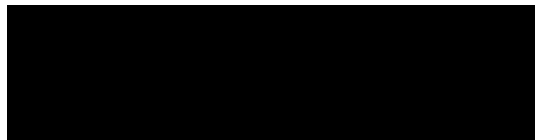
COMMENTS ON THE REPORT

1. The circumstances of this marine casualty were both tragic and preventable in nature. I offer my sincerest condolences to both the family and friends of the operator and crewmember lost at sea as a result of this incident.

ENDORSEMENT/ACTION ON RECOMMENDATIONS

Administrative Recommendation 1 Recommend this investigation be closed.

Endorsement: Concur; recommend that this investigation be closed.



ANTHONY R. MIGLIORINI
Captain, U.S. Coast Guard
Officer in Charge, Marine Inspection



16732
January 27, 2026

**CAPSIZING OF THE VESSEL UNA MAS (OR854ACS), IN THE PACIFIC OCEAN
NEAR GOLD BEACH, OR, WITH LOSS OF LIFE, ON AUGUST 31, 2025.**

EXECUTIVE SUMMARY

On August 31, 2025, at approximately 0650 Pacific Daylight Time (PDT), the UNA MAS departed Gold Beach, OR with three people on board, the Operator, Crewmember 1 (C-1), and Crewmember 2 (C-2), for an offshore commercial tuna fishing trip in the Pacific Ocean. At 1830, after the day of fishing up to 52 nautical miles offshore the UNA MAS began its transit back to Gold Beach, OR with the Operator at the helm, C-1 sitting behind the Operator and C-2 sitting across from C-1. The weather began to deteriorate and swells increased. When the vessel was approximately 04 nautical miles offshore of Gold Beach, OR it encountered a large swell, descending port side first. At the same time, a fish tote that had been secured on the starboard side behind the seating area where C-1 was sitting broke loose and abruptly shifted to port. The vessel capsized, turning over port side first and began floating upside down. C-1 was thrown into the water and resurfaced between the dislodged fish tote and the UNA MAS. The Operator and C-2 were reported to be trapped under the UNA MAS. C-1 climbed onto the hull where, for first 15 to 20 minutes, he heard yelling and banging from under the hull before it fell silent. C-1 utilized a cell phone to call for help. Good Samaritans arrived on-scene and rescued C-1 but were unable to locate the Operator or C-2. The Coast Guard, local authorities, and additional Good Samaritans also responded and conducted a search for the Operator and C-2 but were unsuccessful.

On September 03, 2025, the vessel was towed to shore while still overturned. The Operator was found deceased inside the cabin. The autopsy report later determined the cause of death as asphyxia-drowning. C-2 was never found.

Through its investigation, the Coast Guard determined the initiating event was the capsizing of the UNA MAS. Subsequently, all individuals on board entered the water, resulting in one death and one missing (presumed deceased). Causal factors contributing to this incident include: (1) Improper weight capacity that exceeded the manufacturer's recommendation, (2) Securing strap failure resulted in abrupt weight distribution on the vessel, (3) Failure to disengage auto-pilot and slow the vessel during rapidly deteriorating weather conditions, (4) Lack of barriers or restraints to prevent personnel from entering the water during capsizing, (5) Lack of permanently secured storage to withstand capsizing, (6) Adverse environmental conditions compromised survivability.



16732
January 27, 2026

**CAPSIZING OF THE VESSEL UNA MAS (OR854ACS), IN THE PACIFIC OCEAN
NEAR GOLD BEACH, OR, WITH LOSS OF LIFE, ON AUGUST 31, 2025.**

INVESTIGATING OFFICER'S REPORT

1. Preliminary Statement

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

1.2. No individuals, organizations, or parties were designated as a party-in-interest in accordance with 46 CFR Subsection 4.03-10.

1.3. The Coast Guard was designated as the lead federal agency for all evidence collection activities involving this investigation. The Curry County Sheriff's Office responded on-scene and conducted an investigation in accordance with their independent authorities and jurisdictions subsequently providing their incident report to assist with the investigation.

