RESOURCE DOCUMENT (updated March 2019) *

U.S. Coast Guard, States, NASBLA

Collaborative Policy Project on Recreational Boating Incident Reporting

Introduction to and Background on the Project Workgroup's Recommendations to the U.S. Coast Guard

* **Revised March 2019** to reflect outcomes of first review/comment period

INTRODUCTION

Beginning November 2017, a workgroup made up of 13 representatives[1] from the States, the Coast Guard, and the National Association of State Boating Law Administrators (NASBLA) convened weekly to discuss revisions to the accident reporting policies and procedures within the National Recreational Boating Safety (RBS) Program.

Their discussions, which continued through the end of 2018, marked the latest in a series of efforts to update "Standard Method of Reporting (Boating Accidents)," CG-449, the Coast Guard's operational guidance for States published in 1973 pursuant to the Federal Boat Safety Act of 1971 and the federal regulations promulgated thereafter. While those efforts over the years yielded significant proposals for improvements to the reporting structure and procedures, none resulted in comprehensive revisions to the reporting system, and none were successful in updating the CG-449 guidance that both the Coast Guard and the States recognize as obsolete.

However, in 2017, staff within the Coast Guard's Office of Auxiliary and Boating Safety expressed a strong desire to revisit the accident reporting procedures, and Coast Guard leadership was receptive. NASBLA and the States have long held a similar desire for clear procedures in the interest of uniformity and consistency in federal reporting requirements for boating accidents. As a result, the workgroup of State, Coast Guard, and NASBLA representatives was formed to collectively devise and—*as the first step in an extensive feedback and approval process*—come to initial consensus on recommendations that could be used to inform the Coast Guard's development of national reporting policy and procedures.

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[1] Other State members from NASBLA's Executive Board and the Engineering, Reporting & Analysis Committee (ERAC) often participated in the weekly discussions, but were not voting members of the workgroup. Coast Guard members of the workgroup shared their individual subject matter expertise and perspectives during the teleconferences, but voted as a unit in responding to the online consensus polls that were used to further gauge members' levels of agreement with the drafts.

In the first phase of the project, the workgroup addressed major aspects of the reporting system, structures, and procedures.[2] In February 2019, the consensus recommendations that emerged from the workgroup's discussions were sent to the project's organizational partners[3] for the first[4] of two comment periods to engage stakeholders beyond the workgroup. While that first comment period was underway, and in preparation for a project overview session at the 2019 BLA Workshop, a "working document" of the recommendations under review was released to the States' Boating Law Administrators (BLAs). The limited distribution was done with the understanding that some recommendations might change as a result of the group's consideration of the first set of comments.[5] Ultimately, the workgroup did not delete any of the original recommendations, but did modify six of them and added a new one.

All of the recommendations for review in the current comment period are presented in this revised **Resource Document**. Recommendations that the project workgroup modified as a result of feedback from the first external review are marked up to show the changes from their original wording. Along with the recommendations, this updated document presents detail not included in the Review Document: key discussion points (including outcomes from the first comment period), descriptions of workgroup intent, relationships to existing regulation or policy, and other historical background. **Appendices** provide detail associated with select recommendations and also reflect any revisions made as a result of the first comment period.

As you review this resource, be aware of the following:

1) The term "**boating incident**" is used in place of "boating accident." It is a general term referring to a recreational boating event that results in an injury, fatality, property damage, and/or vessel that is a total loss.

2) "**State**" means any of the 50 States, the District of Columbia, or the five U.S. territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, Virgin Islands).

3) "**First comment period**" refers to the first review period conducted Feb. 19-March 8, 2019, with the policy project's organizational sponsors. Leadership and key staff of the Coast Guard's Office of Auxiliary and Boating Safety, members of the NASBLA Executive Board, and all members of NASBLA's Engineering, Reporting & Analysis Committee (ERAC), including the project workgroup, were invited to participate. A compilation of all submitted comments is available in the **Library** at **OPEN COMMENT -- Recreational Boating Incident Reporting Policy Project.**

4) The workgroup used a "**consensus**"-based process in developing its recommendations.[6] For purposes of this project, the group agreed to an operational definition of "consensus" that will be used throughout the remainder of the review and feedback process.

> ***CONSENSUS*** *means that substantial agreement has been reached by the affected interests, in this case, the States and the Coast Guard. Consensus requires that all views and objections be considered, and that all due effort be made toward their resolution.*

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[2] The second phase of this project will focus on a revised reporting system (currently, the Boating Accident Report Database (BARD)) and "best practices" for effective implementation of revisions to the reporting structure and systems.
[3] The leadership and key staff of the Coast Guard's Office of Auxiliary and Boating Safety, members of the NASBLA Executive Board, and all members of NASBLA's Engineering, Reporting & Analysis Committee (ERAC).
[4] The first comment period ran Feb. 19-March 8, 2019. A compilation of submitted comments is in the **Library** at **OPEN COMMENT -- Recreational Boating Incident Reporting Policy Project.**
[5] On March 11, 2019, via teleconference, the project workgroup took up substantive comments associated with 37 recommendations. Several comments that were submitted did not require immediate attention; however, their substance is reflected, as relevant, in this updated **Resource Document** and narratives associated with the affected recommendations.
[6] In this first phase of the project, seven online "consensus polls" supplemented the workgroup's weekly discussions. In the polls, members rated their level of agreement with each draft statement. Disagreement required the member to offer a reason "why" and an alternative that the rest of the group could consider. Poll results and the resolution of issues were taken up on the group's calls.

