



UNITED STATES COAST GUARD

**INVESTIGATION INTO THE CIRCUMSTANCES
SURROUNDING THE LOSS OF LIFE OF A PARASAIL
PASSENGER FROM THE VESSEL**

ALMOST HEAVEN

**IN THE VICINITY WEST OF LONGBOAT KEY PASS,
FLORIDA ON 06/27/2011**



MISLE ACTIVITY NUMBER: 4060480

U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
United States Coast Guard

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16732/IIA#4060480
17 June 2022

**LOSS OF LIFE ABOARD THE UNINSPECTED PASSENGER VESSEL
ALMOST HEAVEN WHILE CONDUCTING PARASAIL
OPERATIONS IN LONGBOAT PASS, FLORIDA ON JUNE 27, 2011**

ACTION BY THE COMMANDANT

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. This marine casualty investigation is closed.

ACTION ON RECOMMENDATIONS

Recommendation 1: It is recommended that the Commandant of the Coast Guard, along with parasail industry professionals, conduct a review of best safety practices and operating standards published by parasail safety organizations to create a mutually agreed upon set of guidelines for parasail operators. It is recommended that the consolidated operational guidelines be incorporated into federal regulations.

Recommendation 2: It is recommended that the Commandant of the Coast Guard immediately conduct an outreach effort to parasailing operators recommending immediate review of policies for techniques to recover passengers who enter the water unplanned after a loss of propulsion. The outreach effort should stress the importance to strict adherence to recommended techniques established by parasail safety organizations.

Recommendation 3: It is recommended that the Commandant of the Coast Guard make use of marine inspectors to educate parasail operators of the implication of marine casualties occurring during parasail operations.

Recommendation 4: It is recommended that the Commandant of the Coast Guard review licensing criteria for parasail operators and crew to determine if additional licensing endorsements should be applied. By its nature, parasailing requires crews to perform tasks not associated with the operations of a traditional passenger vessel. Through education and testing of proficiency, Coast Guard credentialed mariners can gain a better understanding of the dynamics of a parasail vessel.

Recommendation 5: It is recommended that the contents of this investigation be given widest dissemination amongst national parasailing organizations, operators and OCMI zones with parasail operators.

Recommendation 6: It is recommended that the Commandant of the Coast Guard incorporate the findings of this investigation, as well as those from other parasailing casualties, into a formal course module for incorporation into the Investigation Officer and Marine Inspection course curriculum at Training Center Yorktown.

Recommendation 7: It is recommended that the Commandant of the Coast Guard enact regulations to inspect all parasail vessels that carry at least one passenger for hire.

Recommendations 1-7: I concur with the intent of these recommendations. The Coast Guard currently lacks regulatory authority to compel compliance with regard to parasailing operations, equipment, or parasail specific endorsements for merchant mariner licensing. However, since 2009, the Coast Guard has shepherded the development of consensus standards with Industry stakeholders including the Water Sports Industry Association (WSIA).

In January 2012, the Coast Guard requested that 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 nine years, the most recent version being F3099-19. 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 Coast Guard continues to monitor the industry's implementation of the ASTM standards and evaluate their effectiveness. This is completed through Coast Guard presence at annual parasailing conferences and engagement with the Water Sports Industry Association (WSIA) and by periodically providing casualty data to measure ASTM standard effectiveness.

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

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

- 2012: The Commandant sent message (R 191851Z 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 Coast Guard units.
- 2013: 07-13 Safety Alert 'Parasailing Operations – Know Your Ropes (2)'
- 2014: 05-14 Safety Alert 'Overheating of Parasailing Vessel Hydraulic System'
- 2015: MSIB 003-15 'Parasailing - Flight Safety and Rules'
- 2015: 07-15 Safety Alert 'Prevent Parasail Accidents: Follow ASTM Standards and Follow Manufacturer Instructions!'
- 2018: 12-18 Safety Alert '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 U.S. Coast Guard 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.