1.4. All times used in this report are approximate and listed in the local Pacific Daylight Time (PDT) using a 24-hour format. All dimensions and weights utilized for calculations are approximate.

2. Vessel Involved in the Incident



Figure 1. Photograph of UNA MAS received from owner's son on September 15, 2025.

Official Name:	UNA MAS
Identification Number:	OR854ACS – Oregon State Registration
Flag:	United States
Vessel Class/Type/Sub-Type	Fishing Vessel/Fish Catching Vessel/Hook and Line
Build Year:	2002
Gross Tonnage:	N/A – Not Formally Measured.
Length:	26 feet
Beam/Width:	8 feet 9 inches
Draft/Depth:	1 foot 9 inches
Main/Primary Propulsion: (Configuration/System Type)	Gasoline Outboard, Twin Yamaha 150 HP
Owner:	Samuel Waller Gold Beach, OR U.S.A.
Operator:	Samuel Waller Gold Beach, OR U.S.A.

3. Deceased, Missing, and/or Injured Persons

Relationship to Vessel	Sex	Age	Status
Owner/Operator (Operator)	Male	69	Deceased
Crewmember 2 (C-2)	Male	43	Missing (Presumed Deceased)

4. Findings of Fact

4.1. The Incident:

4.1.1. On August 31, 2025, at 0650, UNA MAS departed from the public boat ramp in Gold Beach, OR, with the Operator, C-1, and C-2 on board for an offshore commercial

tuna fishing trip, during which the vessel operated up to 52 nautical miles west of Gold Beach, OR in the Pacific Ocean.

4.1.2. At 1830, UNA MAS began its transit back with the Operator at the helm reported to be utilizing the auto-pilot feature but with manual capability to adjust as necessary, with C-1 sitting behind the Operator and C-2 sitting across from C-1. The seating arrangement was not fully enclosed, and all occupants were exposed and/or partially exposed to open air. The fish tote storage was full, with 01 tote on each side behind the seating area, 01 ice chest in between captain's chair and opposite seat, and 01 Reliable kill bag forward of ice the chest.

4.1.3. At 2004, C-1 took a video on the UNA MAS as they transited in. The video shows the sunset, C-2 wearing a mustang collar life jacket sitting across from C-1, and part of the back of the vessel with the port fish tote. The vessel was maintaining a plane.

4.1.4. At 2015, C-1 and C-2 called their spouses to check-in. No concerns reported.

4.1.5. At 2020, the Operator slowed or bumped the throttle on the UNA MAS to a slow speed. Slow speed was reported uncomfortable in the weather conditions. Operator brought UNA MAS back up to a plane, approximately 18-22 knots, with the autopilot still engaged.

4.1.6. At 2039, while transiting a swell, the UNA MAS experienced a port side first descend. Concurrently, the starboard tote behind C-1's seating area, became dislodged from its securing strap and rapidly migrated to port.

4.1.7. At 2040, the UNA MAS experienced a capsizing incident, rolling to port, which caused the Operator, C-1, and C-2 to enter the water.