Consensus does not necessarily mean complete agreement. However, it does require that far more of the "affected interests" than not agree with the proposals to some degree and accept them; that the process be designed to encourage varied perspectives to be received and considered in shaping the final product; and that the affected interests understand and ultimately accept the will of the larger group and do not deliberately work against implementation of the policies or actions that are developed or undertaken in response.

5) The workgroup **recommendations** are just that—***expressions of preferred policy directions, courses of action, and options for consideration.*** They are **not** presented in the form of regulatory language or formal policy provisions. As these items move through the process to build consensus among the stakeholders, their content will be refined by the project workgroup before final products are issued to NASBLA membership for voting in 2019.[7] Upon acceptance by membership, the package of consensus recommendations will be passed to the Coast Guard to inform the direction it ultimately takes in drafting actual federal regulatory and policy provisions. As such, reviewers should focus on the substance of the recommendations rather than trying to wordsmith the items into regulatory jargon.

FORMAT OF THIS RESOURCE DOCUMENT

Topic Breakdown. The workgroup's recommendations are presented in eight sections: the structure of reporting; incidents that should (or should not) be reported to the Coast Guard; reporting procedures; vessel determinations; report data elements; future report forms; roles and relationships; and vessel and bridge safety issues. The recommendations have been numbered to facilitate the submission of comments by reviewers and tracking by the project workgroup.

Presentation of Recommendations. Under each section, with the exception of data elements[8], the full list of related recommendations is presented first, followed by background or other general information about the collection of items under that topic. Then, each recommendation is presented individually along with narrative that may include information on the relationship to existing regulation or policy, key workgroup discussion points about it (including issues raised or explanations added as a result of feedback from the first comment period), descriptions of workgroup intent, and historical background.

Appendices. Seven appendices are referenced here and in the Review Document for the second comment period. They are associated with recommendations 2.1 through 2.4 regarding determination of incidents that should require a federal report (APPENDIX A, Decision Matrix); all recommendations under section 5 regarding report data elements (APPENDIX B, summary chart); recommendations 5.3.12 and 5.3.13 regarding vessel subtypes (APPENDIX C); recommendation 5.4.2 regarding accident types / events (APPENDIX D, "incident events"); recommendation 5.4.3 regarding operation (APPENDIX E); recommendation 5.4.4 regarding activity (APPENDIX F); and recommendation 5.4.5 regarding contributing factors/causes.

[7] The States as represented by their Boating Law Administrators (BLAs) or designees.
[8] Given the sheer number of recommendations associated with **Section 5. Incident Report Data Elements, Fields, and Definitions,** the full list does not preface the discussions on the individual recommendations.

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1. INCIDENT REPORTING STRUCTURE: INITIAL NOTIFICATION OF AND FOLLOW-UP ON A RECREATIONAL BOATING INCIDENT

RECOMMENDATIONS (see detail beginning p. 2)

The operator of a vessel should be required to notify law enforcement of an incident without delay, by the quickest means possible.

The operator should have the primary, legal responsibility for notifying law enforcement. If the operator is deceased or otherwise incapacitated, however, the vessel owner or vessel occupants should be required to notify law enforcement of an incident without delay, by the quickest means possible.

The State should require notification from an operator or owner.

The State Reporting Authority should accept notification from an operator, owner, or other entity.

The State should have the means to impose a penalty on the vessel operator or owner for failure to notify law enforcement of an incident.

Federal provisions should identify the minimal required information to be collected for the notification stage.

The State should determine how best to obtain the minimal required information--the preliminary information about an incident--to be collected for the notification stage (e.g., receipt from the operator; gathered by officer/investigator; etc.).

The State Reporting Authority should ensure that an investigation is conducted after notification of an incident.

If the future reporting system can be designed to facilitate the State Reporting Authority's entry and submission of preliminary information about an incident to the Coast Guard,* then within 15 days of being notified of an incident, the State Reporting Authority should submit the incident date, time, location, vessel type(s), and numbers of deceased and injured so that the Coast Guard will have timely, accurate data for its performance measurement requirements.

> **For example, design of system capable of overwriting and updating the information in a way that would not require manual or multiple entry of information to a record—i.e., creating a unique record ID for reuse to update or to delete initial incident information that ultimately is deemed to be false or otherwise "non-reportable.*

BACKGROUND

The current national reporting structure set in federal regulation relies on the recreational boater—owner or operator—to notify the State, and to submit a detailed report to the State on an incident. In 2009, a "two-tier" reporting structure was among 15 recommendations put forth by a task force of the National Boating Safety Advisory Council (NBSAC).[9] In 2016, NBSAC reaffirmed support for the recommendations in Resolution 2016-95-1, and encouraged the Coast Guard to address them. That same year, NASBLA membership approved Resolution 2016-1 encouraging the Coast Guard to factor into its rulemaking the significant recommendations for reporting improvements that emerged from both NBSAC and NASBLA over the prior decade.

