



UNITED STATES COAST GUARD

THE CAPSIZING & LOSS OF LIFE ON THE UNINSPECTED PASSENGER VESSEL GET WET IN THE VICINITY OF MOLASSES REEF, FLORIDA ON DECEMBER 18, 2011 RESULTING IN LOSS OF LIFE



U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
United States Coast Guard

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16732/IIA # 4210580
28 October 2024

**THE CAPSIZING OF THE UNINSPECTED PASSENGER VESSEL GET WET
(O.N. 627133) RESULTING IN THE LOSS OF ONE LIFE WHILE SUPPORTING
A RECREATIONAL DIVE AT MOLASSES REEF OFF KEY LARGO, FLORIDA
ON DECEMBER 11, 2011**

The record and the report of the investigation for this marine casualty were approved and closed on 29 September 2022.

COMMANDANT'S ACTION ON RECOMMENDATIONS

Recommendation 1: It is recommended that the Commandant of the Coast Guard make a copy of this investigation report available to all uninspected passenger vessel examiners, including Coast Guard Auxiliary members.

Action: I concur with this recommendation. The Office of Investigations and Casualty Analysis (CG-INV) will coordinate with the Office of Commercial Vessel Compliance (CG-CVC) and the Office of Auxiliary & Boating Safety (CG-BSX) to distribute the Report of Investigation to all Coast Guard marine inspectors and Coast Guard Auxiliary boat examiners.

Recommendation 2: It is recommended that the Commandant of the Coast Guard direct all Sectors to increase safety boardings of inspected passenger vessels during normal patrols. Any vessel safety concerns should be forwarded to the cognizant Officer in Charge, Marine Inspection (OCMI) for further evaluation and enforcement.

Action: I concur with this recommendation. Increasing safety boardings of uninspected passenger vessels during normal patrols is within policy and is at the discretion of the Captain of the Port (COTP) within their area of responsibility (AOR). Since this incident, the Coast Guard has taken action to increase boardings of these types of vessels nationwide to identify illegal charters. The Coast Guard will continue to pursue development of a national policy to help Coast Guard boarding officers identify and deter illegal passenger vessel operations.


Recommendation 3: It is recommended that the Commandant of the Coast Guard direct Sectors to continue outreach with commercial salvage companies. Coast Guard Sectors should encourage these companies to be our eyes and ears for hazardous operations or illegal uninspected passenger operations.

Action: I concur with this recommendation. Various Coast Guard policies already exist to encourage Sectors to engage commercial salvage companies in their AOR, as appropriate, dependent on which statutory authority. These engagements occur through Area Committees, Area Maritime Security Committees, Harbor Safety Committees, Search and Rescue (SAR) commercial salvor meetings, etc. These venues can be used to promote Coast Guard efforts to mitigate illegal charter operations.

Recommendation 4: It is recommended that the Commandant of the Coast Guard institute a program where vessels that lose their Certificate of Inspection are placed on a targeted monitoring program to ensure that the vessels maintain seaworthiness.

Action: I do not concur with this recommendation. While I do not concur with the recommendation, I acknowledge the importance of COTPs maintaining maritime domain awareness over vessels operating in their zone and utilizing all available laws and regulations to keep vessels, passengers, and their crews safe. The Coast Guard's regulatory framework for COTPs, as detailed in Title 33 Code of Federal Regulations, Part 160, empowers each COTP to restrict vessel operations (both inspected and uninspected vessels) within their zone if they identify "serious repair problems that create a reason to believe the vessel may be unsafe or pose a threat to the marine environment." However, in this case, the issue lies with the owner and operator's disregard for laws and regulations, including failure to report marine casualties, operating a vessel without a merchant mariner credential, and, in some instances, operating as an illegal passenger vessel. The Coast Guard can only intervene when aware of illegal passenger vessel activities and safety concerns, which increased boarding activities, as outlined in Recommendation 2, could help achieve. In this instance, the Coast Guard was unaware of the vessel's history of unsafe operations until conducting the investigation following the vessel's sinking.

Action on Enforcement Recommendations: I note that Sector Key West concurred with the recommendation to pursue administrative Suspension and Revocation against the two credentialed mariners who operated the GET WET illegally. Both mariners subsequently surrendered their merchant mariner credentials in November of 2014 in lieu of participating in an administrative hearing before an Administrative Law Judge. Criminal charges for Seaman's Manslaughter were not pursued in this case and Sector Key West did not initiate a civil penalty against the operating company, which ceased operations and dissolved following the incident.


A. M. BEACH
Captain, U.S. Coast Guard
Director of Inspections and Compliance

U.S. Department of
Homeland Security

United States
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Commandant
United States Coast Guard

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SEP 29 2022

**CAPSIZING & LOSS OF LIFE ON THE UNINSPECTED PASSENGER VESSEL GET
WET IN THE VICINITY OF MOLASSES REEF, FLORIDA ON DECEMBER 18, 2011
RESULTING IN LOSS OF LIFE**

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, and conclusions are approved.

The safety recommendations remain under review and any resulting actions will be documented separately. This marine casualty investigation is closed.


 J. D. NEUBAUER
Captain, U.S. Coast Guard
Chief, Office of Investigations & Casualty Analysis (CG-INV)

U.S. Department of
Homeland Security

United States
Coast Guard



Commander
United States Coast Guard
Sector Key West

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16732
19 Feb 2014

MEMORANDUM

From: [REDACTED]

To: A. S. Young, Sr., CAPT [REDACTED]
CG SECTOR Key West

Subj: REPORT OF INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING
THE CAPSIZING OF THE UNINSPECTED PASSENGER VESSEL GET WET
(627133) IN THE VICINITY OF MOLASSES REEF, FL ON 18 DECEMBER 2011
RESULTING IN A LOSS OF LIFE

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 M16000.10(series)
(d) CG-545 Policy Letter 1-11, of 17 March 11
(e) Mandatory Reporting of Incidents to Coast Guard Investigative Service and
Requesting Investigative Assistance, COMDTINST 5520.5(series)

1. Preliminary Statement

a. On December 18, 2011, I was assigned to conduct an informal investigation into the capsizing of the uninspected passenger vessel GET WET, which resulted in a loss of life and injuries to passengers. Through the investigation I was able to gather the facts, conduct analysis, and draw conclusions per the above references. All times in this Report of Investigation are approximate and referenced in local time. All evidence, correspondence, and testimony gathered during the investigation and used to create this report are included in the Coast Guard's electronic database Marine Information for Safety and Law Enforcement (MISLE) incident investigation activity 4210580.

b. Marine casualties and violations of law listed within the Finding of Facts section of this report were identified during interviews conducted with current and past employees of Key Largo Scuba Shack, LLC and verified through documentary evidence. Additional marine casualties and violations of law likely occurred, but are not specifically pertinent to this investigation and were not recorded in this report, but are documented in the Investigating Officer's Statement / Record of Actions / Interview Summary, filed as evidence number 4210580-JAF-S025.

c. On January 19, 2011, this case was predicated to the Coast Guard Investigative Service (CGIS) per references (c) and (e). Portions of this investigation were conducted in conjunction with Special Agents (S/A) from CGIS. Evidence, correspondence, and testimony gathered during this investigation and in direct support of all alleged criminal offenses are contained in CGIS report number 0018-12GSE18077B[GK].

2. Executive Summary

- a. On December 18, 2011, the uninspected passenger vessel GET WET capsized and sank in approximately 35 feet of water, with six passengers for hire and two crew members aboard, while transiting shore bound from Molasses Reef. This marine casualty resulted in the loss of life of one passenger and serious injuries to three others.
- b. Prior to the capsizing, GET WET had been secured to a mooring ball on Molasses Reef, where the passengers and crew were engaged in recreational SCUBA diving. While the passengers were underwater, the licensed operator observed an increased port list and flooding at the stern of the vessel. The licensed operator investigated the cause, determining that the lazarette compartment bilge pump was not working properly and the compartment was quickly filling with water. A low stern draft and dangerously modified transom allowed water to freely splash aboard and flood the main deck. As was routinely the case, access openings to the engine and lazarette were left unsecured and lacked gasket materials to seal the closure, allowing water flowing onto the deck to down flood into those compartments. With these conditions present, combined with the inoperable lazarette bilge pump and increasing weather conditions, GET WET's stability was greatly jeopardized.
- c. Shortly after discovering the lazarette was flooding, the passengers completed their dive and began boarding GET WET at the stern. The additional weight of the passengers increased the main deck flooding. Unable to control the flooding, the licensed operator attempted to remove the water from GET WET's main deck by getting the vessel underway and up on a plane. This had become a common practice for this operator in attempt to dewater the vessel. However, this time the procedure failed, GET WET continued to flood and lose stability. In a final effort to improve stability, passengers were ordered to move up forward, under a fiberglass bimini. During this time, the deck hand was continuously asking the Master what they should do, but they received no direction. As the passengers gathered underneath the bimini, the licensed operator first radioed Towboat U.S., however, received no response. Then he radioed the Coast Guard requesting emergency assistance, but it was too late. GET WET capsized, sinking stern first with everyone trapped under the bimini canopy.
- d. During the capsizing, the main diesel engine's hatch cover broke free, pinning a passenger's leg to the starboard bulkhead, while entrapping the entire body of another. As GET WET sank, these passengers were unable to escape, sinking to the ocean floor. The remaining passengers, and both crewmembers, managed to swim through openings in the bimini, reaching the surface.
- e. Once on the surface, the passengers and crew held onto a life float, which had self deployed when GET WET sank. With two passengers still trapped inside the sunken vessel, the licensed operator made several attempts to bring them to the surface. After finding dive gear that had floated up from GET WET, the licensed operator successfully located and recovered the passengers that had been trapped inside GET WET. A nearby vessel, VISIBILITY, recovered the passengers and crew from the water and transported them to shore.
- f. Both passengers recovered by the licensed operator were non-responsive. Cardiopulmonary resuscitation (CPR) was administered by the crew of VISIBILITY, saving the life of the first recovered passenger; the second passenger was not able to be resuscitated. That passenger was pronounced deceased by Emergency Medical Services (EMS) ashore. An autopsy completed on that passenger determined the cause of death to be drowning. The operator of

Subj: REPORT OF INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE CAPSIZING OF THE UNINSPECTED PASSENGER VESSEL GET WET (627133) IN THE VICINITY OF MOLASSES REEF, FL ON 18 DECEMBER 2011 RESULTING IN A LOSS OF LIFE

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GET WET contracted Sea Tow Key Largo to salvage the vessel. GET WET was recovered on December 19, 2011, and towed back into port.