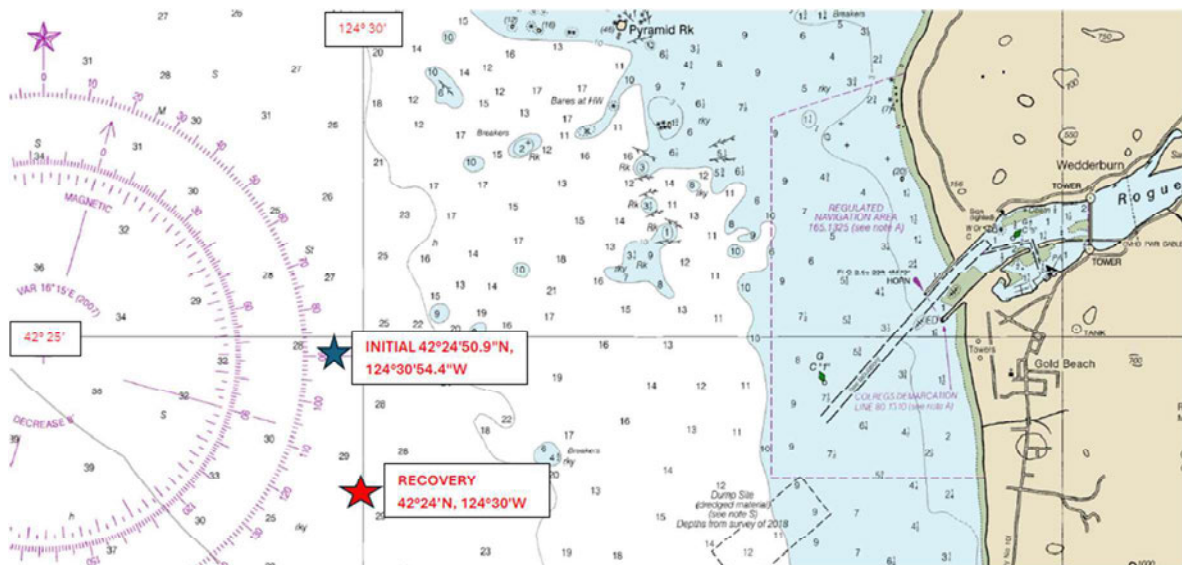


Figure 2. Modified chart image of the approximate location of the initial incident location and recovery of C-1. Not to scale.

4.1.8. Shortly thereafter, C-1 was pulled below the surface of the water by displaced fishing equipment. C-1 had resurfaced between the dislodged fish tote and the overturned UNA MAS. He was able to climb onto the hull. C-1 reported hearing voices

and banging from beneath the vessel. The voices continued for approximately 15 to 20 minutes.

4.1.9. After climbing onto the hull, C-1 was able to utilize his cellphone to call local authorities and a Good Samaritan for help.

4.1.10. At 2053, Coast Guard received notification of incident from local authorities.

4.1.11. At 2130, Good Samaritans responded on-scene and rescued C-1 from on top of the UNA MAS but were unable to locate the Operator or C-2.

4.1.12. At 2150, Good Samaritans took C-1 ashore to be evaluated by emergency services.

4.1.13. At 2154, While UNA MAS was floating inverted, Coast Guard assets arrived and deployed a rescue swimmer on top of the vessel. Rescue swimmer attempted to elicit response from inside the vessel with negative results. Coast Guard, local authorities, and Good Samaritans continued search efforts with negative results.

4.1.14. On September 01, 2025, at 1038, The Coast Guard suspended the search and rescue case.

4.1.15. On September 03, 2025, at 0846, The Operator of the vessel was recovered deceased. A medical autopsy determined cause of death to be from asphyxia drowning, and manner of death was accidental. C-2 was never recovered.

4.1.16. Alcohol and drug testing in accordance with 46 CFR Subpart 4.06 was not completed. The individual determined directly involved was the Operator who was recovered deceased.

4.2. Additional/Supporting Information:

4.2.1. The UNA MAS was an Oregon state registered, 2002, 26-foot Glacier Bay, Coastal Runner 2680, catamaran with two 150 horsepower (HP) outboards. The vessel was utilized for recreational and commercial use. UNA MAS maximum capacities: 2400 pounds including persons, motors, and gear. The vessel was under 05 net tons and not required to have Certificate of Documentation. The UNA MAS was operated by the Owner. UNA MAS had no reported permanent modifications that would change the original hull.