The current project workgroup discussed the implications of instituting such a two-tier reporting structure where the first tier would require initial notification from the people involved in the incident (and the gathering of basic information about the incident), and the second tier would involve a follow-up by law enforcement on the incident (with the fuller collection of information).

In workgroup discussions, some of the State members described their use of a two-tier system or something very similar to it.[10] A workgroup member from Tennessee, for example, noted that the operator is required to immediately notify the agency whenever there is a boating incident that meets reporting requirements. Admittedly, the operator usually is not the source of the notification: for fatal and non-fatal injury cases, notification is usually received from a 911 call, hospital, or local police department. Notifications are usually done by phone and an officer is assigned to the case. The Tennessee State Reporting Authority has a policy on

[9] Recently renamed the National Boating Safety Advisory Committee.

[10] In response to a 2011 Federal Register Notice requesting public comments on the NBSAC recommendations, the vast majority of State respondents also indicated they had a structure resembling a two-tier system and more than 80 percent thought the States would support national implementation of such a structure.

how the officer should proceed with the investigation. Once information is collected, it is entered by the officer into an electronic form; then, a hierarchy of individuals reviews it.

A workgroup member from Texas described a similar structure. Even though Texas law requires the operator to notify of an incident, often times the notification is from 911 calls, EMS, and local agencies. The operator is allowed to notify the Texas Parks and Wildlife Department (TPWD) or an agency certified by TPWD. The member noted that usually an agency will call TPWD to take a report because TPWD is trained. The State has a three-tier hierarchy (warden, supervisor, and TPWD HQ) that reviews cases. Outside agencies submit electronically or on paper on a form that TPWD provides. A clerk from TPWD HQ then enters the information into the reporting system.

Both workgroup members from these States expressed their preference for the two-tier reporting system, citing increased control over the data collection process and improved data quality. One workgroup member originally anticipated, but did not experience a burden in practice.

Following are the project workgroup's specific recommendations on the incident reporting structure with regard to initial notification and follow-up. None were modified as a result of feedback received during the first comment period.

1.1. The operator of a vessel should be required to notify law enforcement of an incident without delay, by the quickest means possible.

Current federal regulation (33 CFR 173.53) requires that an operator notify, without delay, by quickest means available, the nearest reporting authority (listed in Appendix A of Part 173—i.e., the State) in the event a person dies or disappears from a vessel. This workgroup recommendation would update the provision regarding **"who"** should make the notification and "**to whom**" in the context of a two-tier system of initial notification and more detailed report follow-up. This recommendation would also expand the "**breadth"** of cases that would require immediate notification: current regulation only requires immediate notification for deaths and disappearances, whereas this recommendation would require immediate notification for any incident.

In its discussions, the workgroup weighed the use of "[State] reporting authority" (as currently cited in CFR) versus "law enforcement." The workgroup settled on "law enforcement" with the intent that a State could use more specific language in its implementing Statute, if desired.

The workgroup also discussed and then discarded the idea of a web-based reporting system that the public could use to notify law enforcement of an incident. Workgroup members were not in favor of having such a system due to concerns about the burden of reconciling information, the likelihood of late notification, and the possibility of hoaxes.

1.2. The operator should have the primary, legal responsibility for notifying law enforcement. If the operator is deceased or otherwise incapacitated, however, the vessel owner or vessel occupants should be required to notify law enforcement of an incident without delay, by the quickest means possible.

As noted in the discussion of recommendation 1.1, current federal regulation (33 CFR 173.53) requires that an operator notify, without delay and by quickest means available, the nearest reporting authority in the event a person dies or disappears from a vessel. The regulatory provision goes on to require that when the operator cannot give notice, each person on board—the occupant(s)—must notify the "casualty reporting authority" or determine that it has been notified. This recommendation 1.2, like 1.1, would update and clarify aspects of those provisions regarding "**who**" should make the notification and "**to whom**" in the context of a two-tier system of initial notification and more detailed follow-up.

Before achieving consensus on this recommendation, workgroup members expressed differing opinions about requiring vessel occupants to make the notification. Some said it would be difficult to require occupant notification even though federal regulation currently provides for it. They noted that enforcement of an occupant requirement can be difficult because the State has to establish a connection to the vessel. And, even though the States and the Federal government may have the ability to impose fines, no workgroup member was aware of a charge against a vessel occupant for a failure to notify.

Other workgroup members, however, expressed support for an occupant notification requirement. Several members noted that their Statutes already require operator/occupant notification. Other workgroup members cited the necessity of requiring occupant notification because if the operator/owner is deceased as a result of the incident, only the other vessel occupant(s) are left to notify law enforcement.

The workgroup discussed whether the notification method should be specified in regulation or policy. Ultimately, the group recommended the method not be codified given the likely evolution of technology.

1.3. The State should require notification from an operator or owner.

As cited in the discussions of recommendations 1.1 and 1.2, current federal regulation (33 CFR 173.53) requires that an operator make the notification for a death or disappearance, and in the event the operator cannot give notice, the requirement falls to the occupant(s). This recommendation 1.3 updates existing federal requirements for notification in the context of a two-tier system, and acknowledges that enforcement of the federal requirement is passed to the States.