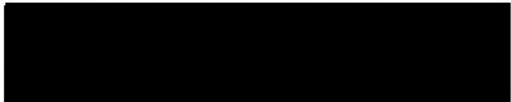
In 2015, U.S. Coast Guard Training Center Yorktown added a parasail casualty scenario to the Investigating Officer Course curriculum. This scenario offers Coast Guard Investigators the opportunity to consider the unique investigation considerations associated with parasail operations.

Since this incident occurred, parasailing fatalities and injuries have declined. The Coast Guard will continue to monitor parasail safety and encourage the combined efforts of stakeholders to improve safety.

Through safety initiatives in public education and outreach, established ASTM standards, and continued partnership with WSIA and ASTM representatives, it is clear that the intent of these recommendations has been addressed as is evidenced through the downward trends in casualties. The closure of this case will allow the Coast Guard to share it and any third party safety recommendations with our parasailing industry partners to further strengthen safety measures within the parasailing industry.

This report, along with similar parasailing cases, will be posted and available to the public on the DCO website here:

<https://www.dco.uscg.mil/Our-Organization/Assistant-Commandant-for-Prevention-Policy-CG-5P/Inspections-Compliance-CG-5PC-/Office-of-Investigations-Casualty-Analysis/Marine-Casualty-Reports/>.



J. D. NEUBAUER
Captain, U.S. Coast Guard
Acting Director of Inspections and Compliance



16732
22 Nov 2011

MEMORANDUM

From: [REDACTED] CWO
[REDACTED] Investigating Officer
To: S. L. Dickinson, CAPT 1/31/12
CG Sector Saint Petersburg
Thru: P.S. Reilly, CDR 2/12
CG Sector Saint Petersburg (sp)

Subj: DEATH OF PARASAIL PASSENGER FROM UNINSPECTED PASSENGER
VESSEL ALMOST HEAVEN IN THE VICINITY WEST OF LONGBOAT KEY
PASS, FLORIDA ON JUNE 27, 2011

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

1. **Executive Summary:** On the evening of June 27, 2011, the M/V ALMOST HEAVEN departed Bradenton Municipal Marina with six passengers on board to engage in parasailing. The vessel proceeded to a safe location approximately one mile west of Longboat Key Pass. The master and crew of the vessel routinely inflated the parasail and conducted two tandem rides which took off from the aft deck of the vessel elevated approximately 800 feet of tow line out and retrieved the parasailers back to the deck of the vessel. While attempting to take Mr. David Sieradzki and [REDACTED] on a parasail ride, Capt. [REDACTED] indicated that the combined weight of the two tandems was too great for the chute. Therefore Capt. [REDACTED] suggested that [REDACTED] go up with [REDACTED] which was agreed upon and Mr. Sieradzki would take a solo parasail flight next. Upon completion of the third parasail flight, Mr. Sieradzki was rigged up for a solo parasail flight. The final flight was elevated to approximately 800 feet of tow line out. The ALMOST HEAVEN experienced a loss of propulsion when it spun its propeller hub and Mr. Sieradzki drifted along with the parasail down to the water. The crew then began to manually bring the 800 feet of tow line on board to get Mr. Sieradzki back from the water. Capt. [REDACTED] discovered the ALMOST HEAVEN had idle speed so he engaged the engine, turned the vessel to retrieve Mr. Sieradzki. When the ALMOST HEAVEN arrived near Mr. Sieradzki in the water he was unresponsive and floating face up with foam emanating from his mouth and nose. Capt. [REDACTED] requested assistance from the USCG Search and Rescue. The crewman entered the water and with the passenger's assistance, got Mr. Sieradzki onto the ALMOST HEAVEN. Emergency resuscitation was started and Mr. Sieradzki remained unresponsive. Mr. Sieradzki and [REDACTED] were transferred to USCG response vessel and taken to Coquina Marina Boat Ramp. Emergency Medical Services arrived at Coquina Marina at 1801 and pronounced Mr. Sieradzki deceased. Capt. [REDACTED] continued to idle the ALMOST HEAVEN back to Bradenton Beach Marina to disembark the passengers and meet with USCG Station Cortez boat crew. Crew of the ALMOST HEAVEN was alcohol tested by USCG boarding officer. All evidence, correspondence, and testimonies gathered during the investigation and used to create this report are included in the Coast Guard's electronic database (MISLE) incident investigation activity 4060480.