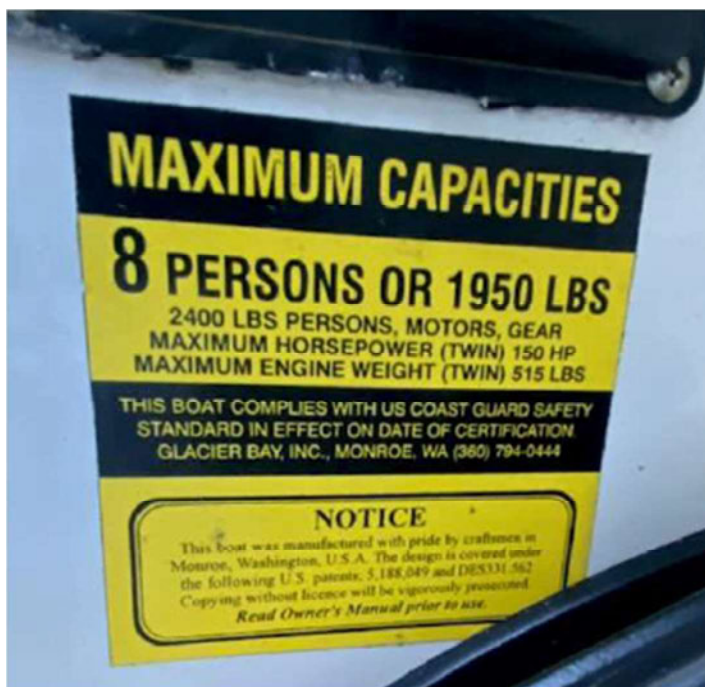


Figure 3. Enlarged photo of maximum capacities label adhered to UNA MAS on September 22, 2025. Obtained from CG Inspector.

4.2.2. The Owner (Operator) of the UNA MAS was a commercial and recreational fisherman. The Operator had experience with the area and ocean transiting. The Operator had been fishing for over 40 years. The Operator held a 100 gross ton merchant mariner credential.

4.2.3. Crewmember 1 (C-1) had worked with the Operator and on the UNA MAS for the last three years. C-1 had experience with the area and ocean transiting. C-1 has overseen another vessel for the last 15 years. C-1 held a 100 gross ton merchant mariner credential and is a commercial fishing guide on another vessel.

4.2.4. Crewmember 2 (C-2) was an experienced recreational fisherman but did not commercially fish. This was C-2's first time on the UNA MAS. C-2 and C-1 were lifelong friends.

4.2.5. At the time of the incident there were three people on board with an approximate combined weight of 550 pounds. The vessel was equipped with two Yamaha 150 HP outboards with a total estimated weight of 1,018 pounds. The vessel also had 02 storage fish totes, 04 feet by 02 feet by 03 feet deep. One was secured on the aft starboard side, and one was secured on the aft port side, directly behind the passenger seating arrangement. Each tote weighed an estimated 803 pounds. 01 ice chest about 40 inches by 18 inches by 20 inches deep was secured between the captain's chair and opposite seat, estimated weight of 382 pounds. 01 large Reliable kill bag approximate size 240 quarts was placed forward of the ice chest near the entry way to the lower cabin, estimated weight 286 pounds. All storage was filled with half ice and half fish calculated to be an estimated weight of 2,274 pounds. The overall total weight on board, including persons, motors, and storage (gear) was approximately 3,842 pounds.

4.2.6. NOAA weather report from two of nearest buoy observation areas: Seas were approximately 03 to 04 feet at 05 to 16 seconds, water temperature was 56° Fahrenheit,

winds north to northwest at 12 knots with gusts up to 16 knots. The buoys were approximately 25 and 35 nautical miles from the incident location. The weather conditions on-scene were observed to have rapidly deteriorated to an observed unforeseen swell of 09 to 12 feet at time of incident.

4.2.7. The Coast Guard calculated survival metrics based on a male approximately six feet tall, weighing 190 pounds, with a body mass index of 23.8%, wearing a long sleeve shirt and mid-weight pants in weather conditions of air temperature: 57°F, water temperature: 55°F, relative humidity: 96.0%, wind speed: 20.0 knots, immersion: water to neck, and immersion state: turbulent. The calculations revealed a functional time of 8.5 hours, cold survival time of 11.5 hours, and a maximum immersed survival time of 20.6 hours.