3. Vessel Data

UPV GET WET Previous Names (TROPICAL DAZE / LEDGE-ND)	
Official Number	627133
Hailing Port	Key Largo, Florida
Service	Commercial, Uninspected Passenger Vessel
Year Built	1980
Length	24.8 feet
Gross Tons	7 gross tons; 6 net tons
Owner	Key Largo Scuba Shack, LLC
Operator	Key Largo Scuba Shack, LLC
Crew Requirement	One licensed operator



File Photo Taken From Internet

4. Personnel and Organizational Data

GET WET		
Name	Role	Status
Key Largo Scuba Shack, LLC	Operating Company	-
[REDACTED]	Coast Guard Licensed Operator	At Risk / Not Injured
[REDACTED]	Crewmember / Dive Guide	At Risk / Not Injured
[REDACTED]	Passenger	At Risk / Deceased
[REDACTED]	Passenger	At Risk / Injured
[REDACTED]	Passenger	At Risk / Injured
[REDACTED]	Passenger	At Risk / Injured
[REDACTED]	Passenger	At Risk / Not Injured
[REDACTED]	Passenger	At Risk / Not Injured

VISIBILITY		
Name	Role	Status
Coral Reef Park, Co	Operating Company	-
[REDACTED]	Coast Guard Licensed Master	Not At Risk
[REDACTED]	Crewmember	Not At Risk
[REDACTED]	Passenger	Not At Risk
[REDACTED]	Passenger	Not At Risk
[REDACTED]	Passenger	Not At Risk
[REDACTED]	Passenger	Not At Risk
[REDACTED]	Passenger	Not At Risk
[REDACTED]	Passenger	Not At Risk

Subj: REPORT OF INVESTIGATION INTO THE CIRCUMSTANCES
 SURROUNDING THE CAPSIZING OF THE UNINSPECTED PASSENGER
 VESSEL GET WET (627133) IN THE VICINITY OF MOLASSES REEF,
 FL ON 18 DECEMBER 2011 RESULTING IN A LOSS OF LIFE

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KEY LARGO SCUBA SHACK, LLC – Direct Relationship	
Name	Role
[REDACTED]	Owner / Operator Key Largo Scuba Shack, LLC
[REDACTED]	Owner / Operator Key Largo Scuba Shack, LLC
[REDACTED]	Owner / Operator Key Largo Scuba Shack, LLC
[REDACTED]	Owner / Operator Key Largo Scuba Shack, LLC
[REDACTED]	Documented Owner of GET WET
[REDACTED]	Key Largo Scuba Shack Manager
[REDACTED]	Coast Guard Licensed Operator (Terminated prior to 12/18/11)
[REDACTED]	Coast Guard Licensed Operator (Part-time)
[REDACTED]	Key Largo Scuba Shack Employee (Terminated prior to 12/18/11)
[REDACTED]	Coast Guard Licensed Operator (Terminated prior to 12/18/11)
[REDACTED]	Previous Documented owner of GET WET
[REDACTED]	Coast Guard Licensed Operator (Terminated prior to 12/18/11) Previous Documented owner of GET WET
[REDACTED]	Key Largo Scuba Shack Employee (Terminated prior to 12/18/11)

KEY LARGO SCUBA SHACK, LLC – Indirect Relationship	
Name	Role
Eagle Ray Divers, LLC	Previous Operating Company of TROPICAL DAZE (GET WET)
[REDACTED]	Owner / Operator Eagle Ray Divers, LLC
SEA TOW Key Largo	Salvage Company Used to Salvage GET WET
[REDACTED]	Owner SEA TOW Key Largo
[REDACTED]	Salvage Diver SEA TOW Key Largo
TOW BOAT U.S. Key Largo	Contract Salvage and Towing Key Largo Scuba Shack, LLC
[REDACTED]	Owner TOW BOAT U.S. Key Largo

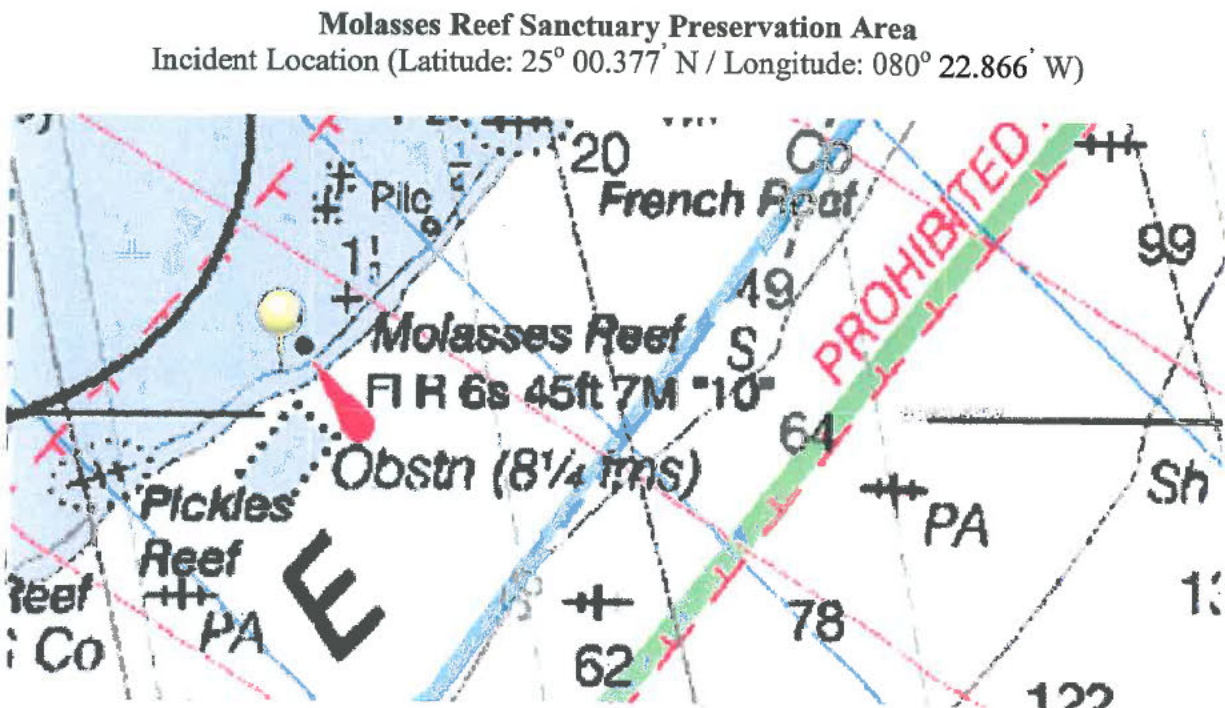
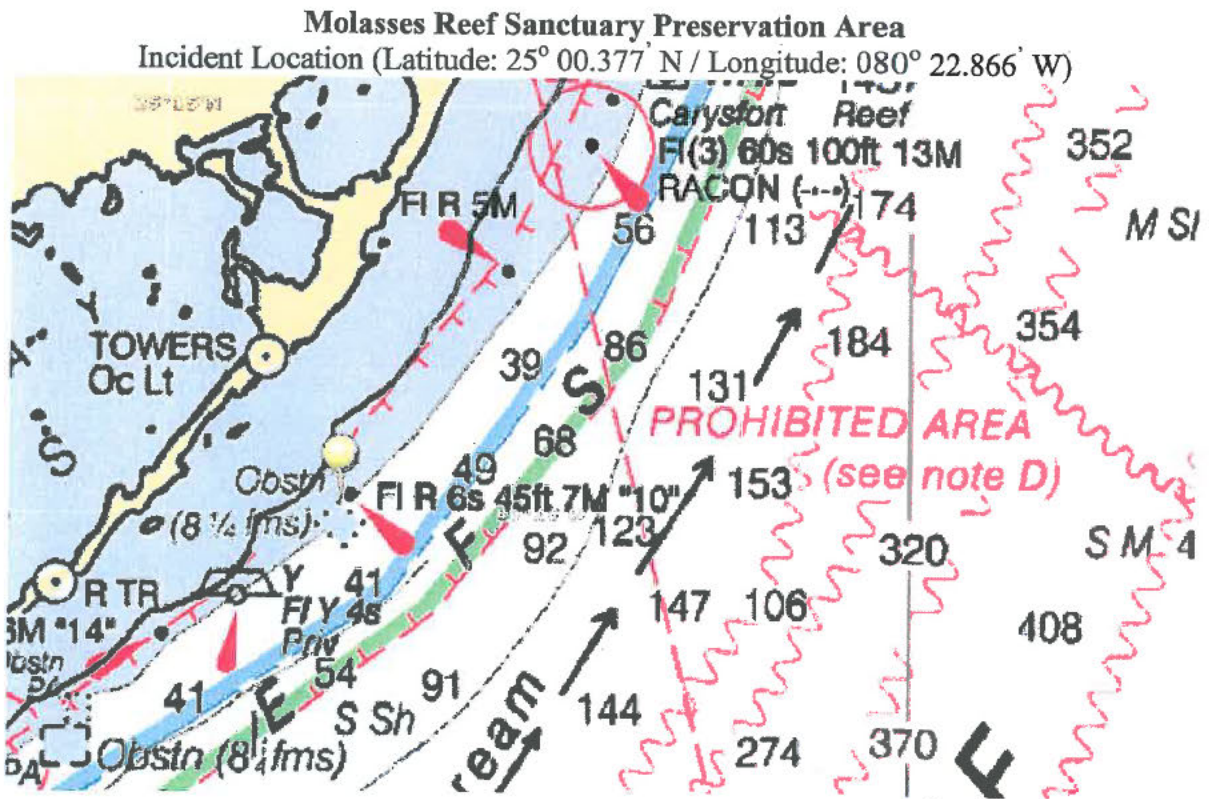
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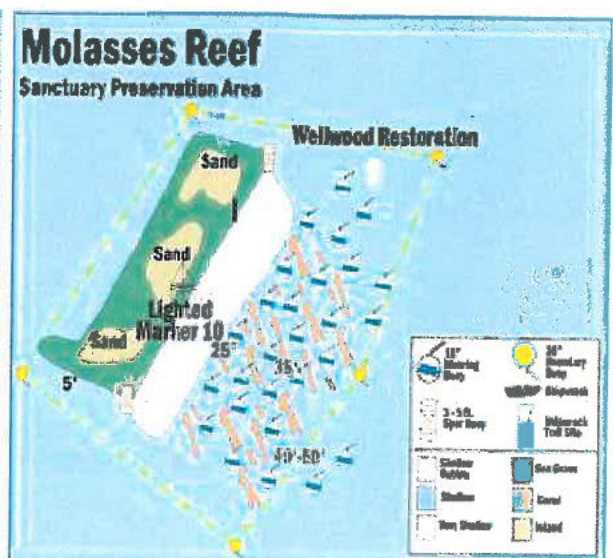
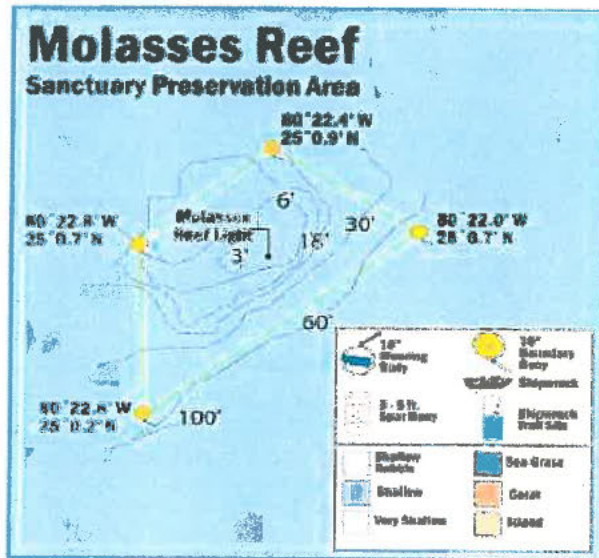
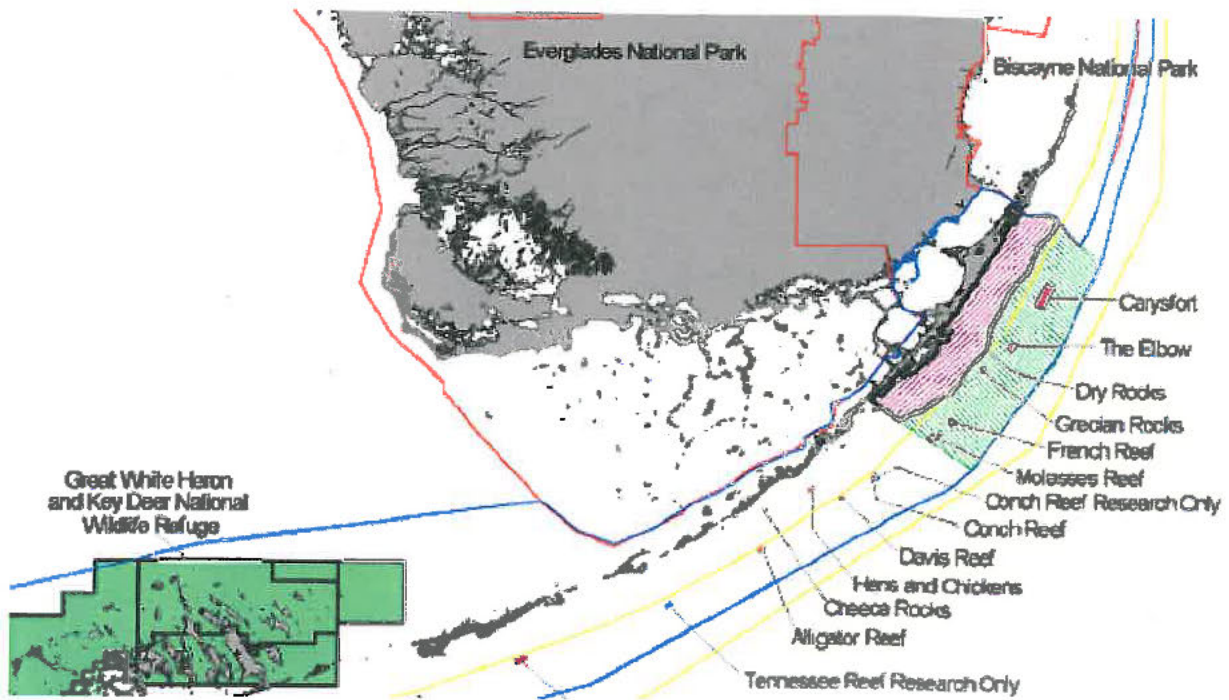
KEY LARGO SCUBA SHACK, LLC – Indirect Relationship (Continued)	
Name	Role
Keys Consortium	Contract Drug Testing Consortium Key Largo Scuba Shack, LLC
[REDACTED]	Keys Consortium Certified Collector
[REDACTED]	Contract Medical Review Officer Key Largo Scuba Shack, LLC