Before achieving consensus on this recommendation, some workgroup members expressed concern about the States' legal ability to enforce such a requirement, and argued that it should be enforced by the federal authority. In response, the Coast Guard noted that while there is a federal requirement for operator or owner notification (that would continue even under a two-tier system), the requirement—and enforcement—is and would still be passed onto the State via the grant agreement because it is not possible for the Coast Guard to be "everywhere."

In further discussion, there was consensus that specifying an agency within the State—notably the "State Reporting Authority"—would be inappropriate; while the State Reporting Authority is the point of contact with the Coast Guard, the grant agreement is between the Coast Guard and the State, and the State is the authority in Statute. Further, implicit in the reference to "State" in the recommendation is the State's authority to delegate enforcement of the requirement. One workgroup member noted, for example, that any State authority—from a local municipality to the State Reporting Authority—has the ability to enforce the requirement.

As part of their larger discussions on this matter, workgroup members considered whether a State could require notification from an agency that responds to an incident. There was some variation among the States in terms of current policy and practice. A member from Wisconsin noted a legal requirement to do so, explaining that any law enforcement agency receiving a report must forward it to the State Reporting Agency within five days, and any agency investigating an accident must report to the State Reporting Agency within 15 days. Another member indicated that Florida did not have the ability to require notification from a responding agency, but the State does require local agencies to forward reports once complete. Ultimately, workgroup members discarded the idea of requiring notification from a responding agency, but suggested alternate methods of increasing notification. Most members suggested relationship-building activities with local agencies to facilitate awareness of reporting requirements. Some already engage their officers in the community through visits to hospitals and local agencies. Other workgroup members said that they provide training to local agencies.

1.4. The State Reporting Authority should accept notification from an operator, owner, or other entity.

As already described in the entries for recommendations 1.1 through 1.3, current federal regulation (33 CFR 173.53) requires that an operator make the notification of a death or disappearance, and in the event the operator cannot give notice, the requirement falls to the occupant(s). The workgroup's recommendations in this series align with or update the requirements in the context of the two-tier system and the notification of an incident. The workgroup recommended acceptance of notification from an "operator, owner, **or other entity**" because they foresaw incidents in which both the operator and owner were deceased. Before settling on the term "other entity," the workgroup considered "responsible parties," but ultimately discarding the suggestion because the term is ambiguous. In this recommendation, then, examples of "other entities" could include a responding agency, 911 dispatch, a witness to the incident, insurance company, or legal representative of a person involved in the incident. Acceptance of notification from "an operator, owner, or other entity," does not absolve anyone involved from complying with the investigation of the incident.

1.5. The State should have the means to impose a penalty on the vessel operator or owner for failure to notify law enforcement of an incident.

In line with recommendation 1.3. on the State requiring notification, this recommendation 1.5. is a component of the recommended updates to existing federal requirements for initial notification in the context of a two-tier system; it acknowledges that the authority and enforcement of the federal requirement is (and would continue to be) passed to the States via the grant agreement with the Coast Guard. It would not preclude the Coast Guard from also imposing penalties for failure to notify.

1.6. Federal provisions should identify the minimal required information to be collected for the notification stage. *[The "minimal required information" – the preliminary information about an incident – is described in recommendation 1.9.]*

Current federal regulations require the operator to submit the casualty or accident report in cases where the stated reporting thresholds are met (33 CFR 173.55), and to provide all of the detailed report information requested in 33 CFR Part 173.57. In the context of a two-tier reporting system, this recommendation 1.6 acknowledges that information collected at the notification stage still should be established in federal regulation, but the requirement would be for minimal information. See related recommendations 1.7 and 1.9.

1.7. The State should determine how best to obtain the minimal required information--the preliminary information about an incident--to be collected for the notification stage (e.g., receipt from the operator; gathered by officer/investigator; etc.).

In line with recommendations 1.6 and 1.9., this recommendation 1.7 would give the States discretion in determining how to gather the preliminary information about the incident. The method would not be established in federal regulation, but in "best practices" developed to assist States in implementation.

1.8. The State Reporting Authority should ensure that an investigation is conducted after notification of an incident.

This recommendation 1.8 pertains to the second tier in the proposed two-tier incident reporting system—that is, follow-up by law enforcement on the incident with the more detailed gathering of information (see related recommendations under **Section 3. Gathering all incident data, reviewing and submitting final reports to the Coast Guard** and **Section 5. Incident report data elements-fields-definitions).** During the first comment period, a member of the project workgroup proposed that the role of the report thresholds be acknowledged in the recommendation. A Coast Guard member of the group, however, advised that it would not be necessary to specifically state that the report threshold criteria (presented in recommendations under 2.1.2) would need to be met first—the thresholds would be a preamble in the revised regulatory scheme. As part of this discussion in the wake of the first comment period, the workgroup also considered the reference to "investigation" and the likely differences between what it means at the state vice federal level. For the Coast Guard (under statutory authority 46 U.S. Code Ch. 63), an "investigation" is conducted "to decide cause."

