UNITED STATES COAST GUARD

REPORT OF INVESTIGATION

INTO THE
LOSS OF LIFE ONBOARD THE PONTOON VESSEL FL 1161 PS WHILE IN THE CHOCTAWHATCHEE BAY, DESTIN, FL ON APRIL 21, 2019

MISLE ACTIVITY NUMBER: 6670600

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

Commandant
United States Coast Guard

2703 Martin Luther King Jr. Ave. SE
Stop 7501
Washington, DC 20593-7501
Staff Symbol: CG-INV
Phone: (202) 372-1032
E-mail: CG-INV1@uscg.mil

16732/IIA # 6670600
20 June 2025

LOSS OF LIFE WHILE SNORKELING FROM THE UNINSPECTED PASSENGER VESSEL FL1161PS IN CHOCTAWHATCHEE BAY NEAR DESTIN, FLORIDA ON APRIL 21, 2019

ACTION BY THE COMMANDANT

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

[redacted]

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

U.S. Department of Homeland Security

United States Coast Guard

Commander
Eighth Coast Guard District

Hale Boggs Federal Bldg.
500 Poydras Street
New Orleans, LA 70130
Staff Symbol: dp
Phone: (504) 671-2087

16732
MAY 12 2020

LOSS OF LIFE ONBOARD THE PONTOON VESSEL FL 1161 PS WHILE IN THE CHOCTAWHATCHEE BAY, DESTIN, FL ON APRIL 21, 2019

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 passenger was a tragic and preventable accident. I offer my sincere condolences to family and friends of the person who lost their 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]

J. E. FOTHERGILL
Commander, U.S. Coast Guard
Chief of Prevention, Acting
Eighth Coast Guard District
By Direction

U.S. Department of Homeland Security

United States Coast Guard

Officer in Charge, Marine Inspection
United States Coast Guard
Sector Mobile

1500 15th Street
Mobile, Al 36615
Staff Symbol: (s)
Phone: (251) 441-5971

16732

LOSS OF LIFE ONBOARD THE PONTOON VESSEL FL 1161 PS WHILE IN THE CHOCTAWHATCHEE BAY, DESTIN, FL ON APRIL 21, 2019

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 REPORT

[redacted]

U. S. Mullins
Captain, U.S. Coast Guard
Officer in Charge, Marine Inspection

TABLE OF CONTENTS

U.S. Department of Homeland Security

United States Coast Guard

Officer in Charge, Marine Inspection
United States Coast Guard
Sector Mobile

1500 15th Street
Mobile, Al 36615
Staff Symbol: (spv)
Phone: (251) 441-5971

16732

LOSS OF LIFE ONBOARD THE PONTOON VESSEL FL 1161 PS WHILE IN THE CHOCTAWHATCHEE BAY, DESTIN, FL ON APRIL 21, 2019

EXECUTIVE SUMMARY

On April 21, 2019 at approximately 1730, the pontoon vessel FL 1161 PS was underway near the East Jetty of Destin Channel, Destin, FL when one of the five passengers on board went missing while snorkeling.

The subject vessel was operating as an Uninspected Passenger Vessel (UPV) and scheduled to take the five passengers out in the Choctawhatchee Bay for the afternoon. The owner of the vessel was hired as the Master to take them out specifically for sightseeing and snorkeling activities.

Upon arriving at the desired location near the East Jetty, the Master and four of the five passengers entered the water to commence snorkeling activities. Shortly after disembarking, the Master climbed back on board the vessel to set up a drone for photography purposes. While setting up the drone, one of the passengers re-boarded the vessel and informed the Master that one of the fellow passengers was missing, and despite initial efforts, was unable to locate him. The Master, noting at this time that the passenger in question was without a personal floatation device, immediately entered the water to locate the missing passenger but was also unsuccessful. The Master, along with the four passengers now all on board, proceeded to call 911 to initiate search and rescue efforts to locate the missing snorkeler.

The following day, on April 22, 2019, the local Sheriff's Office located the missing passenger who was pronounced deceased at the scene.