INVESTIGATION TEAM		
Name	Role and Responsibility Association	
[REDACTED]	Lead Investigator	Coast Guard Sector Key West
[REDACTED]	Investigator	Coast Guard Sector Key West
[REDACTED]	Investigator	Coast Guard Sector Key West
[REDACTED]	Investigator	Coast Guard Sector Key West
[REDACTED]	Investigator	Coast Guard Sector Key West
[REDACTED]	Special Agent	Coast Guard Investigative Service
[REDACTED]	Investigator	FL Fish and Wildlife Conservation
[REDACTED]	Investigator	FL Fish and Wildlife Conservation
[REDACTED]	Investigator	FL Fish and Wildlife Conservation

5. Incident Location and Weather



**Diagrams of Molasses Reef Sanctuary Preservation Area Overview
Incident Location**



Reported Weather Conditions

Date: December 18, 2011 **Time:** 1153
Location: Molasses Reef Light (MLRF1) and Incident Location
Source: National Oceanic and Atmospheric Administration Station (MLRF1)

Surface Conditions

Sea Conditions

Temperature:	75 degrees	Seas:	2-4 feet
Visibility:	10 nautical miles	Visibility:	Not Applicable
Wind Speed:	15 – 25 knots	Current:	1 knot
Wind Gusts:	25 knots	Direction:	South, South East
Direction:	North, North East	Advisory:	None

General Conditions: On scene weather reports were obtained from Coast Guard response assets, passengers, crew and witnesses from other vessels. All conditions reported were consistent, in that wave height was greater than 2 feet and that it was windy. However, weather conditions reportedly worsened with increasing wind and wave conditions while the passengers from GET WET were completing their planned first dive.

6. Findings of Fact

a. GET WET was initially constructed by Lindsey Boat Works in 1980 for Twin Fin Dive Society, Inc. The vessel was operated by Twin Fin Dive Society, Inc. as the LEDGE-ND, until it was sold to Gallen's Undersea, Inc. in December 1985. From December 1985 until December 2001, ownership of GET WET was transferred between several operators, including [REDACTED] and Tropical Reef Divers Inc., who changed the name of the vessel from LEDGE-ND to TROPICAL DAZE on October 21, 1999. In December 2001, Eagle Ray Divers, LLC took ownership of TROPICAL DAZE (GET WET), from Tropical Reef Divers, Inc. TROPICAL DAZE (GET WET) was operated primarily as an inspected, small passenger vessel from 1985 until the vessel was taken out of service by Eagle Ray Divers, LLC in October 2009. The regulations that governed TROPICAL DAZE (GET WET) during this period are found in Title 46 of the Code of Federal Regulations, Subchapter T – Small Passenger Vessels (Under 100 Gross Tons).

b. GET WET's formal tonnage is listed as six net tons. Per Title 46 of the Code of Federal Regulations, Subchapter G, GET WET is required to have a valid Certificate of Documentation while engaged in commercial service and coastwise trade.

c. Eagle Ray Divers, LLC operated TROPICAL DAZE (GET WET) from December 2001 until October 2009. On July 1, 2008, the Coast Guard issued Eagle Ray Divers, LLC a

Certificate of Inspection for TROPICAL DAZE (GET WET) allowing the vessel to operate commercially as an inspected, small passenger vessel.

d. On October 1, 2009, The Certificate of Inspection issued to Eagle Ray Divers, LLC for TROPICAL DAZE (GET WET) became invalid. The operator of TROPICAL DAZE (GET WET) was required to have the vessel successfully complete an annual inspection no later than October 1, 2009 and a hull inspection no later than May 28, 2010, for the issued Certificate of Inspection to remain valid. The TROPICAL DAZE (GET WET) had suffered a major mechanical failure to the main diesel engine. This failure required Eagle Ray Divers, LLC to remove TROPICAL DAZE (GET WET) from commercial service, placing the vessel in dry-dock for repairs. Eagle Ray Divers, LLC notified the Coast Guard, in a letter dated October 5, 2009, of this failure.

e. On October 16, 2009, Chief Warrant Officer (CWO) [REDACTED] conducted a damage survey inspection of TROPICAL DAZE (GET WET). [REDACTED] of Eagle Ray Divers, LLC was in attendance. [REDACTED] reviewed TROPICAL DAZE's (GET WET) Certificate of Inspection and instructed WOOD that an inspection would need to be completed prior to placing TROPICAL DAZE (GET WET) back into service. [REDACTED] issued WOOD a Marine Vessel/Facility Inspection Requirements form (CG-835), prohibiting TROPICAL DAZE (GET WET) from passenger service operations until all inspection requirements were completed. This inspection was documented in MISLE, under activity number 3618278.

f. On May 28, 2010, [REDACTED] conducted a Hull Examination inspection on TROPICAL DAZE (GET WET). [REDACTED] of Eagle Ray Divers, LLC was present for the inspection. During this inspection, CWO [REDACTED] was informed that the Eagle Ray Divers, LLC was in the process of selling TROPICAL DAZE (GET WET) and that no further repairs would be made. CWO FISK issued another CG-835 requirement, prohibiting TROPICAL DAZE (GET WET) from passenger service operations until all inspection requirements were completed. This inspection was documented in MISLE under activity number 3773315.

g. On July 1, 2010, TROPICAL DAZE (GET WET) was sold to Key Largo Scuba Shack, LLC. Key Largo Scuba Shack, LLC was initially owned and operated by [REDACTED] and [REDACTED].

h. On or about July 1, 2010, Key Largo Scuba Shack, LLC submitted a Certificate of Documentation application and bill of sale, naming employee [REDACTED] as the owner of TROPICAL DAZE (GET WET), to the National Vessel Documentation Center. Title 46 of the Code of Federal Regulations, Subchapter G requires that Certificates of Documentation be issued only to vessels which are wholly owned by United States citizens. Neither [REDACTED], nor [REDACTED], are United States Citizens. The bill of sale submitted with the application contained "Eagle Ray Diver's LLC" in the letterhead and was signed by [REDACTED] on behalf of Eagle Ray Diver, LLC". The bill of sale was notarized by Jose [REDACTED], an acquaintance of [REDACTED] and [REDACTED].

i. On July 20, 2010, [REDACTED] and [REDACTED] submitted documentation to the Florida Department of State, Division of Corporations, officially forming the limited liability company, Key Largo Scuba Shack, LLC. [REDACTED] and [REDACTED] were listed in this filing as the owners of Key Largo Scuba Shack, LLC. Key Largo Scuba Shack, LLC, while in operation, operated the following vessels commercially: GET WET, DEEP SIX (FL6112NX), FISHSTALKER, and N2DEEP (FL4492LD).

j. In August 2010, [REDACTED] and [REDACTED] opened Key Largo Scuba Shack and began operating the company, providing recreational diving and snorkeling charters, scuba diving lessons and retail sales. Key Largo Scuba Shack, LLC maintained a physical office, retail store and dive shop at the Seafarer Resort. [REDACTED] was hired and began working on GET WET as an unlicensed crewmember. GET WET, which was originally operated from the Seafarer Resort location, was moved to several different locations, including the home residences of [REDACTED] and [REDACTED], as well as the Port Largo Homeowners Park, Key Largo, FL. After the initial opening, [REDACTED] and [REDACTED] departed the United States to Panama, on a four month charter, returning to the United States in December 2010. While in operation, the Key Largo Scuba Shack experienced several similar periods of absentee ownership. Each time [REDACTED] and [REDACTED] departed the country, the Key Largo Scuba Shack employees were left in-charge of daily operations, but instructed to contact them and ask permission prior to making any business decisions.

k. On September 8, 2010, CWO [REDACTED] conducted a deficiency follow-up inspection on TROPICAL DAZE (GET WET); [REDACTED] of Key Largo Scuba Shack was present for the inspection. CWO [REDACTED] issued another CG-835 requirement, prohibiting TROPICAL DAZE (GET WET) from passenger service operations until all inspection requirements were completed. This inspection was documented in MISLE under activity number 3773315.

l. On September 13, 2010, CWO [REDACTED] inspected TROPICAL DAZE (GET WET) after the vessel was launched and moved to Seafarers Motel and Dive Shop, Key Largo, FL. During this inspection, representatives from Key Largo Scuba Shack, LLC were unable to produce a valid Certificate of Documentation for TROPICAL DAZE (GET WET). This inspection was documented in MISLE under activity number 3773315.

m. On or about September 27, 2010, Key Largo Scuba Shack, LLC submitted another Certificate of Documentation application and bill of sale, naming [REDACTED] as the owner of TROPICAL DAZE (GET WET), to the National Vessel Documentation Center.

n. On September 28, 2010, [REDACTED] graduated from Sea School in Miami, FL and applied for a Coast Guard Operator of Uninspected Passenger Vessel (OUPV) license.

o. From October 2010 through December 2011, Key Largo Scuba Shack experienced a high rate of employee turnover through both termination and resignation. Key Largo Scuba Shack employees were often required to work long hours without compensation, were paid late or were penalized financially by [REDACTED] and [REDACTED].

p. In October of 2010, employees [REDACTED] and [REDACTED] were terminated by [REDACTED]. [REDACTED] alleged that [REDACTED] and [REDACTED] were wasting too much money and failing at their job.

q. In October 2010, TROPICAL DAZE (GET WET); was involved in a marine casualty rendering the vessel unfit for service, after the main diesel engine failed. [REDACTED] leased the N2DEEP from Pirate Island Divers in order to continue running charters while TROPICAL DAZE (GET WET); was repaired. This marine casualty was not reported to the Coast Guard.

r. From October 2010 through June 2011 [REDACTED] operated vessels, owned by Key Largo Scuba Shack, LLC, with passengers for hire aboard, without a valid Coast Guard license.

s. On January 7, 2011 [REDACTED], acting on behalf of Key Largo Scuba Shack, LLC, sent an email to CWO [REDACTED] stating that TROPICAL DAZE (GET WET) would be operated as an uninspected passenger vessel and that "We will no longer be continuing with our Coast Guard paperwork". The regulations that govern uninspected passenger vessels are found in Title 46 of the Code of Federal Regulations, Subchapter C – Uninspected Vessels.