In prior workgroup's discussions on this recommendation, the members identified scenarios in which there could be exceptions to States assuming responsibility for taking the investigative lead on an incident. A notable example: The U.S. Coast Guard should and would be responsible for collecting and entering information on incidents that occur under the sole jurisdiction of another federal entity, such as the National Park Service, U.S. Forest Service, or U.S. Army Corps of Engineers, or when such federal agency assumes the investigative lead on any such incident. The Coast Guard would pursue Memoranda of Understanding (MOUs) with other federal agencies to accomplish this task.

The recording of data on such incidents where a federal authority has assumed the lead in the investigation is yet to be decided. One suggestion offered during workgroup discussions was to record incidents under sole federal jurisdiction or federal investigative lead as a separate "federal code" as opposed to combining the data with a State code (such as AL or AK). However, one advantage of coding such an incident with a State code is to better educate the public about the geographical location of incidents. If the incident occurred on concurrent jurisdiction, the data would be attributed to the State.

In the event an incident occurred on concurrent jurisdiction, the State would still be in charge of conducting the investigation. Even if a federal entity assumed the role of the investigator, the State could elect to investigate the incident.

1.9. If the future reporting system can be designed to facilitate the State Reporting Authority's entry and submission of preliminary information about an incident to the Coast Guard,* then within 15 days of being notified of an incident, the State Reporting Authority should submit the incident date, time, location, vessel type(s), and numbers of deceased and injured so that the Coast Guard will have timely, accurate data for its performance measurement requirements.

**For example, design of system capable of overwriting and updating the information in a way that would not require manual or multiple entry of information to a record—i.e., creating a unique record ID for reuse to update or to delete initial incident information that ultimately is deemed to be false or otherwise "non-reportable.*

As noted in the discussion on recommendation 1.6, current federal regulations require the operator to submit the casualty or accident report in cases where the stated reporting thresholds are met (33 CFR 173.55), and to provide all of the detailed report information requested in 33 CFR Part 173.57. The State, in turn, is required to "forward" the report to the Coast Guard within 30 days of receipt of it. The previous recommendations (1.6, 1.7, 1.8) describe the proposed modification to the collection of information in the context of a two-tier reporting system, but do not identify the timeline for submitting either the preliminary or final (all available) data to the Coast Guard. This recommendation 1.9 describes the preliminary information that would be collected and the potential timeframe for submitting the data but with one large caveat—that a revised reporting system would facilitate, not burden, the State's compliance with such a timeframe (see the concerns immediately below).

In the course of considering the scope of information needed by the Coast Guard to fulfill its performance measurement requirements and a workable timeframe for the States to provide the data, some workgroup members were concerned that a requirement to submit preliminary information within 15 days of notification of an incident would be a burden, without real benefit to their RBS program. Particular concern was expressed by States that have a large volume of incidents. One group member was concerned about duplicating preliminary report information since hundreds of incidents would need to be tracked.

Other group members were concerned about burdensome updates that would need to be made to their State's independent third-party reporting system in order to comply with such a requirement. One group member was concerned about limited control over the State's reporting system contract and the ability to make changes to it. The member also expressed concern about the possibility of a malfunctioning update to preliminary information. Another issue identified was the time required for a supervisor to review the preliminary information prior to submission.

To address these concerns, Coast Guard representatives suggested that there would need to be a phase-in period to accommodate this requirement, and that a State would be able to use grant money to make changes to independent third-party systems. If information was not transferring or updating properly, a State could also use the helpdesk staff to correct the issue.

Some workgroup members suggested an alternative timeline for submission whereby if a final report (all available data about the incident) was not available within 30 days of the incident, the State would submit a preliminary report that included the minimal information required by the Coast Guard. The Coast Guard representatives, however, held to their interest in a 15-day timeframe because of the requirement that the Coast Guard periodically report casualty performance metrics.

Several of the workgroup members noted that they usually have information within 15 days of the incident, but requested that the language of the recommendation specify that submission would be within 15 days "of being notified of an incident" so that the State would not be "on the hook" for submitting information on incidents for which the State Reporting Authority received late notification.

The group also recommended that the future reporting system facilitate deleting or designating as "non-reportable" initial reports that later are found to be false or unneeded. This feature will be defined in Phase 2 of this project (development of a revised reporting system to accommodate the reporting revisions). There was a further recommendation that only the Coast Guard or a State Reporting Authority should be

able to delete the report; an officer in the field should not be able to do so.

Finally, there was consideration that additional training or resources may be needed by some State Reporting Authorities to comply with this and other recommended requirements should they be accepted.