2. Vessel Data:

ALMOST HEAVEN	
Official Number	FL 9877 MT
Hailing Port	Bradenton Beach Municipal Marina, Florida
Service	Uninspected Passenger Vessel; Parasail
Year Built	1994
Gross Tonnage	Unknown
Length	28' 0"
Owner	Fun & Sun Parasail, LLC
Crew Compliment	Two; OUPV Master required

3. Personnel Data:

Name	Age	Position	Status
David Richard Sieradzki	█	Passenger/Parasailer	Deceased
█ █	█	Licensed Master	Not at risk
█	█	Deckhand	Not at risk
█	█	Passenger/Parasailer	Not at risk
█	█	Passenger/Parasailer	Not at risk
█	█	Passenger/Parasailer	Not at risk
█	█	Passenger/Parasailer	Not at risk
█	█	Passenger/Parasailer	Not at risk
█ ns	█	Owner	Not at risk

4. Findings of Fact:

a. M/V ALMOST HEAVEN and Fun & Sun Parasail were purchased by █ on February 7, 2011. M/V ALMOST HEAVEN is an uninspected passenger vessel. Crewmembers on board the M/V ALMOST HEAVEN were properly licensed and experienced in the parasail industry. Fun & Sun Parasail is not a member of a parasail industry safety organization (PAPO or Parasail Safety Council).

- b. Employees of Fun & Sun Parasail changed the outdrive of the M/V ALMOST HEAVEN on or around June 3rd, 2011.
- c. On June 26, 2011, the crew of the M/V ALMOST HEAVEN changed out the parasail tow line (5/16" Spectra) purchased from Custom Chutes, INC.
- d. On June 27, 2011, at approximately 1545, David Richard Sieradzki, his spouse [REDACTED] his sister [REDACTED], her boyfriend [REDACTED], other passengers [REDACTED] and [REDACTED] arrived at Fun and Sun Parasail at Bradenton Beach Municipal Marina to parasail. Passengers were greeted by Fun & Sun Parasail office personnel and all passengers signed a Release of Liability/Waiver.
- e. At approximately 1600, passengers met with the crew and were instructed to remove their shoes. Passengers were also given properly fitting USCG approved personal flotation devices (PFD) and instructed to wear the PFDs while in the boat and on parasail rides.
- f. At approximately 1605, the M/V ALMOST HEAVEN got underway from Sun & Fun Parasail at Bradenton Beach Municipal Marina with 06 passengers and 02 crew.
- g. While transiting to the parasail location, the passengers reported that they received no safety brief regarding parasailing except how to get into the parasail harnesses and how to launch and land from the boat's rear deck. Passengers [REDACTED] and [REDACTED] did not speak English.
- h. At approximately 1620, Capt. [REDACTED] and deckhand [REDACTED] arrived at desired parasail location approximately 1 nautical mile west of the Longboat Key Pass entrance marker. The Capt. and deckhand inflated the parasail and made the rig ready to carry passengers in the parasail arrangement.
- i. At approximately 1623, the first parasail tandem passengers' ride consisted of passengers [REDACTED] and [REDACTED]. Parasail ride was without incident.
- j. At approximately 1640, the second parasail tandem passengers' ride consisted of [REDACTED] and [REDACTED]. Parasail ride was without incident.
- k. At approximately 1700, third parasail tandem passengers consisting of Mr. Sieradzki and [REDACTED] prepared to ride. The deckhand instructed tandem riders into harness and connected them to the parasail spreader bar. Capt. [REDACTED] attempted to create lift by engaging the M/V ALMOST HEAVEN into forward. Capt. [REDACTED] stated he could not create enough lift because of weight constraints. The tandem of Mr. Sieradzki and [REDACTED] was too heavy. Capt. [REDACTED] suggested that [REDACTED] ride with [REDACTED] instead of Mr. Sieradzki so the weight would be less. [REDACTED] agreed to ride again, third ride completed without incident.
- l. At approximately 1720, the fourth unplanned parasail ride consisting of Mr. Sieradzki was rigged by deckhand. The forth flight was a solo flight. Capt. [REDACTED] stated that he let the