t. On January 12, 2011, the National Vessel Documentation Center issued [REDACTED] a Certificate of Documentation for TROPICAL DAZE (GET WET). This same day, Key Largo Scuba Shack, LLC submitted an application to the National Vessel Documentation Center, changing the name of the TROPICAL DAZE to GET WET.

u. On January 18, 2011, the National Vessel Documentation Center issued [REDACTED] another Certificate of Documentation. This certificate was in response to the name change of the TROPICAL DAZE to GET WET.

v. In February 2011 [REDACTED] and [REDACTED] left the United States for Panama on a two week charter to get their expiring visa's stamped in order to return to the country. [REDACTED] and [REDACTED] returned to the United States in March 2011.

w. On or just prior to February 4, 2011, employee [REDACTED] procured a \$25,000 bank loan from a bank in Auburn, Alabama. [REDACTED] is a U.S. Citizen. [REDACTED] provided the funds from the loan to [REDACTED]. [REDACTED] agreed to make all loan payments for [REDACTED] and placed GET WET in [REDACTED] name as security against the loan. Key Largo Scuba Shack, LLC submitted a Certificate of Documentation application and bill of sale, naming [REDACTED] as the owner of GET WET, to the National Vessel Documentation Center.

x. From approximately March 2011 through August 2011, [REDACTED] operated vessels, owned by Key Largo Scuba Shack, LLC, with passengers for hire aboard, without a valid Coast Guard license.

y. On March 31, 2011, the National Vessel Documentation Center issued [REDACTED] a Certificate of Documentation for GET WET.

z. From April 2011 through July 2011, employees [REDACTED] was directed by [REDACTED] to carry more than six passengers for hire on commercial uninspected passenger vessels operated by Key Largo Scuba Shack and to count those extra passengers as deckhands.

aa. From April 18, 2011 through September 3, 2011, Key Largo Scuba Shack, LLC operated the recreational vessel FISHSTALKER at least 15 times as a commercial, uninspected passenger vessel. Regulations require vessels to be properly documented for the service provided.

bb. On or about April 18, 2011, GET WET was involved in a marine casualty while carrying passengers for hire when the aft bilge pump failed and the vessel began flooding. Water on deck, indicated as ankle deep, flooded the engine and lazarette compartments through deck plates that were not properly secured and without gaskets. [REDACTED] determined that the electrical wiring on the bilge pump had become corroded and separated, as it was not secured with watertight connections. [REDACTED] reconnected the wires on the bilge pump and successfully dewatered the vessel. [REDACTED] notified [REDACTED] that GET WET almost sunk. This marine casualty was not reported to the Coast Guard.

cc. On or about April 21, 2011 through July 30, 2011, [REDACTED] and [REDACTED] allegedly observed [REDACTED] and [REDACTED] discharging fuel and bilge oil into navigable waterways of the United States and the Florida Keys National Marine Sanctuary during fueling operations and bilge cleanings. [REDACTED] observed both [REDACTED] and [REDACTED] diluting the discharged oil with soap, which is a violation of regulations.

dd. From April 30, 2011 through November 23, 2011, Key Largo Scuba Shack, LLC operated commercial uninspected passenger vessels at least 11 times, carrying more than six passengers for hire. Regulations require commercial vessels desiring to carry more than 6 passengers for hire successfully complete a Coast Guard inspection and obtain a valid Certificate of Inspection.

ee. In June 2011, [REDACTED] and [REDACTED] attempted to get their visa's stamped in the Bahamas, but were denied. [REDACTED] and [REDACTED] traveled to England to resolve the issue, returning to the United States approximately 14 days later.

ff. In June 2011, [REDACTED] and [REDACTED] were brought in as investors, and part owners, of Key Largo Scuba Shack, LLC.

gg. In July 2011, [REDACTED] resigned from working at Key Largo Scuba Shack after [REDACTED] reprimanded her for issuing a refund to a customer without seeking his permission.

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hh. On July 6, 2011, the Coast Guard issued [REDACTED] an OUPV License, number [REDACTED]. Key Largo Scuba Shack, LLC placed [REDACTED] in charge of vessel operations and maintenance. [REDACTED] did not hold any certifications as a mechanic or marine mechanic.

ii. On July 30, 2011, [REDACTED] resigned from working at Key Largo Scuba Shack. [REDACTED] had accused [REDACTED] of being "bad luck" after [REDACTED] was involved in several equipment failure marine casualties on GET WET.

jj. On September 7, 2011, [REDACTED] accused [REDACTED] of losing the company money, after a customer did not purchase Nitrox for a dive and deducted \$68 from [REDACTED] paycheck. As a result, [REDACTED] resigned from working at Key Largo Scuba Shack.

kk. On September 8, 2011, September 10, 2011 and again on September 11, 2011, [REDACTED] sent emails to [REDACTED] requesting that [REDACTED] write a letter stating that he is not the owner of GET WET.

ll. On September 12, 2011, [REDACTED] sent a letter to [REDACTED] stating that he "hold(s) the title to the dive vessel "GET WET" as security against a loan to [REDACTED] for the original amount of \$25,250.00 USD".

mm. On October 21, 22, and 27, 2011, and December 7, 10, 17, and 18, 2011, [REDACTED] used his cellular telephone to make Facebook posts while passengers for hire were aboard or underwater diving.

nn. On October 29, 2011, GET WET was involved in a marine casualty while carrying passengers for hire, resulting in a loss of propulsion. The licensed operator of GET WET, [REDACTED] contacted Tow Boat U.S. Key Largo to tow the vessel into port. [REDACTED] used his father's Tow Boat U.S. membership to pay for the tow, as recorded on the Tow Boat U.S. Key Largo invoice. This marine casualty was not reported to the Coast Guard.

oo. From November 2011, through December 18, 2011, internal conflicts existed between the owners and employees of Key Largo Scuba Shack. Prior to [REDACTED] and [REDACTED] departure to the Bahamas, employee [REDACTED] was designated by [REDACTED] as the manager of Key Largo Scuba Shack. During this period, [REDACTED] decisions were often questioned and contradicted by [REDACTED]. These conflicts were made visible to the employees of Key Largo Scuba Shack and discussed with [REDACTED] and [REDACTED] through email. [REDACTED] began deducting money from the paychecks of [REDACTED] and [REDACTED] after GET WET experienced marine casualties resulting in charter cancellations and the refunding of money to the passengers aboard. [REDACTED] argued that the canceled trips were not his fault [REDACTED] and [REDACTED] replied stating "If we don't get paid, you don't get paid".

pp. From November 2011, through December 10, 2011, [REDACTED] limited the number of passengers he would take out on GET WET, in rough weather conditions, to three. [REDACTED] implemented this self-imposed policy to reduce the downflooding on GET WET. [REDACTED] asked [REDACTED] for \$100 to seal the lazarette and engine compartment deck plates. [REDACTED] told [REDACTED] that the money would be recovered on his first charter, as he could take six passengers, not just three. [REDACTED] did not provide [REDACTED] the money to implement the repair.

qq. On November 16, 2011, [REDACTED] was hired by Key Largo Scuba Shack, LLC and began working on GET WET as a divemaster and crewmember. [REDACTED] was responsible for instructing and guiding divers while in the water and for the mooring and unmooring of the vessel. Key Largo Scuba Shack, LLC did not provide [REDACTED] with any emergency procedures training and considered her to be a "sub-contractor", paying [REDACTED] per trip.

rr. On or about the week of November 20, 2011, [REDACTED] and [REDACTED] left the United States for the Bahamas to complete work on the new Bimini Scuba Shack. While [REDACTED] and [REDACTED] were out of the country, the [REDACTED] assisted overseeing operations from their home in West Palm Beach, FL, and at the Key Largo Scuba Shack. [REDACTED] and [REDACTED] were still in the Bahamas when GET WET capsized on December 18, 2011.

ss. On November 21, 2011, GET WET was involved in a marine casualty while carrying passengers for hire. The licensed operator of GET WET was [REDACTED]. This marine casualty was not reported to the Coast Guard.

tt. On or about November 23, 2011, [REDACTED] directed [REDACTED] and [REDACTED] to carry more than six passengers for hire aboard vessels operated by the Key Largo Scuba Shack. In addition, [REDACTED] directed [REDACTED] and [REDACTED] to allow [REDACTED] to operate as a guide and divemaster for passengers for hire during charters aboard vessels operated by the Key Largo Scuba Shack, without having required certifications.

uu. On December 6, 2011, GET WET was involved in a marine casualty while carrying passengers for hire when the main diesel engine overheated after a belt on the engines water pump failed, causing it to cease. The licensed operator of GET WET [REDACTED] contacted Tow Boat U.S. Key Largo to tow the vessel in. This marine casualty was not reported to the Coast Guard.

vv. On December 7, 2011 [REDACTED] sent an email to [REDACTED] identifying himself as "an owner of the business" (Key Largo Scuba Shack, LLC). [REDACTED] was copied in that email.

ww. On December 9, 2011, GET WET was involved in a marine casualty while carrying passengers for hire when the main diesel engine failed, resulting in a loss of propulsion. The

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licensed operator of GET WET, [REDACTED] contacted Tow Boat U.S. Key Largo to tow the vessel into port.

xx. On December 10, 2011, [REDACTED] discussed this marine casualty in an email sent to [REDACTED] and [REDACTED]. [REDACTED] stated in that email, "We broke down approximately 200 yards from Molasses... uugh", "That was my 5th tow" and "We were not able to dive but I did snorkel with the clients while [REDACTED] attempted repairs and then while we waited for the tow boat." This marine casualty was not reported to the Coast Guard.

yy. On December 11, 2011, [REDACTED] resigned from working at Key Largo Scuba Shack after [REDACTED] did not offer a solution to [REDACTED] regarding his deducted pay and late paychecks.

zz. On December 15, 2011, [REDACTED] was terminated by [REDACTED], after disagreeing on deductions from his paycheck, but was provided two weeks' notice.

aaa. On December 18, 2011, at 1342 [REDACTED] emailed [REDACTED] allowing him to continue working at Key Largo Scuba Shack as a guide only. [REDACTED] stated in the email that [REDACTED] would assume the additional duties of manager.

bbb. On December 18, 2011, GET WET was a documented, uninspected passenger vessel, subject to the regulations found in Title 46 of the Code of Federal Regulations, Subchapter C – Uninspected Vessels. On this date, Key Largo Scuba Shack, LLC, operated GET WET, with 6 passengers for hire and 2 crewmembers aboard, with the following conditions present:

(1) Forward Compartment: A small enclosed compartment, accessible through a step down door, was located in the bow of the vessel. The forward most bulkhead in this compartment contained an access panel, held onto the bulkhead by four screws; nine bolt/screw holes were left empty.

(2) Grey / Fresh Water Compartment Hatch: A 29-inch by 36-inch access opening to the grey / fresh water compartment was covered by a fiberglass lift hatch. This hatch was secured by hinges on the port side and an installed, metal latching handle on the starboard side. A gasket was not installed under the grey / fresh water compartment hatch and water could downflood this compartment.

(3) Engine Hatch Cover: GET WET's original engine hatch cover had been modified after initial construction and was converted into a pair of bench seats, with a tank storage rack, to accommodate passengers being outfitted with dive gear. (Eagle Ray Divers designed and modified the engine hatch cover). The engine hatch cover was constructed of marine grade plywood, fiberglass and insulation, the plywood on the engine hatch cover had several areas of rot and decay. The engine hatch cover rested on a rubber gasket, on top of a 3.5-inch coaming; measured 66-inches long, 36-inches wide, 41-inches high and weighed

over 300 lbs, without gear or tanks attached. Four to five scuba tanks were attached to the engine hatch cover when GET WET capsized. The engine hatch cover was secured with four latches; each latch was constructed of a three inch carriage bolt, two metal brackets and a wing nut. Each bracket was attached using three 1-inch wood screws, drilled directly into the engine hatch and coaming. The carriage bolt was inserted through the brackets and tightened with the wing nut. The latches were positioned in the corners on the engine hatch cover, two forward and two aft.