2. DETERMINING WHICH INCIDENTS REQUIRE A REPORT TO THE COAST GUARD (see Recreational Boating Incident Report Decision Matrix in APPENDIX A for graphic representation)

RECOMMENDATIONS (see detail beginning p. 8)

Incident should meet three initial, qualifying conditions:

1. Occurred on State or concurrent jurisdictional waters;

2. Involved at least one of the federal report thresholds:
--- A person dies.
--- A person is injured. For purposes of meeting this threshold, an injury is defined as a physical harm or hurt for which a person received treatment by a medical professional at a licensed medical facility. Observation without treatment is not considered an injury.
--- A person disappears from the vessel under circumstances that indicate likely death or injury.
--- Damages to the vessel(s) and other property are ≥ $2,000*, with the following qualifications:

a. For the notification stage, the $2,000* amount would be a general estimate based on damages associated with all vessels and property involved in incident. [*Exceptions are described in recommendations b. and c., below.*]

b. The costs of damages to the vessel's structural, mechanical, and electronic components or to other associated equipment of the vessel, and the material costs of restoring boating infrastructure should be included in calculations to determine whether the incident meets this dollar threshold.

c. The value of personal property that may have been on the vessel at the time of the incident should be excluded from consideration ("Best practices" should describe/define what personal or non-vessel property means).

**An alternate proposal from the Coast Guard to increase the threshold to $2,800 is on the table; see discussion on pages 10-12 of this document, pertaining to recommendation 2.1.2.4. Workgroup is seeking feedback.*

--- The vessel is a total loss. "Total loss" is defined by situations where: the vessel is known or presumed to have been destroyed; is presumed to have sunk and its location is unknown; has sunk and its location is known, but it is unrecoverable due to availability and costs; and where it is a constructive total loss, i.e. the vessel is so severely damaged that it is not financially worth recovering and/or repairing.

3. Involved at least one of the following:
---a vessel used for recreational purpose,
---a State-numbered uninspected vessel.

Incident should be further evaluated for a federal reporting requirement based on these conditions:

For docked or moored vessels, a report to the Coast Guard is required if the incident involved one or more of the following events:
---carbon monoxide exposure;
---stray electrical current that was attributed to the vessel;
---fires/explosions that occurred while fueling or starting the vessel.

For anchored vessels, the list of "Non-Reportable Events" should be consulted (see below). A report to the Coast Guard is required if the incident is **NOT** covered by one of the Non-Reportable Events.

For vessels that had an operational status other than docked, moored, or anchored, determination should first be made as to whether the incident was the result of any of the following:
---operation
---vessel's construction
---vessel's seaworthiness
---vessel's machinery

---vessel's equipment
---loading of the vessel
---environmental forces.

If the incident met at least one of these criteria, the list of "Non-Reportable Events" should be consulted. A report to the Coast Guard is required if an incident is **NOT** covered by one of the Non-Reportable Events.

Non-Reportable Events:

- ✓ Person voluntarily departed vessel: The first and only event involved a person voluntarily departing a vessel (or departing shore to swim after a vessel).
- ✓ Towed watersports injury exceptions: A person suffers an injury while participating in towed watersports (including wake surfing) that wasn't due to the operation or equipment of a vessel.
- ✓ Vessel use exceptions: The only vessel(s) involved were used solely for governmental, criminal (activities in the course of a criminal offense, with the exception of impairment and boating safety-related offenses), disaster response, or sanctioned activity (when competing in an organized or sanctioned race or training program approved by a national or international body, or by appropriate permit, and where adequate safety precautions are in place).
- ✓ Self-inflicted injuries: Self-inflicted injuries were the cause (examples include: self-inflicted wounds, ingestion of controlled substances or poison, gunshot wounds).
- ✓ Assaults. A person suffers an injury, dies, or is missing as a result of an assault by another person or persons while aboard a vessel. (Added by workgroup as a result of feedback from first comment period.)
- ✓ Medical events: A medical event (does not include physical impairments such as poor eyesight, poor hearing, or mobility difficulties) was involved, when the vessel did not contribute, and when no other reporting threshold was met.
- ✓ Watercraft not a "vessel": The only watercraft involved were not considered "vessels" (examples include: a pool float toy, innertube, float tube propelled by feet or fins, surfboard, submersible, diving propulsion aid, stock tank, air mattress, fish box, floating dock, unmodified log, snowmobile, and/or seaplane). (See definition of "vessel" for purposes of national RBS program and casualty reporting in recommendation 4.1.1)
- ✓ Foreign flag vessels: The only vessel(s) involved were foreign flag vessels.
- ✓ Natural phenomenon: A natural phenomenon was involved (such as interaction with marine life (e.g., carp causes injury to person) and interaction with nature (e.g., mountain side falls onto vessel causing damage)) when no other event occurred and when no other reporting threshold was met.
- ✓ Launching/recovery injuries, fatalities, damages: Launching or recovery when the vessel is not on the water and capable of use (free from the apparatus from which it is being launched).
- ✓ Embarking/disembarking injuries, fatalities: A person suffers an injury while embarking or disembarking a docked, moored, or anchored vessel, when no other event occurs and when no other reporting threshold was met.

Best Practices should be developed to accompany the Recreational Boating Incident Report Decision Matrix**.**

BACKGROUND

Current federal regulation (33 CFR 173.55) requires submission of a report when, as a result of an incident involving the boat or its equipment, a person dies or disappears, a person is injured and needs treatment beyond first aid, there is $2,000 or more damage to the vessel(s) or property, or there is a complete loss of a vessel. Under the proposed two-tier incident reporting system, thresholds and other conditions would still need to be met to prompt a report requirement. And, just as is currently the case for reports received, not all incidents for which notifications are made may ultimately be deemed "reportable" within the National Recreational Boating Safety (RBS) Program. Examples of the types of incidents that reflect current Coast Guard national RBS policy are listed in the introductory section of the Coast Guard's annual statistics publication.