tow rope out for the fourth flight for the usual length (approximately 800 feet) and was navigating the vessel in forward propulsion. (Next images show Mr. Sieradzki during the launch of the fourth parasail flight)



m. At approximately 1726, 5-6 minutes into the parasail flight, the M/V ALMOST HEAVEN experienced a loss of propulsion. The reason for the loss of propulsion was unknown at the time, but the Captain of the vessel thought it was because of the M/V ALMOST HEAVEN's outdrive. The vessel was thought to be totally without propulsion.

n. After the loss in propulsion, the parasail lost its lift and began drifting down to the water with approximately 800 feet of tow line out (between 400-500 foot elevation) Mr. Sieradzki was still secured into the parasail harness when it drifted down and entered the Gulf of Mexico in approximately 20 feet of water.

o. When Mr. Sieradzki entered the water, statements report that he waved with his arms over his head. The witnesses thought that he was signaling that he was "OK".

p. The crew of the M/V ALMOST HEAVEN immediately began taking up the tow line. Initially the tow line was brought in by hand onto the launch deck of the vessel. Statements and interviews vary regarding the recovery of the parasailer. Predominately it was reported that the crew pulled in the passenger by hand and the winch recovered the slack that was on board. It was also reported that the captain discovered that the M/V ALMOST HEAVEN had minimum steerage, turned the vessel toward the person in the water and idled the vessel to him.

q. As the M/V ALMOST HEAVEN approached Mr. Sieradzki, who was in the water attached to the parasail, it is stated that he was out of view, possibly underwater for nearly 1 minute while being pulled by the towrope.

r. Mr. Sieradzki was not tangled in the tow rope or parasail rigging.

- s. It is estimated that it took between 3-5 minutes to get Mr. Sieradzki from where he entered the water to the M/V ALMOST HEAVEN.
- t. At approximately 1733, Mr. Sieradzki was visible from the M/V ALMOST HEAVEN. Mr. Sieradzki was face up with his PFD on, observed to be unconscious and unresponsive, strapped into the parasail harness, with foam emanating from his mouth and nose. [REDACTED], deckhand, jumped into the water to recover Mr. Sieradzki.
- u. At approximately 1734, Capt. [REDACTED] called USCG Sector St. Petersburg via VHF-FM radio requesting assistance from the Coast Guard. In his request, Capt. [REDACTED] stated that the parasailer was unconscious, non responsive and in need of Coast Guard help.
- v. After getting Mr. Sieradzki onto the M/V ALMOST HEAVEN, [REDACTED] and Capt. [REDACTED] began Cardio Pulmonary Resuscitation (CPR).
- w. At approximately 1748, CG 25679 arrived on scene and took Mr. Sieradzki and [REDACTED] on board. CPR continued.
- x. At approximately 1755, CG 25679 arrived at Coquina Boat Ramp, awaiting Emergency Medical Services.
- y. At approximately 1804, EMS arrived on scene and found Mr. Sieradzki to be asystolic and was pronounced deceased. He was transported to Manatee County Coroner's Office.
- z. Crewmembers from the M/V ALMOST HEAVEN took post casualty drug tests on 28 June 2011, results [REDACTED]
- aa. On July 19, 2011, USCG Investigators, Florida Fish and Wildlife Conservation Commission (FWC) Investigators and Fun & Sun Parasail owner, [REDACTED], transported the M/V ALMOST HEAVEN from the FWC impound on Gandy Blvd in Tampa, to Boat and Motor Superstores, Palm Harbor, FL for inspection. At Boat and Motor Superstore, [REDACTED], Mercury Mercruiser Master Technician, diagnosed the vessels motor and outdrive. Mr. [REDACTED] found that the vessels outdrive experienced a material failure on the propeller hub. The propeller hub had separated in the rubber housing (commonly called a "spun" hub). This failure was indicative of how the M/V ALMOST HEAVEN reacted during the loss of propulsion on 27 June 2011 when Mr. Sieradzki was aloft in a parasail.
- bb. On July 21, 2011, USCG transported the parasail, harness, yoke, and spreader bar to Custom Chutes in Bradenton, FL to be inspected. Mr. [REDACTED] and Mr. [REDACTED] inspected all the equipment. Mr. [REDACTED] and Mr. [REDACTED] stated that all equipment was in serviceable condition and that, in their professional opinion, all equipment would be good for use. They stated that the parasail was designed to float and that the particular parasail used in the casualty should have floated. USCG Investigators questioned Mr. [REDACTED] and Mr. [REDACTED] about the techniques used to recover a person in the water after a vessel loses its propulsion.