(4) Engine Compartment Deck Plate: A 32 inch by 30 inch access opening to the engine compartment was covered by a fiberglass deck plate. This deck plate could be secured to the deck using a watertight gasket and 30 bolts, but wasn't. The gaskets and bolts securing this deck plate had been removed when the deck of the vessel was repainted on or around August 2010 and was not replaced. The deck plate was left unsecured and without a gasket in place. [REDACTED] had placed two to three screws in the corner bolt hole openings, to keep the deck plate from sliding around, in lieu of the 30 bolts required by design. Water could downflood the engine compartment through the bolt holes and under the deck plate edges. The deck plate had two permanently installed, nine inch diameter circular inspection ports. One of the two plastic cover inspection ports was missing a two inch by four inch section.

(5) Lazarette Deck Plate: A 32-inch by 32-inch access opening to the lazarette compartment was covered by a fiberglass deck plate. This deck plate could be secured to the deck using a watertight gasket and 30 bolts, but wasn't. The gaskets and bolts securing this deck plate had been removed when the deck of the vessel was repainted on or around August 2010 and were not replaced. The deck plate was left unsecured and without a gasket in place. [REDACTED] had placed two to three screws, in lieu of the 30 bolts required by design, in the corner bolt hole opening to keep the deck plate in place and to allow for easy access, considering the constant need to check the space for flooding. Water could downflood the lazarette compartment through the bolt holes and under the un-gasketed deck plate edges. The deck plate had a permanently installed, 20-inch by 19-inch, plastic inspection hatch.

(6) Lazarette Bilge Pump: The vessel was equipped with four electric submersible bilge pumps for dewatering; one in the grey / fresh water compartment, two in the engine compartment and another in the lazarette. The pump installed in the lazarette was an electric submersible Rule Model 10, a 2,000 gallon per hour, bilge pump manufactured by Xylem. The lazarette bilge pump had been disassembled and incorrectly reassembled. The lazarette bilge pump was a non-serviceable item and not consumer repairable. Four screws were missing from the casing of the bilge pump, when it was incorrectly reassembled, the internal o-ring on the pump was not adequately compressed, allowing water to penetrate and corrode the electric motor housing and components. It is possible that the lazarette pump wasn't working prior to the vessel getting underway as a post casualty examination of this pump determined that the electric motor components and housing were heavily corroded. In addition, the float switch installed for the lazarette bilge pump was not manufactured by

Xylem and the overboard discharge for this pump, was partially obstructed by debris, including plastic black zip-ties and marine debris.

(7) Transom: GET WET's transom had been modified after initial construction by the original owner of the vessel, to accommodate divers, making it easier to access the vessel's dive platform. A 30-inch wide by 20-inch section of the transom was removed contrary to the original design. GET WET had six inches of freeboard at the transom under normal operating conditions and often negative freeboard, as the vessel's stern was submerged while passengers or equipment were directly on or near the transom. The transom opening was secured while the vessel was underway with a single length of rope.

(8) The mounted chair for the operator of the vessel had been removed, but the bolt holes on the main deck, which had been used to secure the chair to the deck, were never patched or made watertight. Water could downflood this compartment through those bolt holes.

(9) It was common for GET WET's main deck to flood in two to three foot seas, with an estimated $\frac{1}{4}$ inch of water covering the deck, up to and just forward of the lazarette deck plate.

(10) The bulkheads separating the compartments on the vessel had various size holes drilled through them. Both the empty holes and the ones used for wire runs had not been properly stuffed to ensure the watertight integrity of the bulkhead. This provided opportunities for progressive flooding.

(11) The float switch for the high water alarm was installed seven inches above the bilge, on the bulkhead in the forward part of the engine room compartment, on the starboard side, and was the only float switch for this system. The vessel naturally was trimmed to stern while underway as well when passengers were on or near the diving platform.

(12) The Standard Horizon GX 1150 VHF Radio installed on the vessel was described as working sporadically.

(13) The vessel's engine compartment was equipped with a pre-engineered fixed fire fighting system, manufactured by Fire Boy. The system was last serviced on September 3, 2010 which was out of service by three months. The engine override switch for the system was inoperative which prevents engines from being restarted after emergency shutdown due to fixed system discharge.

(14) The portable dry chemical fire extinguishers aboard the vessel were last serviced on September 3, 2010 which was out of service by three months.

(15) Prior to getting underway, vessel checks were performed by [REDACTED] "from memory", the written check sheets located aboard the vessel were not used.

(16) [REDACTED] described the safety brief he provided to passengers prior to getting the vessel underway as a "comedy routine". It is clear that all the required safety instructions were not presented to the passengers.

(17) The emergency instructions listed in 46 CFR 26.03-2 were not posted aboard the vessel.

(18) Key Largo Scuba Shack, LLC did not remove the Coast Guard Inspected Small Passenger Vessel Certificate sticker from the forward bulkhead after the company chose to remove the vessel from Inspected service and operate as an uninspected passenger vessel.

ccc. On December 18, 2011, at approximately 1300, GET WET departed from Key Largo Homeowners Park, Key Largo, FL en route to Molasses Reef on a recreational diving excursion in the Florida Keys National Marine Sanctuary. During this excursion [REDACTED] was serving as the Coast Guard licensed operator and [REDACTED] was acting as a divemaster and crewmember. Out of the six passengers onboard [REDACTED] and [REDACTED] were certified as divers. The remaining three passengers, [REDACTED], [REDACTED] and [REDACTED], were uncertified and had enrolled in a Professional Association of Diving Instructors Discover Scuba Diving course. During this trip, [REDACTED] and [REDACTED] were to complete their first open water dive. Upon reaching Molasses Reef, approximate position (Latitude 25° 00.378' N / Longitude 080° 22.883' W), [REDACTED] and [REDACTED] moored GET WET to a mooring buoy, and began making preparations for the passengers to enter the water.

ddd. On December 18, 2011, at approximately 1420, the passengers began entering the water to begin their first planned dive. [REDACTED] guided the passengers safely into the water and began a descent.

eee. On December 18, 2011, between 1420 and 1449, while [REDACTED] and the passengers were conducting their dive, water was flooding the deck of GET WET as increasing wind and sea conditions pushed water through the cut out in the transom. The water on deck began flooding the engine room and lazarette compartment bilges, through the open bolt holes and under the edges of the deck plate that did not have gaskets installed. The inoperable bilge pump prevented the flooding in the lazarette compartment from being pumped out, exacerbating the situation.

fff. On December 18, 2011, at approximately 1449, [REDACTED] detected for the first time that the lazarette bilge pump wasn't working properly. [REDACTED] posted "Great aft bilge pump went out on the boat and I'm taking waves through the back... Another day on the reef almost over. - at molasses reef" on Facebook, from his cellular phone.

ggg. On December 18, 2011, at approximately 1450, [REDACTED] and the passengers completed their dive, ascending to the surface. Each person reboarded GET WET by utilizing the dive platform on the stern of the vessel. The addition of weight to the vessel's stern eliminated GET WET's freeboard, allowing even more water to flow continuously onto the deck. As water continued to flow onto the deck and to downflood GET WET, items on the deck began to float freely. [REDACTED] asked [REDACTED] "what was happening", [REDACTED] tried to persuade [REDACTED] to have the passengers complete the second planned dive, but [REDACTED] refused.

hhh. On December 18, 2011, at approximately 1500, [REDACTED] decided to abort the trip and return to port. [REDACTED] told [REDACTED] that if he got GET WET on a plane it would push the water off the deck. [REDACTED] unmoored GET WET. [REDACTED] got the vessel underway and attempted to get the vessel on a plane. [REDACTED] had successfully used the technique of getting GET WET underway and up on plane to remove water from the deck on a previous trip. While underway, GET WET continued to take on water and flood. [REDACTED] ordered the passengers to move up under the fiberglass bimini to remove as much weight as possible from the stern of the vessel. While all of the passengers were under the fiberglass bimini, GET WET began rocking from port to starboard. [REDACTED] and [REDACTED] began directing the passengers to move from side-to-side, in an attempt to shift weight and stabilize the vessel. [REDACTED] continued to ask [REDACTED] for direction (What should we do and what was wrong?), but he did not reply.

iii. On December 18, 2011, at approximately 1512, [REDACTED] used the VHF radio aboard GET WET to contact Towboat U.S. for commercial assistance, but did not receive a reply.

jjj. On December 18, 2011, at approximately 1513, [REDACTED] used the VHF radio aboard GET WET to contact the Coast Guard Sector Key West. [REDACTED] stated that GET WET was taking on water and needed an emergency pump out. Sector Key West issued an Urgent Marine Information Broadcast, requested air support and launched the Station Islamorada CG 33142 to assist.

kkk. On December 18, 2011, approximately 30 seconds later, GET WET rocked sharply to port, capsized and began sinking stern down, trapping everyone aboard under the fiberglass bimini. As the vessel capsized, the engine hatch cover broke free, pinning [REDACTED] leg against the starboard bulkhead and [REDACTED] head against the port side. As the remaining air space under the bimini quickly filled with water, [REDACTED] was able to free [REDACTED] and escape with her through an opening in the side of the bimini, while [REDACTED] followed [REDACTED] through the port side window. [REDACTED] and [REDACTED] escaped through the starboard side window, as [REDACTED] left she heard [REDACTED] screaming "Get out! Get Out!" [REDACTED] and [REDACTED] swam to the surface. [REDACTED] guided [REDACTED] and [REDACTED] over to the life float, which had self-deployed as GET WET sank. [REDACTED] and [REDACTED] remained trapped inside GET WET and sank to the bottom with the vessel, in approximately 35 feet of water.

lll. On December 18, 2011, at approximately 1515, the licensed master of the small passenger vessel VISIBILITY, [REDACTED] responded to the Urgent Marine Information Broadcast and got the vessel underway to assist.

mmm. While on the surface, [REDACTED] was told by [REDACTED] that passengers were still missing. [REDACTED] attempted to swim down to GET WET but was unable. Upon surfacing, [REDACTED] located SCUBA gear which had floated to the surface from GET WET. [REDACTED] donned this gear, was provided a mask from [REDACTED] and made another attempt. As [REDACTED] swam down to GET WET, he found GET WET on the bottom, sitting on its keel. The engine hatch cover was turned sideways and trapped under the fiberglass bimini. [REDACTED] searched under the bimini for the missing passengers and located [REDACTED] who was unresponsive, and trapped under the engine hatch cover. [REDACTED] placed a regulator in [REDACTED] mouth and swam him to the surface.

nnn. On December 18, 2011, at approximately 1517, the crew of the VISIBILITY located and recovered [REDACTED], [REDACTED] and [REDACTED] from the water. [REDACTED] surfaced with [REDACTED] and swam him to the VISIBILITY. The crew of the VISIBILITY recovered [REDACTED] from the water and began administering CPR and oxygen. While boarding the VISIBILITY, [REDACTED] was told that [REDACTED] was still missing. [REDACTED] swam back down to GET WET to search for [REDACTED]. [REDACTED] located [REDACTED]'s arm hanging outside the starboard window, under the bimini. [REDACTED] attempted to pull [REDACTED] through the window but was unsuccessful. [REDACTED] swam inside the bimini and observed that [REDACTED] was unresponsive and her leg was pinned against the starboard bulkhead by the engine hatch cover. [REDACTED] freed [REDACTED] leg, taking approximately three minutes to do so, placed a regulator in her mouth and swam her to the surface.

ooo. On December 18, 2011, at approximately 1524, [REDACTED] and [REDACTED] were recovered from the water by the crew of the VISIBILITY. [REDACTED] was administered CPR.

ppp. On December 18, 2011, at approximately 1525, Emergency Medical Services was notified.

qqq. On December 18, 2011, at approximately 1526, [REDACTED] got the VISIBILITY underway, en route to Port Largo Home Owners Park, Key Largo.

rrr. On December 18, 2011, at approximately 1541, the Station Islamorada CG 33142 arrived next to the VISIBILITY and escorted the vessel back to Port Largo Home Owners Park.

sss. On December 18, 2011, at approximately 1552, the VISIBILITY moored at Port Largo Home Owners Park. [REDACTED] and [REDACTED] were transferred to Emergency Medical Services, already on scene.