5. Analysis

5.1. Improper weight capacity that exceeded the manufacturer's recommendation.

5.1.1. The UNA MAS, a 2002 Glacier Bay Coastal Runner 2680 catamaran, had a manufacturer-specified maximum weight capacity of 2,400 pounds for persons, motors, and gear, as indicated on the label at the captain's station. At the time of the incident, the vessel carried three people with a combined weight of approximately 550 pounds and was equipped with two Yamaha 150 HP outboards totaling 1,018 pounds. Considering the report of how much fish, ice, and storage was on board the calculated approximate weight was 2,274 pounds. The total estimated weight of persons, motors, and gear on board was 3,842 pounds, exceeding the manufacturer's recommended limit. This excess weight, combined with severe weather and increasing swells, may have compromised the vessel's ability to right itself, potentially contributing to its capsizing. A proactive assessment of the anticipated total weight by the Operator may have identified these risks and allowed for preventive adjustments.

5.2. Securing strap failure resulted in abrupt weight distribution on the vessel.

5.2.1. The UNA MAS had two storage totes, each weighing approximately 803 pounds and containing a mixture of ice and fish, secured on both sides of the aft deck behind the seating area. Shortly before the capsizing, the vessel encountered a significant swell. As the vessel descended into the wave trough, port side first, the securing strap on the starboard tote failed, causing the tote to shift rapidly to port. This abrupt shift in weight distribution, combined with the vessel's port side descent and severe weather conditions, may have contributed to the vessel's listing and subsequent overturning. Had the strap functioned as intended, it is reasonable to believe that the abrupt shift in weight distribution may not have occurred, and the vessel may have remained upright, avoiding overturning.

5.3. Failure to disengage auto-pilot and slow the vessel during rapidly deteriorating weather conditions.

5.3.1. At the time of the incident, the vessel was reported to be operating on a plane, approximately 18 to 22 knots, with the auto-pilot feature engaged, while the Operator remained at the helm, actively making corrective adjustments as needed. An autopilot

system is designed to maintain a predetermined course and speed, making reactive adjustments to prevailing conditions as they are detected. Weather on-scene was observed to have deteriorated rapidly with swells steadily increasing to a sudden 09 to 12 feet when they capsized. It is reasonable to believe the Operator was unaware of the severity and suddenness of the swells. There is a potential that if the Operator slowed the vessel and disengaged the autopilot to have full manual control in an effort to preemptively combat the deteriorating weather changes and increasing swells, he may have been able to perform more effective real-time vessel maneuvers. This increased responsiveness and slower speed may have assisted in mitigating the impact of adverse conditions and potentially prevented the vessel from capsizing.

5.4. Lack of barriers or restraints to prevent personnel from entering the water during capsizing.

5.4.1. The vessel was equipped with a seating arrangement that was not fully enclosed, resulting in each occupant being either fully or partially exposed to the elements. Consequently, when the vessel capsized, there were no barriers or restraints in place to prevent personnel from being exposed to the water.

5.5. Lack of permanently secured storage to withstand capsizing.

5.5.1. Following the capsizing event, reports indicated that two individuals may have become trapped beneath the overturned vessel. The vessel was outfitted with fishing gear, lines, and additional storage items that were not permanently affixed to the vessel. Upon overturning, the equipment that was not permanently affixed to the vessel may have not been able to withstand a capsizing event, becoming dislodged, creating entanglement hazards beneath the vessel. These hazards may have impeded the individuals' ability to escape safely, resulting in their disappearance or subsequent recovery in a deceased state.