They stated that hand over hand tow line retrieval; winch tow line retrieval and navigating the vessel back to the location of the person in the water are all recommended techniques.

cc. August 02, 2011, USCG Investigator transported the propeller from the M/V ALMOST HEAVEN to General Propeller in Bradenton, FL to be inspected. Mr. [REDACTED], Vice President of General Propeller, stated that his company had "most likely" serviced the propeller although he could not find a service report. Mr. [REDACTED] stated that it was probably more than 18 months before, but the propeller stamping was from his shop. Mr. [REDACTED] ran the propeller on a Prop Scan EPS and found variations in the propeller, but stated that the propeller would still be in serviceable condition once the propeller was re-hubbed. Mr. [REDACTED] also stated that his company would not warrantee the new hub until the propeller was machined to repair variances.

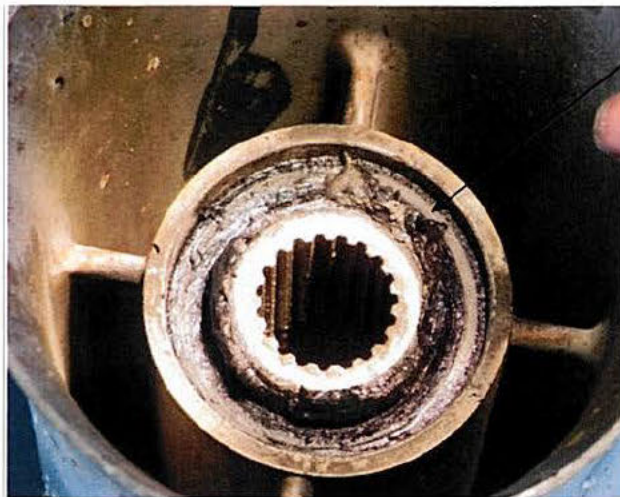
dd. On August 30, 2011, USCG received results from the Medical Examiner's Autopsy. Results indicated that Mr. Sieradzki's cause of death was drowning. Medical Examiner's statements include "Findings associated with drowning, e.g. exuberant edema, were not specifically found, however the absence of such findings does not exclude drowning, especially after vigorous attempts at resuscitation. (Note that the observation of foam around the mouth and nose when the body was first retrieved is indicative of exuberant edema and thus suggestive of drowning, but is not entirely specific for that diagnosis.) [REDACTED] no underlying disease process was observed to explain the enlargement. [REDACTED] The Medical Examiner also stated, "For drowning to have thus occurred, the most likely precipitating factor would be a loss of consciousness" the Medical Examiner stated the most likely cause of unconsciousness would be a concussion. The Medical Examiner stated that there is no sign of a concussion but "Another, more likely explanation for sudden unconsciousness is the scenario of cardiac arrhythmia, precipitated by the immediate stress of the event and its effect on his [REDACTED] Such a cardiac arrhythmia might result not only in unconsciousness but in full-blown cardiac arrest." The Medical Examiner concludes his report stating, "It is my opinion that the cause of death is drowning. Specific individual risk factors for drowning are not conclusively confirmed, though, among these, cardiac arrhythmia due to underlying [REDACTED] is most likely. Given such, stress from the event probably played a role in the development of arrhythmia."