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ttt. On December 18, 2011, at approximately 1556, [REDACTED] was pronounced deceased by Emergency Medical Services.

uuu. On December 18, 2011, at approximately 1559, Sector Key West diverted the Coast Guard Medium Range Surveillance Aircraft the HC-144 2310 to conduct an over flight at the location where GET WET sank.

vvv. On December 18, 2011, at approximately 1617, Emergency Medical Services transported [REDACTED] to Mariners Hospital, Tavernier, FL. [REDACTED] was later transferred to Baptist Hospital, Miami, FL for further care.

www. On December 18, 2011, at approximately 1633, Petty Officer [REDACTED] administered a post casualty alcohol test to [REDACTED]. The result of the test was [REDACTED]. Key Largo Scuba Shack, LLC failed to ensure that post casualty alcohol testing was completed for [REDACTED]. [REDACTED] was not administered a post casualty alcohol test.

xxx. Alcohol tests for [REDACTED] and [REDACTED] were administered by [REDACTED] an employee of Coral Reef Park who own and operate the VISIBILITY. The results of those tests were [REDACTED].

yyy. On December 18, 2011, at approximately 1647, the crew of the HC-144 2310 observed a 200 x 20 yard oil sheen around GET WET. GET WET sank with approximately 15 gallons of diesel aboard.

zzz. On December 19, 2011, at approximately 1220, [REDACTED] took a post casualty drug test at Keys Consortium, Tavernier, FL. The result of that test was [REDACTED].

aaaa. On December 19, 2011, at approximately 1230, Lieutenant [REDACTED] directed [REDACTED] to complete a post casualty drug test.

bbbb. On December 19, 2011, at approximately 1525, [REDACTED] took a post casualty drug test at Keys Consortium, Tavernier, FL. The result of that test was [REDACTED].

cccc. At approximately 1732, Sea Tow Key Largo salvaged GET WET and towed it into Key Largo Harbor Marina, Key Largo, FL.

dddd. A post casualty damage assessment of GET WET was completed by Lieutenant [REDACTED] Chief Warrant Officer [REDACTED] and Officer [REDACTED] (FL Fish and Wildlife Conservation). Findings from this assessment are documented in the Investigating Officer's Statement / Record of Actions / Interview Summary, filed as evidence 4210580-JAF-S025.

eeee. Injuries and death caused to passengers, as a direct result of GET WET capsizing, are as follows:

(1) [REDACTED] On December 19, 2011, an autopsy was completed on [REDACTED] by Monroe County Medical Examiner's Office. The results of the autopsy concluded that the cause of [REDACTED] death was saltwater drowning. The manner of [REDACTED] death was determined to be an accident. The result of the blood and urine screen conducted was [REDACTED]

(2) [REDACTED] On January 5, 2012, [REDACTED] was released from Baptist Hospital. [REDACTED] was diagnosed with near drowning with cardiac arrest, respiratory failure and acute pulmonary edema. In addition, [REDACTED] had suffered vocal cord damage causing a reduction in his ability to speak.

(3) [REDACTED]: On December 21, 2011, [REDACTED] was examined, treated and released from St. Lukes Hospital, Jacksonville, FL for right shoulder and left knee pain.

(4) [REDACTED] On December 21, 2011, [REDACTED] was examined, treated and released from St. Lukes Hospital, Jacksonville, FL for a head injury.

ffff. On January 30, 2012, [REDACTED] confirmed to Coast Guard investigators that the bill of sale submitted to the National Vessel Documentation Center listing [REDACTED] signing on behalf of Eagle Ray, LLC" and listing "Eagle Ray Diver's, LLC" in the letterhead, as being fraudulent. [REDACTED] confirmed that Eagle Ray Divers, LLC had never employed anyone named [REDACTED]

7. Analysis

a. *Vessel Condition - Flooding*: On December 18, 2011, and dates prior, GET WET was operated in a condition that left the vessel extremely susceptible to downflooding, jeopardizing the seaworthiness of the vessel.

(1) *Main Deck Flooding:* It was common for the main deck of the vessel to flood with ¼ inch of standing water, covering the stern, up to the forward edge of the lazarette deck plate. GET WET had a six inch stern freeboard, which was further decreased by the addition of crew, passengers and dive gear. Water would flood the main deck, by splashing over the gunnels or passing easily through the 2 ½ foot section that was cut-out of the transom to provide passengers easy access to the dive platform.



A section of the transom removed for divers' access to the swim platform



Water freely passing through the transom opening onto the main deck.



Water flooding the main deck covering the lazarette deck plate.

(2) *Down Flooding:* While [REDACTED] was diving with the passengers, GET WET was taking on water at the stern, flooding stern part of the main deck. Once water was on deck, it would downflood into the engine room and lazarette compartments by passing through open bolt holes and underneath the ungasketed edges of the deck plates, if they had been properly in place they would have secured openings to those compartments. Each deck plate, measured roughly 32-inches by 32-inches, had 30-bolt holes drilled around the perimeter and was intended to be installed water tight, with a gasket. To accomplish this, an operator would insert a fabricated gasket between the deck plate and meeting edge of the main deck, thread a bolt through the bolt hole and secure that bolt with a washer and nut, from the underside of the main deck. This process required the operator to either climb into an extremely tight space and hold the nut and washer in place, while someone on deck tightened the nut, or utilize the removable hatch / inspection ports on each deck plate to bolt them down. Either method required a significant amount of time and effort, making it difficult to freely remove the deck plates for general maintenance. The deck plates were initially removed after Key Largo Scuba Shack, LLC purchased GET WET (TROPICAL DAZE) from Eagle Ray Divers, LLC for painting, maintenance and engine repair, but the deck plates were replaced without gaskets or bolts. Instead, screws were dropped into some of the corner bolt holes on each plate, to prevent the deck plates from sliding, while GET WET was underway. It was easier for the Crew to frequently check for flooding in these compartments with only 3 screws. As water on deck downflooded the engine and lazarette compartments, the vessel's stern freeboard would decrease, allowing even more water on deck, causing further downflooding.



Unsecured deck plates. A single screw is visible on the lazarette deck plate.

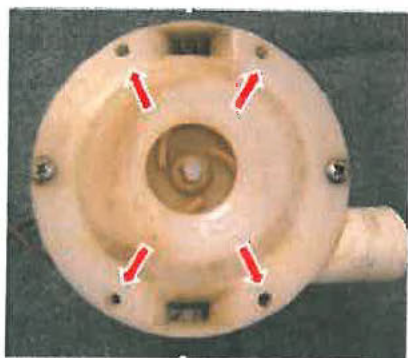


Lazarette deck plate, replaced as it had floated off after capsizing.

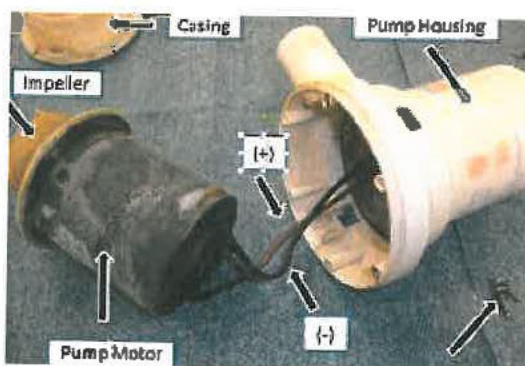


Underside of engine compartment deck plate, no gasket or sealant visible.

(3) *Lazarette Bilge Pump*: On December 18, 2011, as [REDACTED] went to check the lazarette compartment, discovering a large volume of water had filled the lazarette. [REDACTED] checked the lazarette's bilge pump and discovered it had not been operating. GET WET's lazarette compartment was fitted with a Rule, 2,000 gallon per hour electric submersible bilge pump. That pump had been previously disassembled and incorrectly reassembled, compromising the watertight integrity of the pump. Water intrusion into the pump housing and motor caused the pump to cease and fail presumably before the date of the incident. Without the pump, the lazarette compartment could not be dewatered and continued to fill from downflooding. As the lazarette compartment filled, the stern freeboard decreased and the water on deck increased, subsequently downflooding the engine compartment. After [REDACTED] and the passengers completed their first scheduled dive and reboarded GET WET at the stern, they began removing their dive gear. This added weight, combined with the weight of the water already on deck and in the partially flooded lazarette compartment, further decreased the freeboard. This allowed even more water to flood the deck, amplifying the effects of the continuous downflooding.



Missing screws from incorrectly reassembling lazarette bilge pump.



Water intrusion and corrosion visible. Improperly compressed o-ring resulted during reassembly.



Visible corrosion. Making it likely that the pump had been inoperable for some time, possibly after the failed attempted self repair.

(4) *Engine Hatch Cover*: GET WET was equipped with an inboard, diesel engine, located in the engine compartment. Access to that engine was provided by an approximate 36

inch wide by 66-inch long access opening in the main deck. This opening was secured with an engine hatch cover, which sat on a small coaming. The original engine hatch cover was modified throughout the years, turning it into bench seats with tank storage racks. The modified engine hatch cover weighed over 300 pounds, without SCUBA tanks attached, and measured an approximate 66-inches long, 36-inches wide and 41-inches high.



Hatch cover with tanks mounted, photo taken October 9, 2010.



Hatch cover coaming.



Hatch cover reassembled post casualty.

This hatch cover sat on top of the small coaming, secured with four lag bolts, fed through brackets, and tightened with wing nuts. The brackets were attached to the hatch cover and coaming utilizing one inch wood screws.



Securing device in place.



Coaming bracket installed.



Bracket, carriage bolts and wingnut.

The engine hatch cover broke free as sea and stability conditions caused the GET WET to rock violently and capsize. As GET WET began to sink stern down, the buoyancy of the hatch cover forced it towards the passengers, entrapping them within the fiberglass bimini. [REDACTED] became entrapped under the engine hatch cover and [REDACTED] leg was pinned to the bulkhead; both were unable to escape the sinking vessel. The combined weight of the 300 pound hatch cover, and six tanks that were secured to it, would have made it nearly impossible for them to free themselves. The causal factors that caused the engine hatch cover to break free are design

modification, condition and the capsizing of the vessel. The hatch cover modification significantly increased the cover's weight and size considering that SCUBA tanks were attached to the back of the bench seat area. The cover also sat on a small thin coaming, secured with four removable lag bolts and brackets, hand tightened. The brackets used were secured with three 1-inch wood screws drilled directly into the cover and coaming. The wood on the hatch cover suffered from wet rot, enabling the screws to easily pull out. Finally, the motion of the vessel, combined with the weight and condition of the hatch cover, allowed it to break free and become a significant hazard.



View of engine hatch cover. The hatch cover moved forward, under the bimini as the vessel sank.



Interior wet rot and decay of the engine hatch cover.



one inch wood screws used to secure the brackets for the hatch cover.

b. *Personnel:* The crew aboard GET WET were inexperienced with recognizing emergency situations and lacked the knowledge of how to respond to them. The series of bad decisions made by [REDACTED] and [REDACTED] resulted from a lack of training, knowledge and maturity, and directly contributed to the occurrence of this casualty, ultimately leading to the death of [REDACTED] and injuries to three others.