As a result of its investigation the Coast Guard determined that the initiating event for this incident was the death of the passenger. The causal factors that led to the initiating event were: 1) the Master brought the passengers to a known high risk area to snorkel during unsafe weather/water conditions, 2) the Master did not ensure that the passengers kept their lifejackets on while snorkeling, 3) the Master did not maintain a proper lookout for the passengers' safety while they were in the water, and 4) the deceased passenger was not an experienced swimmer.

U.S. Department of Homeland Security

United States Coast Guard

Officer in Charge, Marine Inspection
United States Coast Guard
Sector Mobile

1500 15th Street
Mobile, Al 36615
Staff Symbol: (spv)
Phone: (251) 441-5971

16732

LOSS OF LIFE ONBOARD THE PONTOON VESSEL FL 1161 PS WHILE IN THE CHOCTAWHATCHEE BAY NEAR DESTIN, FL ON APRIL 21, 2019

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 persons or organizations were designated as party-in-interest in this investigation in accordance with 46 CFR Subsection 4.03-10.

1.3. The U.S. Coast Guard (USCG) was the lead agency for all evidence collection activities involving this investigation.

1.4. This Report was authored four years post incident. Therefore contents contained therein, the undersigned author relied solely upon documentary evidence and investigative efforts of the assigned Investigating Officer at the time of the incident. Accordingly, the factual elements and causal analysis reported by the Investigating Officer remain materially unaltered.

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

2. Vessel Involved in the Incident

Figure 1. Recreational Vessel FL 1161 PS (July 2017 [redacted]

Official Name:	N/A
Identification Number:	FL 1161 PS
Flag:	United States
Vessel Class/Type/Sub-Type	Recreational/Pontoon
Build Year:	2013
Length:	22 Feet (L.O.A)
Main/Primary Propulsion: (Configuration/System Type, Ahead Horse Power)	115
Owner:	True Blue Pontoon Rentals of FWB, LLC.
Operator:	[redacted]

3. Deceased, Missing and/or Injured Persons

Relationship to Vessel	Sex	Age	Status
Passenger	Male	28	Deceased

4. Findings of Fact

4.1. The Incident:

4.1.1. At 1200, April 21, 2019, five passengers met the Master in Destin, Florida for a pre-scheduled sightseeing and snorkeling trip. After providing a general safety brief, the Master inquired as to who was not a good swimmer. Two individuals, including the deceased passenger, came forward and were provided with a personal floatation device (PFD) which they reportedly donned for most of the trip.

4.1.2. The vessel departed Dewey's Sea Food in Destin, Florida at 1215, underway in the Choctawhatchee Bay for the sightseeing portion of the voyage.

4.1.3. Upon completing nearly five hours of sightseeing, the Master positioned the vessel and set anchor at the Destin East Pass, East Jetty to commence snorkeling operations.

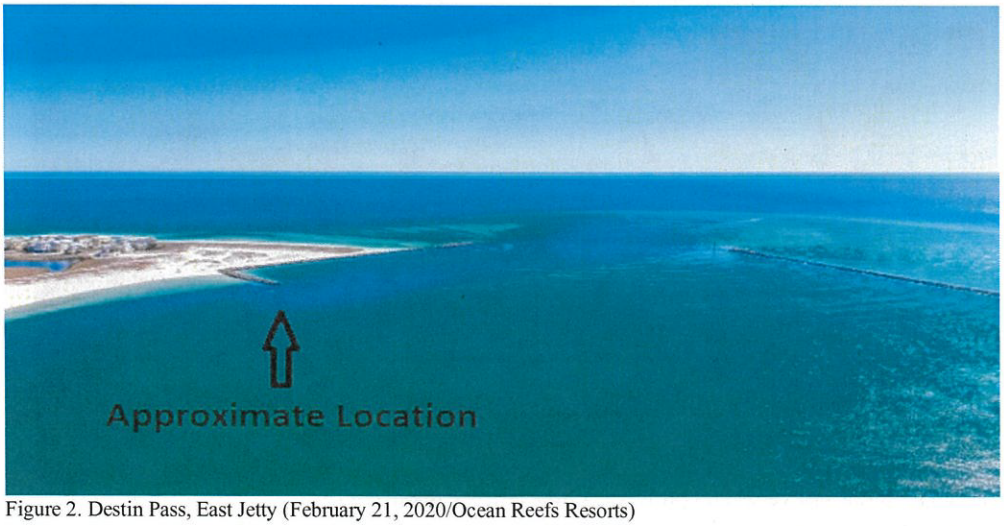

Figure 2. Destin Pass, East Jetty (February 21, 2020/Ocean Reefs Resorts)

Figure 3. Destin Pass, East Jetty (February 21, 2020/Ocean Reefs Resorts)

4.1.4. Shortly after arriving on-scene around 1700, the Master entered the water with four of the five passengers to acclimate them with the area in which they would be snorkeling.