The workgroup recommendations that follow propose to update and clarify the conditions under which a recreational boating incident would require a report to the Coast Guard. While updates to the federal report thresholds would require regulatory action, the other conditions that are described could be accommodated and implemented via policy.

For the graphical representation of these recommendations, see **APPENDIX A, Recreational Boating Incident Report Decision Matrix, and note the comment boxes inserted on the PDF.**

Regarding the Matrix: while the overall sentiment of project workgroup members and other commenters from the first comment period was favorable, at least two thought that the "double negatives" in the question blocks regarding anchored vessels and all other operational statuses would create some confusion. A similar critique was expressed by a BLA following the March 1 BLA Workshop presentation on this project. Ultimately, the workgroup agreed to move the Matrix forward with the current configuration and gather more feedback and

alternatives in the second comment period. The only substantive change is the addition of “Assaults” to the list of Non-Reportable Events under 2.3 and the second page of the Matrix. Additional background and discussion regarding the Matrix can also be found in the narrative under recommendation 2.4.

2.1. Incident should meet three initial, qualifying conditions:

2.1.1. Occurred on State or concurrent jurisdictional waters;

In considering this basic condition, the workgroup weighed using other terms such as “public waters” and “navigable waters” to describe the waters upon which reporting would be required. However, members expressed concerns about the definition and use of both terms, and ultimately the workgroup decided that “State and concurrent jurisdictional waters” would be the most appropriate reference. If a State currently investigates incidents on private waters, this language would not impact that authority as “State” jurisdiction would be as defined by that State.

2.1.2. Involved at least one of the federal report thresholds:

2.1.2.1. A person dies.

This recommendation 2.1.2.1 aligns with current federal regulation (33 CFR 173.55). In the course of discussions, however, the workgroup surfaced issues associated with this threshold that would benefit from policy clarification.

The workgroup discussed, for example, whether a fetus would be considered a death if a pregnant woman lost her fetus in a boating incident. For reference, Coast Guard staff indicated that 10 years ago, the National Highway Traffic Safety Administration (NHTSA) did not consider the fetus a death because it would not be able to function outside of the mother’s womb. The Coast Guard was concerned about making a determination regarding a fetus because States may already have a determination in State law. One workgroup member noted, for example, that North Carolina would count a mother and fetus that perished in a car accident as two deaths, whereas in Massachusetts the death of a fetus would not warrant a death certificate; instead, a certificate of fetal demise would be issued.

The workgroup also discussed whether an injury incident record should be updated to a death record if the injured person dies as a result of injuries sustained from a boating incident, *regardless of the amount of time between incident date and death*. Workgroup members recommended updating an injury record to a fatality record if notified about the victim’s change in status. Likewise, a fatality record marked as a disappearance should be updated if the victim who disappeared was later found.

2.1.2.2. A person is injured. For purposes of meeting this threshold, an injury is defined as a physical harm or hurt for which a person received treatment by a medical professional at a licensed medical facility. Observation without treatment is not considered an injury.

Current federal regulation (33 CFR 173.55) defines an injury as “A person is injured and requires medical treatment beyond first aid.” The recommended revisions to the threshold would require regulatory and policy modification, as well as further guidance to the States in the form of “best practices” for its application.

Workgroup members discussed the best way to reframe a threshold that has been a source of varying interpretation because of its vague definition. In doing so, the group considered a 2009 NBSAC task force recommendation for possible adoption of appropriate language from the Occupational Safety and Health Administration (OSHA). However, due to concerns about the long list of criteria and follow-up to determine whether an injury really was met, the workgroup discarded the OSHA definition as a possible framework.

The workgroup then considered whether an injury threshold should involve someone seen at a licensed medical facility. There were concerns about whether observation without

treatment would be included (for instance, a person who received x-rays that revealed no injury and was soon after released). In particular, one workgroup member noted that people in incidents often are automatically transported to a facility, whether or not they elect to be transported, and are released shortly thereafter. The member does not value such “injury” data because a State would not be able to develop interventions based on “observation only” data. As a result of this discussion, “Observation without treatment is not considered an injury” was added to the proposed, revised injury threshold.

Some workgroup members felt that if a doctor examined someone at a medical facility, the person should be considered as having treatment. For this reason, members added the condition “received treatment by a medical professional” to the threshold definition. Nevertheless, some members were concerned that limiting treatment by a “medical professional” might inadvertently create inconsistency in reporting. One member felt a non-medical professional could put a splint on a person’s arm just as a medical professional would. In this situation, one incident would meet the threshold; the other would not.

Group members also expressed concern about whether “emotional harm or hurt” would qualify as an injury if the victim sought medical counseling. The injury threshold was not intended to include “emotional” injury, however, thus the specification of a “physical” harm or hurt.

Group members further discussed whether States would be able to document the severity of treatment to be able to differentiate between grave injuries that required surgery versus ones that were out-patient. Ultimately, group members expected difficulty documenting the severity of treatment: some cited HIPAA hindrances, while others were concerned about the amount of follow-up required to track down information on injury severity.