(1) [REDACTED] Upon graduating high school, [REDACTED] was hired by Key Largo Scuba Shack, LLC where he began working as a deckhand and apprentice under the supervision of [REDACTED] however, was soon let go and [REDACTED] was promoted to the "head captain" for Key Largo Scuba Shack, LLC. As part of this promotion, [REDACTED] was placed in charge of all vessel maintenance for the company. [REDACTED] was unqualified for both of these positions. [REDACTED] did not hold a valid Coast Guard operator's license until July, 6, 2011 when he was first issued a license. Additionally, he did not hold any certifications as a mechanic or marine mechanic, nor did he attend any technical schools or mechanical training. Instead, [REDACTED] vessel operating skills, boating knowledge and mechanical skills were learned on the job, at Key Largo Scuba Shack, LLC and from his limited personal experience on the water operating recreational boats. While [REDACTED] was learning on the job, he wasn't learning the correct procedures and skills required to run a safe operation. The vessels [REDACTED] operated to gain his commercial vessel experience were in subpar condition, partially due to his own mechanical work. GET WET was susceptible to

downflooding, through the ungasketed deck plates and hatches, electrical connections to the bilge pumps were not made watertight causing shorts, and engine and equipment failures were frequent. [REDACTED] accepted these conditions as the norm, used temporary or non-standard measures to fix reoccurring problems, while ignoring warnings that latent unsafe conditions existed. [REDACTED] decision to dewater the deck of GET WET by getting the vessel underway is a good example of his inability to recognize emergency situations and respond to them properly. Flooding of the main deck and bilges of GET WET, as well as bilge pump failure, were not new to [REDACTED]. While on a charter with [REDACTED] GET WET's deck and bilges began flooding. After gathering all of the passengers aboard, [REDACTED] brought GET WET up on plane, effectively removing water from the deck of the vessel. This action slowed the downflooding, as the bilge pump dewatered the lazarette. [REDACTED] should have learned from that experience and prevented it from happening again, but he did not. [REDACTED] didn't make any repairs to eliminate the flooding of the main deck and downflooding of the engine and lazarette compartments. [REDACTED] accepted these conditions and continued to operate GET WET in this condition. On December 18, 2011, [REDACTED]'s lack of experience and training manifested. As GET WET again flooded, [REDACTED] made a series of bad decisions. First [REDACTED] ordered all of the passengers off of the stern, placing them under an enclosed fiberglass bimini. Next, [REDACTED] attempted to dewater GET WET by bringing the vessel up on a plane, but this time, GET WET continued to sink. As GET WET began rocking violently, [REDACTED] ordered passengers to move from side-to-side to counteract the vessel's movement and improve stability. When [REDACTED] realized that none of [REDACTED] measures were working, she asked him for more direction, but [REDACTED] remained silent. He was unsure of what to do next. Finally, seconds before GET WET capsized, killing [REDACTED] and injuring others, [REDACTED] attempted to call for a pump out. Receiving no response from Towboat U.S., he then hailed the Coast Guard, but it was too late. Prior to July, 6, 2011, [REDACTED] operated GET WET with passengers aboard, numerous times, without a Coast Guard license. On November 23, 2011, after [REDACTED] disagreed with [REDACTED] order to violate the law and take more than six passengers out at a time, [REDACTED] stated that overloading charters "is no big deal" and if he got caught, "it was just a slap on the wrist". On December 18, 2011, [REDACTED] got underway on GET WET, with passengers aboard, without ensuring that all safety equipment was in place and in working condition. When [REDACTED] was asked by Investigating Officers about the safety orientation brief he gave to passengers, he commented that it was more of a "comedy routine". Instead of contacting the Coast Guard after the lazarette bilge pump was discovered inoperable and the flooding of GET WET was worsening, [REDACTED] made a post to Facebook. [REDACTED] never gave the order to abandon ship. When asked by Investigating Officers why not, [REDACTED] replied "I didn't think about it".

(2) [REDACTED] was serving as the divemaster and guide aboard GET WET when this casualty occurred. [REDACTED] was hired by Key Largo Scuba Shack, LLC one month prior to this casualty and split time between working in the dive shop and acting as a divemaster, instructor and guide for Key Largo Scuba Shack, LLC. [REDACTED] position on GET WET was not statutorily required for the safe operation of the vessel, as such; Key Largo Scuba Shack, LLC did not provide [REDACTED] with any training regarding the safe operation of vessels or

emergency procedures. [REDACTED] personal knowledge of emergency procedures was weak, as well. This was evident during her response to this casualty. As GET WET sank, [REDACTED] was completely unaware of what emergency procedures needed to be conducted and looked only to [REDACTED] for direction. Even as conditions worsened and [REDACTED] orders and countermeasures failed, [REDACTED] took no further action, except to ask for more direction. [REDACTED] also lacked the general boating knowledge required to properly identify the dangerous conditions she had witnessed aboard GET WET, prior to this casualty. The main deck of GET WET had flooded while [REDACTED] was aboard with [REDACTED] causing buckets on deck to start floating. [REDACTED] asked [REDACTED] if the flooding was normal, [REDACTED] replied "Yes". [REDACTED] had only worked at Key Largo Scuba Shack for a month, but had already been involved in three marine casualties on GET WET, requiring commercial towing assistance to bring the vessel back to port. [REDACTED] also observed other unsafe conditions including: a two inch hole in a plastic inspection port cover leading directly to the engine compartment bilge, overheard [REDACTED] describe the issue of the missing deck plate gaskets to Michael [REDACTED] and knew the VHF radio had garbled transmissions on several occasions. Even after having observed all of these unsafe conditions, [REDACTED] willingly boarded GET WET to instruct and guide passengers on diving charters. Had [REDACTED] and [REDACTED] been properly trained, had more experience and competence enough to recognize the dangers GET WET posed to them, this casualty may have been prevented.

c. *Management:* Key Largo Scuba Shack, LLC, was comprised of four primary managers, [REDACTED]. Key Largo Scuba Shack, LLC's mismanagement of maintenance on company vessels, and of its employees, created an atmosphere where inadequately trained and poorly treated employees were left to operate company vessels in unsafe conditions or face company imposed penalties. In addition, Key Largo Scuba Shack, LLC fostered an atmosphere where it was an acceptable practice to violate law and regulation in order to achieve profits. Again, increasing the risk to passenger and crew safety.

(1) *Maintenance:* The majority of routine maintenance and mechanical repairs on GET WET were performed by unqualified, inexperienced employees, often utilizing inappropriate parts such as reducing the number of bolts for the hatch covers, attempting to repair the bilge pump outside of manufacturer's direction, and not using water tight gaskets. These procedures left GET WET in an unseaworthy condition, unfit for service, and operated by Key Largo Scuba Shack, LLC in a grossly negligent manner. Passengers were allowed access to a vessel that continuously experienced main deck flooding and downflooding of its compartments. The vessel's watertight integrity was compromised by un-gasketed deck plates, an un-gasketed forward hatch and unfilled holes in the main deck. The lazarette bilge pump, whether incorrectly serviced by a Key Largo Scuba Shack, LLC employee or obtained in that condition from another operator, should have been thoroughly inspected and rejected, instead of installed. The installed, pre-engineered fire system was allowed to go un-serviced. Additionally, the emergency engine override switch for that system was inoperative. Electrical wiring connections and splices, throughout the vessel, were made using non-watertight connections and the VHF radio worked intermittently. Requests to correct some of these deficiencies, made by [REDACTED]

and [REDACTED] were either met with temporary repairs or ignored by Key Largo Scuba Shack, LLC.

(2) *Work Environment:* Key Largo Scuba Shack, LLC created an unsafe and hostile work environment for its employees. First, training was virtually non-existent for vessel operators, leaving it up to the employee to determine how the company's vessels would operate. Key Largo Scuba Shack did not have an established training program or employee handbook. They didn't utilize vessel check-off sheets nor have a formal vessel familiarization process. Also, a process for correcting unsafe behavior or conditions did not exist. Secondly, employee morale was low and conflicts among the workforce existed. With rapid turnover and absentee management, employees that remained at the Key Largo Scuba Shack were subject to working long hours without compensation. Vessel operators and divemasters were paid per trip, but given additional responsibilities, such as filling tanks and conducting other dive shop duties, without receiving additional compensation. With [REDACTED] and [REDACTED] often out of the country and the [REDACTED] residing in the West Palm Beach, FL area, the employees were often left alone to manage the company. The only real guidance provided was conducted by emails that were often conflicting and confusing. In November 2011, [REDACTED] was left in charge of the Key Largo Scuba Shack as the "manager", while [REDACTED] and [REDACTED] were in The Bahamas setting up a new dive shop. [REDACTED] new title was only a title, as he was not provided with the authority needed to effectively manage the company. Emails sent back and forth between [REDACTED] illustrate this, as [REDACTED] and [REDACTED] would override the policies [REDACTED] tried to implement, even conflicting their own previous guidance at times. Because of this, employees were left confused over who was in-charge of the company; [REDACTED] the manager, [REDACTED] the head captain, the [REDACTED] who claimed to be "owners" or [REDACTED] and [REDACTED]. Conflicts between management were visible to everyone. For example, a management conflict occurred on or about November 23, 2011, when [REDACTED] drove to the Key Largo Scuba Shack and held a company meeting with [REDACTED]. Specifically, [REDACTED] instructed the employees to openly violate regulations by overbooking charters, taking more passengers out than allowed, and to start utilizing [REDACTED] as a dive instructor, even though she was not qualified. [REDACTED] strongly disagreed with these practices, but they were supported by [REDACTED]. Additionally, employees were penalized or threatened for events that occurred outside of their control. [REDACTED] deducted \$68 from [REDACTED]s check after [REDACTED] was unable to fill SCUBA tanks due to a bad compressor, [REDACTED] was accused of being "bad luck" after GET WET nearly sank because of its poor materiel condition and [REDACTED] instituted a policy that would deduct money from paychecks if company vessels broke down or trips were canceled due to dangerous weather.

(3) *Violations of Law and Regulation:* Key Largo Scuba Shack, LLC openly encouraged employees to violate law and regulation. On numerous occasions [REDACTED] and [REDACTED] allowed unlicensed individuals, including themselves, to operate company vessels with passengers for hire aboard. Recreational vessels were operated commercially, fuel spills were never reported, company vessels were overloaded, placing more passengers than allowed by law on their vessels and documents were fraudulently submitted to the National Vessel

Documentation Center to obtain certifications for commercial operation. While Key Largo Scuba Shack's disregard for law and regulations placed passengers and crew in dangerous situations, it was the failure to report the recurring marine casualties that did not allow the Coast Guard to detect and, possibly prevent this casualty from occurring. Under Title 46, Code of Federal Regulations, Chapter I, Subchapter A, Part 4, "a vessel owner, agent, master, operator or person in charge *shall* notify the nearest (Coast Guard) Sector Office whenever a vessel is involved in a marine casualty". From October 2010 through December 17, 2011, GET WET was involved in at least six unreported marine casualties, four of which occurred in the past three months alone. Had the Coast Guard been notified of these casualties, more likely than not, the unsecured deck plates would have been identified as an especially hazardous condition and the Coast Guard would have issued orders halting the operation of GET WET, until the vessel was brought into a seaworthy condition. But these marine casualties were never reported and consequently the dangerous conditions were not detected by authorities. While the owners and operators of Key Largo Scuba Shack, LLC, [REDACTED] and the [REDACTED] primarily share the responsibility for this failure, it must be mentioned that [REDACTED] and [REDACTED] at a minimum, were either directly involved or had knowledge of some, or all, of these unreported marine casualties or violations of law and never reported them to the Coast Guard.

8. Conclusions

a. Per the Marine Safety Manual, Volume V, the Initiating Event (or first unwanted outcome) for this casualty was the main deck flooding.

b. The causal factors that led to the casualty are as follows:

(1) Weather conditions: Specifically, the increasing sea height and winds presented an environmental hazard to GET WET's stability. Increasing weather conditions placed additional water on the main deck of GET WET. This additional water increased the downflooding of the vessel's engine and lazarette compartments, as their water tight integrity had been compromised.

(2) Vessel Conditions: There are six primary causal factors regarding the conditions present aboard GET WET.