4.1.5. After showing the passengers the surrounding area, the Master climbed back on board the vessel and began setting up a drone to be used for aerial photography.

4.1.6. While setting up the drone, one of the four disembarked passengers climbed on board the vessel and informed the Master that a fellow disembarked passenger had gone missing. At this time, the Master noticed a PFD on the deck of the vessel and realized the passenger in question had removed his PFD prior to entering the water.

4.1.7. Immediately after being informed, the Master re-entered the water to search for the missing passenger.

4.1.8. After searching unsuccessfully, the Master and all remaining passengers climbed back on board the vessel. Once on board, the Master contacted 911 to inform emergency services that a passenger was missing.

4.1.9. Emergency services arrived on-scene and began searching for the missing passenger. A local Sheriff's vessel, which was equipped with side scan sonar capabilities, relayed to the Sheriff's Dive Team that an object had been located under water.

4.1.10. Due to the environmental hazards, including rip currents and nightfall, the Dive Team Coordinator deemed it too dangerous to descend and therefore postponed dive operations until the following day.

4.1.11. The morning of April 22, 2023, eight members of the Sheriff's Office Dive Team mustered at Coast Guard Station Destin and briefed the recovery plan for the object in question.

4.1.12. The Dive Team proceeded underway and arrived on scene. Two divers entered the water and quickly recovered the missing passenger who was pronounced deceased at the scene.

4.2. Additional/Supporting Information:

4.2.1. Witnesses reported rough seas and a strong current at the time and location of the incident. According to weather records, at the approximate time of the incident the temperature was 72 °F, winds directed from the SSW at 13 mph, and overall conditions were documented as "Fair".

4.2.2. The Master was the previous holder of a U.S. Coast Guard issued Merchant Mariners Credential with an Operator, Uninspected Passenger Vessel limitation. These credentials expired on March 7, 2019. Further, the Master was not enrolled in pre-employment nor a random drug testing program.

4.2.3. The deceased passenger was reportedly consuming alcohol during the sightseeing portion of the voyage leading up to his entry into the water.

4.2.4. In accordance with 46 CFR 4.06, the Master was directly involved in a Serious Marine Incident, though he failed to submit to drug and alcohol testing. On May 13, 2019, the Master conducted pre-employment drug testing and subsequent enrollment in The Maritime Drug Consortium, Inc. drug testing program. The results were negative.

5. Analysis

5.1. *Unsafe Environmental Conditions.* Destin East Pass, the general location of the incident, has the topographical makeup of an area highly susceptible to rapid changes in tide, and therefore, current. According to involved persons, the passengers entered the water near the Destin East Pass, East Jetty at 1800, a time when the tide was on the latter half of a downward trend. Further, the winds recorded at the time of the incident marked gusts up to 13 mph. Taking into account the apparent tidal currents and wind conditions, it is noted that the environmental conditions, particularly that of the current, were less than favorable. Ultimately, the Master, whom despite not being a properly licensed mariner at the time of the incident but nevertheless maintained 40 years familiarity with the surrounding conditions and the appropriate safety precautions to be met, bared the responsibility of dictating the present conditions as being safe or unsafe for water entry. Had the Master determined said conditions as being unsafe or otherwise too dangerous for swimming, the passengers would have presumably followed the Master's commands to refrain from entering the water. Without water entry, it is likely that no drowning incident would have occurred.