5.6. Adverse environmental conditions compromised survivability

5.6.1. Two individuals were reported to have been trapped beneath the overturned vessel, potentially submerged in the water to their necks. The Coast Guard calculated survival metrics based on a male approximately six feet tall, weighing 190 pounds, with a body mass index of 23.8%, wearing a long sleeve shirt and mid-weight pants in weather conditions of air temperature: 57°F, water temperature: 55°F, relative humidity 96.0%, wind speed: 20.0 knots, immersion: water to neck, and immersion state: turbulent. The estimated Functional Time (period during which an individual can sustain a core temperature above 93.2°F, allowing them to perform self-rescue or survival actions to mitigate exposure risks) was 8.5 hours, while the Cold Survival Time (time until core temperature drops to 82.4°F, at which point the risk of death from hypothermia increases significantly) was calculated to be 11.5 hours. The maximum immersed survival time (MIST) was calculated to be 20.5 hours. MIST represents an estimated survival time derived from historical accounts of individuals of varying weights, ages, and clothing types who survived the longest immersion times at the same water temperature. The challenging environmental factors, including cold water exposure and adverse weather, may have contributed to the probability of survival. Had environmental conditions been more favorable, the chances of survival may have been greater.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty occurred when the vessel UNA MAS capsized during adverse weather conditions. The causal factors identified to have potentially led to this event were:

6.1.1.1. The vessel may have been operated with a weight that did not adhere to manufacturer's recommendations.

6.1.1.2. The abrupt and uneven redistribution of weight towards the port side of the vessel after a securing strap failed.

6.1.1.3. The utilization of the vessel's auto-pilot system and the vessel speed amid adverse weather conditions and intensifying sea swells.

6.1.2. After the vessel capsized, the next event was the Operator, C-1, and C-2 entered the water. Factors that may have prevented this event were:

6.1.2.1. At the time of capsizing, the vessel was not fully enclosed and lacked barriers or restraints designed to prevent personnel from being forced into the water.

6.1.3. The next subsequent event was the missing (presumed deceased) of the Operator and C-2. Factors that may have prevented this event were:

6.1.3.1. Entanglement hazards loomed after gear and storage items were not securely fastened in a manner to withstand the vessel being inverted.

6.1.4. The final subsequent event was the asphyxia drowning leading to the death of the Operator. Factors that may have prevented this event were:

6.1.4.1. The adverse weather conditions while the Operator and C-2 were in the water.

6.2. Evidence of Act(s) or Violation(s) of Law by Any Coast Guard Credentialed Mariner Subject to Action Under 46 USC Chapter 77: There were no potential acts of misconduct, incompetence, negligence, unskillfulness, or violations of law by a credentialed mariner identified as part of this investigation.

6.3. Evidence of Act(s) or Violation(s) of Law by U.S. Coast Guard Personnel, or any other person: There were no potential acts of misconduct, incompetence, negligence, unskillfulness, or violations of law by Coast Guard employees or any other person that contributed to this casualty.

6.4. Evidence of Act(s) Subject to Civil Penalty: This investigation did not identify any potential violations of U.S. law warranting Coast Guard civil penalty actions.

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

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

6.7. Unsafe Actions or Conditions that were not Causal Factors: There were no actions or conditions that were determined to be a non-causal factor.

7. Actions Taken Since the Incident

7.1. As of the date of this report, the Investigating Officer has not been made aware of any corrective actions taken by any party involved in this incident.

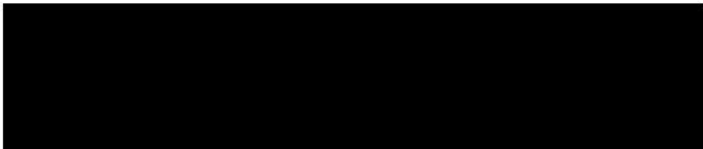
8. Recommendations

8.1. Safety Recommendation:

8.1.1. This investigation did not identify any new safety recommendations.

8.2. Administrative Recommendations:

8.2.1.1. Recommend this investigation be closed.



CWO2, U.S. Coast Guard
Investigating Officer