(a) Main deck flooding: GET WET was operated in a condition in which it was common for the main deck of the vessel to flood with ¼ inch of standing water, covering the stern, up to the forward edge of the lazarette deck plate. The flooding of GET WET's main deck was caused by a combination of weather conditions, dangerous modifications to the transom and the addition of weight to the stern, from passengers with dive gear, reducing the vessel's six inch stern freeboard. Operating GET WET in a condition, in which the stern is partially sunk, significantly increased the chance of this casualty occurring.

(b) Downflooding through non-watertight deck plates: GET WET was operated in a condition in which compartments below the main deck were susceptible to downflooding, jeopardizing the vessel's stability and causing the potential for capsizing. The standing water on

the main deck of GET WET poured through the un-gasketed, non-watertight deck plates, covering the lazarette and engine compartments, into the bilge. Making the deck plates on GET WET watertight would have greatly reduced the risk of downflooding and in all likelihood would have prevented this casualty from occurring.

(c) Lazarette Bilge Pump Failure: GET WET's lazarette compartment was fitted with a Rule, electric submersible bilge pump that had been disassembled and incorrectly reassembled, compromising the watertight integrity of the pump, rendering it inoperable. It was not of the design type to be repaired, but rather was required by design to be completely replaced if faulty. Without the pump, the lazarette compartment could not be dewatered and continued to fill from downflooding. As the lazarette compartment filled, the stern freeboard decreased, the water on deck increased and the engine compartment began downflooding. While a properly installed, fully functional bilge pump would not have prevented the downflooding it could have provided adequate dewatering for the vessel to return to port safely.

(d) Improper installation of high water alarm: While high water alarms are not required by law or regulation to be installed on uninspected passenger vessels, the high water alarm that was installed on GET WET was done so incorrectly. The float switch, that triggers the alarm as water in the bilge rises, was positioned forward of the main diesel engine, approximately seven inches above the bilge. The lazarette compartment did not contain a float switch and therefore was not protected by the alarm. With a trim to the stern, the water level within GET WET's lazarette and engine compartment would have had to be significant to trigger the alarm. While the proper installation of the high water alarm in the lazarette compartment would not have prevented the downflooding or bilge pump failure, in all likelihood it would have alerted [REDACTED] sooner, while the level of water in the lazarette compartment was still manageable.

(e) Failure to post emergency instructions: GET WET was operated without the emergency instructions found in 46 CFR 26.03-2 posted. These emergency instructions are provided to inform the passengers and remind the crew of precautionary measures that may be necessary if an emergency situation occurs. Specifically identified within this regulation is the importance of watertight integrity to prevent water from coming aboard, keeping bilges dry, contacting the Coast Guard in emergencies, and evenly distributing passengers while providing each with a life preserver. The lack of posted emergency instructions, combined with the inadequate safety orientation [REDACTED] provided, left passengers unprepared for the emergencies that occurred aboard GET WET.

(f) Engine Hatch Cover: The engine hatch cover had been modified from its original construction. The modifications to the hatch cover and its poor condition were latent unsafe conditions. As GET WET rocked violently from side-to-side, the 300 plus pound hatch cover broke free, pinning [REDACTED] leg against the starboard bulkhead, causing her to drown, and entrapping and injuring [REDACTED]. Had the hatch cover remained secured, [REDACTED] and [REDACTED] chances of escaping the sinking vessel would have significantly increased.

(3) Crew Conditions: The primary causal factors affecting the performance of GET WET's crew are as follows:

(a) [REDACTED] was inexperienced, inadequately trained and lacked knowledge of safe vessel operations. He failed to recognize the latently unsafe conditions that were present aboard GET WET. This led to [REDACTED] decision to operate GET WET with passengers for hire aboard. His mechanical ability and maintenance of GET WET were inadequate, only increasing the present dangers aboard. [REDACTED] was placed in a position where he neither had the experience, nor the qualifications. [REDACTED] inability to properly maintain GET WET, including the ungasketed deck plates and lazarette bilge pump, directly contributed to the cause of this casualty.

(b) [REDACTED] provided an immature and unprofessional safety orientation, describing it as "more of a comedy routine". [REDACTED] failed to properly inform the passengers of the emergency procedures that would be required to be performed if an emergency were to occur on GET WET. [REDACTED] inadequate brief significantly decreased the passengers awareness of proper emergency procedures and contributed to the confusion that occurred while this casualty occurred.

(c) [REDACTED] was inexperienced, inadequately trained and lacked knowledge of safe vessel operations. She failed to recognize the latently unsafe conditions that were present aboard GET WET, even after she had experienced the main deck vessel flooding on a previous trip. [REDACTED] failure to recognize the hazardous conditions aboard GET WET caused her to board the vessel to instruct and guide the passengers during the planned dive.

(4) Management Conditions: There are two primary causal factors regarding management conditions.

(a) Maintenance: Instead of using qualified and experienced mechanics, Key Largo Scuba Shack, LLC placed a recently licensed, unqualified individual in charge of all vessel maintenance. Company vessels, specifically GET WET, were inadequately maintained, as equipment aboard was incorrectly installed or did not function properly. Key Largo Scuba Shack, LLC's failure to implement an adequate maintenance program and to ensure qualified, competent individuals maintained their vessels directly caused the hazardous conditions aboard GET WET, and contributed to the cause of this casualty.

(b) Treatment of Employees / Absentee Supervision: Key Largo Scuba Shack, LLC created a workplace climate that was hostile toward its employees. Employees were pressured into violating law and regulation by company officers [REDACTED] and [REDACTED] including being financially penalized for mechanical failures on company vessels or for choosing to cancel charters because conditions were unsafe. In addition, employees were left unsupervised, placed in charge of the safety of company vessels and passengers, without adequate training. This atmosphere promoted risk taking by some employees and ignorance of safe operations.

(5) Violations of Law and Regulation: There are two primary causal factors regarding violations of law and regulation.

(a) Failure to Report Marine Casualties: Key Largo Scuba Shack, LLC failed to report marine casualties that occurred aboard GET WET from October 2010 through December 2011. Failing to report these casualties to the Coast Guard, as required by law, significantly prevented the Coast Guard from detecting the latent unsafe conditions aboard GET WET. Had these marine casualties been reported, the Coast Guard would have conducted a standard marine casualty investigation, significantly increasing the chances of detecting these unsafe conditions. The results of an investigation could have enabled an Investigating Officer to utilize operational control measures against GET WET, until the vessel was brought into a safe operating condition and in all likelihood, prevented this casualty.

(b) Post Casualty Alcohol Test: Key Largo Scuba Shack, LLC failed to ensure post casualty alcohol testing was completed for [REDACTED] who was directly involved in a serious marine incident and marine casualty. Without conducting a post casualty alcohol test, the Coast Guard cannot completely rule out the use of alcohol, by [REDACTED] as a casual factor of this casualty. The Coast Guard has concluded that there is no evidence available that indicates [REDACTED] was intoxicated with alcohol during this incident.

c. The causal factors that existed or occurred during the rescue efforts and abandon ship are as follows:

(1) Failure to Abandon Ship: [REDACTED] failed to give the timely and appropriate order to abandon ship. [REDACTED]'s decision to dewater GET WET by getting the vessel underway, instead of contacting the Coast Guard, have the passengers don life jackets, launch the life float and have passengers abandon ship, directly contributed to the death of Aimee [REDACTED] and resulting injuries to other passengers aboard the vessel.

(2) Communications Failure: [REDACTED] stated that he did not hear a response to the urgent distress call he made over the VHF radio aboard GET WET. Recordings of that distress call are available, confirming that the radio transmitted. It is unknown whether the radio received any transmissions sent back. Regardless, [REDACTED] did not radio for help until just a few minutes prior to the capsizing of GET WET. [REDACTED] determined that the lazarette bilge pump had failed, that GET WET was sinking and that he needed to dewater the main deck. Instead of immediately contacting the Coast Guard using the VHF radio, [REDACTED] made a post on Facebook and got the vessel underway. Had [REDACTED] immediately reacted using the VHF radio to call for emergency assistance, the chances of GET WET capsizing would have been significantly reduced. Furthermore, when he did finally radio for help it was to TowBoat US first and only then after not receiving a reply, did he radio the Coast Guard for help.

(3) Directing Passengers: [REDACTED] directed the passengers to move under a partially enclosed fiberglass bimini top, in an attempt to trim the vessel, while GET WET's stern was continuing to sink. This order caused [REDACTED] and the passengers to become entrapped under the bimini, after GET WET capsized and sank to the ocean floor. Had [REDACTED]

ordered the passengers to move on top of the bimini or up onto the bow of the vessel, the danger of entrapment would have been significantly reduced.

d. Although not deemed a casual factor, it should be mentioned that other violations of law and regulation existed.

(1) Documentation Fraud: [REDACTED] and [REDACTED] willingly and intentionally, submitted fraudulent documentation to the National Vessel Documentation Center in order to obtain a Certificate of Documentation for GET WET. This fraud was committed for [REDACTED] and [REDACTED] who as foreign citizens, could not obtain the Certificate of Documentation on their own.

(2) Overloading of Charters: Key Largo Scuba Shack, LLC, willingly and intentionally, operated commercial vessels 11 times, from April 30, 2011 through November 23, 2011, with more than six passengers for hire aboard. Direct orders were given by [REDACTED] and [REDACTED] to carry more passengers than allowed by law.

(3) Operating Without a Valid License: [REDACTED] and [REDACTED] operated commercial vessels, with passengers for hire aboard, without having been issued valid Coast Guard licenses.

(4) Discharge of Oil: Key Largo Scuba Shack, LLC discharged oil into a navigable waterway, causing a sheen on the surface of the water, after GET WET capsized and sank at Molasses Reef.

(5) Illegal Use of Dispersants: [REDACTED] and [REDACTED] allegedly discharged oil into a navigable waterway, causing a sheen on the surface of the water, during fueling operations. [REDACTED] and [REDACTED] utilized dispersants to reduce this sheen, pouring those dispersants into the Florida Keys National Marine Sanctuary.

e. Although not deemed a casual factor, it should be mentioned that the heroic actions performed by the licensed master and crew of the VISIBILITY saved the life of Amit [REDACTED] and directly contributed to the successful rescue at sea of six other persons.

9. Recommendations:

a. Safety:

(1) It is recommended that the Commandant of the Coast Guard make a copy of this investigation report available to all voluntary uninspected passenger vessel examiners, including Coast Guard Auxiliary members.

(2) It is recommended that the Commandant of the Coast Guard direct all Sectors to increase safety boarding's of uninspected passenger vessels during normal patrols. Any vessel safety concerns should be forwarded to the cognizant OCMI for further evaluation and enforcement.

(3) It is recommended that the Commandant of the Coast Guard direct Sectors to continue outreach with commercial salvage companies. Coast Guard Sectors should encourage these companies to be our eyes & ears for hazardous operations or illegal uninspected passenger operations.

(4) It is recommended that the Commandant of the Coast Guard institute a program where vessels that lose their Certificate of Inspection are placed on a targeted monitoring program to ensure that the vessels maintain seaworthiness.

a. Enforcement

(1) It is recommended that Sector Key West conduct a Personnel Action marine investigation and initiate Suspension and Revocation action against [REDACTED] for negligence, misconduct, incompetence and violation of law or regulation.

(2) It is recommended that Sector Key West conduct a Personnel Action marine investigation and initiate Suspension and Revocation action against [REDACTED] for violation of law or regulation.

(3) Evidence collected during this investigation uncovered criminal acts that were committed by Key Largo Scuba Shack, LLC company officers, employees and associates. Further investigation of these acts has been predicated to the Coast Guard Investigative Service. If it is determined by CGIS that violations of law identified within this report do not amount to a criminal act, or are declined for prosecution by the United States Attorney's Office, then it is recommended that civil penalty enforcement be initiated by Sector Key West.

b. Other: It is recommended that this casualty investigation be closed.

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