5.2. *Failure to Don PFDs.* The Master, similar to the previous analysis, bares the responsibility of ensuring the appropriate lifesaving equipment is utilized when required. The Master is not expected to, nor should, attempt to gauge an individual's swimming capabilities, especially having only met the passengers in question just a few hours prior. Although no Federal nor State law requiring donning of a PFD when entering the water finds application in this incident, the Master admitted to feeling otherwise aghast upon discovering the deceased passenger left his PFD on board. Knowing the Master had apprehensions when it came to swimming without a PFD, he should have applied safeguards to prevent passengers from entering the water without one. The PFD left on board by the passenger was

of the appropriate type and size, leaving one to presume that it would have kept him afloat, even considering the environmental conditions. In other words, if the passenger donned the PFD, as should have been required and confirmed by the Master, it is likely that the individual would not have drowned.

5.3. *Failure to Maintain a Proper Lookout.* Upon arriving to the East Jetty swimming and snorkeling location, the Master thought it necessary to enter the water along with the passengers to show them the surrounding area. Although one passenger remained aboard, no record indicates that the duties and responsibilities were transferred to them, nor did they have the adequate training or experience if they had been. Taking these actions and conditions into account, the vessel was in effect left without a proper lookout or watch. Compounding the present hazards were the four passengers in the water, whom, for all intents and purposes, remained unaccounted for. After climbing back aboard the vessel, the Master made no effort to re-commence a proper lookout or watch, instead focusing his attention on setting up a drone for aerial footage. If the Master remained on board, giving him a more favorable line of sight view of the passengers in the water and making it possible that he would have detected the drowning passenger and initiated rescue efforts, which may have prevented his death.

5.4. *Lack of Swimming Capability.* The deceased passenger himself made it clear from the outset of the voyage that he was not a strong swimmer. Knowing the passengers were consuming alcohol throughout the day and were swimming in water conditions varying in depth and including tidal currents, even the most experience of swimmers would have likely struggled to some degree. Suppose the deceased passenger were sober – a direct correlation to physical abilities – and were a more experienced swimmer, they may have been able to swim back to the vessel, to the nearby jetty, or at the very least, remained afloat for a longer period of time, thus increasing their chances of being detected by the Master, fellow passenger, or nearby good Samaritan. Detection may have resulted in timely rescue and potentially prevented his death.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this incident was the death of the passenger. The causal factors leading to this event were:

6.1.1.1. Unsafe Environmental Conditions.

6.1.1.2. Failure to Don PFDs.

6.1.1.3. Failure to Maintain a Proper Lookout.

6.1.1.4. Lack of Swimming Capability.

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 acts of misconduct, negligence and violations of the relevant rules by a Coast Guard Credentialed Mariner. Namely, the subject mariner failed to keep a proper look-out, provided false statements to the Investigating Officer, and submitted fraudulent documents related to the ownership of the vessel.

Although no action was taken as a direct result of this incident, the subject mariner was issued a complaint under the provisions set forth on 46 USC 7703 for actions related to a separate incident. This individual's license was eventually voluntarily surrendered to Coast Guard Sector Mobile.

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 violation by a Coast Guard employee identified as a part of this investigation.

6.4. Evidence of Act(s) Subject to Civil Penalty: Evidence of acts subject to civil penalty were identified as part of this investigation. Of note, the Master is believed to have failed to keep a proper lookout, a violation of 33 CFR 83.05 (RULE 5). Additionally, in confirming that the vessel was being operated in an Uninspected Passenger Vessel capacity, the Master was required to meet the standards set forth in 46 CFR 210-250 related to chemical testing requirements. None of the aforementioned requirements were met. As this report is being drafted nearly four years after the events took place, it was determined that civil action is unnecessary at this point in time.

6.5. Evidence of Criminal Act(s): The Master provided a fraudulent document related to the ownership of the vessel in violation of 18 USC 371 – Conspiracy to commit offense or to defraud the United States. Coast Guard Investigative Services was notified of this act.

6.6. Need for New or Amended U.S. Law or Regulation: This investigation did not reveal a need to amend any U.S. laws or regulations.

6.7. Unsafe Actions or Conditions that Were Not Causal Factors: There were no unsafe actions or conditions that were not causal factors in this casualty.

7. Actions Taken Since the Incident

7.1. None.

8. Recommendations

8.1. Safety Recommendations: None

8.2. Administrative Recommendations: None

[redacted]

Joshua B. French
Lieutenant
U.S. Coast Guard
Investigating Officer