5. **Causal/Human Error Analysis:**

- a. After having the M/V ALMOST HEAVEN examined by a certified Mercruiser Master Technician, it was apparent that the rubber hub on the propeller of the outdrive of the Bravo II failed and caused the M/V ALMOST HEAVEN to lose propulsion.
- b. According to statements, Mr. Sieradzki was not briefed on procedures to take if he were to enter the water unexpectedly. The crew of the M/V ALMOST HEAVEN did not adequately brief safety procedures to their parasail passengers. Although parasail passenger safety briefings are not a federal or state requirement, passenger safety

briefings are a requirement for inspected vessels and are a part of the standard safety practice required for parasail vessels belonging to parasail industry safety organizations.

6. **Conclusions:** In accordance with Marine Safety Manual, Volume V, the Initiating Event (or first unwanted outcome for this casualty) was when M/V ALMOST HEAVEN lost propulsion because the vessel “spun” its propeller hub (photos below of propeller hub). The vessel has a single inboard / outboard engine. The loss of propulsion caused Mr. Sieradzki, who was being towed in a parasail aloft behind the M/V ALMOST HEAVEN, to lose lift and enter the waters of the Gulf of Mexico. When Mr. Sieradzki entered the water he waved his hands above the water. Capt. [REDACTED] retrieved Mr. Sieradzki by pulling the parasail towline in by hand, by winch and by navigating the M/V ALMOST HEAVEN at idle speed toward Mr. Sieradzki’s location. Mr. Sieradzki was out of view for an unknown period of time while being pulled back to the vessel (between 3-5 minutes). Mr. Sieradzki was unconscious / unresponsive and floating face up when he was seen approximately 100 feet from the vessel. Mr. Sieradzki was recovered on board the M/V ALMOST HEAVEN and cardiopulmonary resuscitation was administered. USCG responded to the scene and took Mr. Sieradzki and [REDACTED] to Coquina Boat Ramp where EMS declared Mr. Sieradzki deceased. Although not deemed to be a causal factor, it should be mentioned that all passengers stated that they received no safety briefing before or during the parasail rides. There is no evidence of failure to properly respond to this situation by retrieving / recovering the person in the water using different techniques (pulling / winching / navigating) by the vessel’s crew. With exception to the medical explanations, it is unknown, what other factors contributed to Mr. Sieradzki’s death.



7. **Safety Recommendations:**

- a. It is recommended that the Commandant of the Coast Guard, along with parasail industry professionals, conduct a review of best safety practices and operating standards published by parasail safety organizations to create a mutually agreed upon set of guidelines for

parasail operators. It is recommended that the consolidated operational guidelines be incorporated into federal regulations.

- b. It is recommended that the Commandant of the Coast Guard immediately conduct an outreach effort to parasailing operators recommending immediate review of policies for techniques to recover passengers who enter the water unplanned after a loss of propulsion. The outreach effort should stress the importance to strict adherence to recommended techniques established by parasail safety organizations.
- c. It is recommended that the Commandant of the Coast Guard make use of marine inspectors to educate parasail operators of the implication of marine casualties occurring during parasail operations.
- d. It is recommended that the Commandant of the Coast Guard review licensing criteria for parasail operators and crew to determine if additional licensing endorsements should be applied. By its nature, parasailing requires crews to perform tasks not associated with the operations of a traditional passenger vessel. Through education and testing of proficiency, Coast Guard credentialed mariners can gain a better understanding of the dynamics of a parasail vessel.
- e. It is recommended that the contents of this investigation be given widest dissemination among national parasailing organizations, operators and OCMI zones with parasail operators.
- f. It is recommended that the Commandant of the Coast Guard incorporate the findings of this investigation, as well as those from other parasailing casualties, into a formal course module for incorporation into the Investigating Officer and Marine Inspection course curriculum at Training Center Yorktown.
- g. It is recommended that the Commandant of the Coast Guard enact regulations to inspect all parasail vessels that carry at least one passenger for hire.

8. **Administrative Recommendations:**

- a. No enforcement action recommended as a result of this investigation.
- b. It is recommended that this casualty investigation be closed.

#