There was some concern that revising this threshold could cause the National RBS Program to miss some injuries where people refused treatment for an injury that would be considered on par with others that were reported. The workgroup originally considered adding language to include an injury for which a “reasonable or prudent person” would seek treatment. However, there were concerns about the subjectivity of “reasonable” and “prudent,” even though the concepts are commonly used in law. Consideration also was given to indicating that “a person received or should have received treatment.” Again, given concerns about subjectivity, the condition “*should* have received” was discarded. The workgroup decided that removing that component would not significantly affect the number of injured victims; the expectation is that the number of injuries missed would be low.

Overall, the group expected the severity of injuries represented in the revised injury definition to be “on par” with the severity of injuries captured under the current report threshold, and anticipated a similar number of reports.

“Best practices,” however, will need to be developed and shared to help the States better define the receipt of “treatment.” Examples of scenarios that would be covered include: 1) If a person received x-rays at a hospital and was found to have sustained no broken bones, would the x-rays be considered “treatment” or would the case involve “observation without treatment?” 2) Would a person who received a bandage at a licensed facility by a medical professional be considered as having received “treatment”? 3) Would blankets at a hospital for hypothermia be considered “treatment”?

2.1.2.3. A person disappears from the vessel under circumstances that indicate likely death or injury.

This recommendation aligns with current federal regulation (33 CFR 173.55). In the course of discussions, however, the workgroup surfaced an issue with this threshold that would benefit from policy clarification and an associated “best practice.”

Some workgroup members expressed concern about reporting disappearances, noting that some could involve a hoax or fraud. Ultimately, the workgroup suggested collecting

information on disappearances until they are determined to have involved a hoax, fraud, or "found" person.

2.1.2.4. Damages to the vessel(s) and other property are ≥ $2,000*, with the following qualifications:

**An alternate proposal from the Coast Guard to increase the threshold to $2,800 is on the table; see discussion on pages 10-12. Workgroup received feedback during the first comment period and is seeking additional input in this second round of review and commenting.*

2.1.2.4.1. For the notification stage, the $2,000* amount would be a general estimate based on damages associated with all vessels and property involved in incident. Exceptions are described in recommendations 2.1.2.4.2 and 2.1.2.4.3.

2.1.2.4.2. The costs of damages to the vessel's structural, mechanical, and electronic components or to other associated equipment of the vessel, and the material costs of restoring boating infrastructure should be included in calculations to determine whether the incident meets this dollar threshold.

2.1.2.4.3. The value of personal property that may have been on the vessel at the time of the incident should be excluded from consideration ("Best practices" should further describe/define what personal or non-vessel property means).

The basic damages recommendation presented on page 9 aligns with the current dollar threshold set in federal regulation (33 CFR 173.55). *[There is an alternate proposal from the Coast Guard to increase the threshold to $2,800; see discussion beginning next page. Workgroup is seeking feedback.]* In the course of discussions, the workgroup reviewed historical information on prior adjustments associated with this threshold, used the opportunity to consider other options, and then developed a set of qualifications to delineate what should and should not be included in calculating the dollar amount (see 2.1.2.4.1, 2.1.2.4.2, and 2.1.2.4.3.). Later in the project, the group also considered and developed recommendations regarding the collection and recording of vessel and non-vessel property damage data (see recommendations under **Section 5. Incident report data elements, fields, definitions** and, specifically, recommendation **5.5 Damages to vessels and other property**).

Discussions about this federal damage threshold reflected the group's interest in reducing the reporting burden for the public, States, and Coast Guard; members' acknowledgment of the need to take into account differences in repair costs within and across jurisdictions; concerns about the usefulness of collecting data in lower damage accidents; and consideration that since damage-only accidents are already underreported, any increases to the threshold could have the unintended effect of eliminating even more information. If the threshold were to change, some workgroup members suggested that the amount or formula be revisited over a lengthy period of time, such as every 10 years, since it typically takes time to promote awareness of changes to reporting thresholds.

In its discussions on damages, the workgroup first addressed whether the dollar amount of the federal threshold should be increased. Since 1958, the dollar amount has risen four times, from $100 to $200 to $500 to the current $2,000. The Federal Register Notices and Final Rules associated with these changes provided the workgroup with some insights into possible alternative methods and the implications of making adjustments. For example, in the past, the Coast Guard had used the Gross National Product (GNP) and the Producer Price Index (which no longer exists) to determine inflation. One of the Notices described a plan for the Coast Guard to review the threshold annually and to increase it in $100 increments; neither has been done. According to narrative in Raising the Threshold of Property Damage for Reports of Accidents Involving Recreational Vessels-Final Rule (effective 7-2-2001), NASBLA's Boat Accident Investigation, Reporting, and Analysis Committee (BAIRAC)—predecessor to ERAC—had recommended the $2,000 threshold. The rationale was that raising the threshold from $500 to a $2,000 threshold would reduce paperwork and the reporting burden, and take into account rising repair costs. BAIRAC

also had recommended collecting data on vessel crashes regardless of the value of damages, but that suggestion was not implemented in the Final Rule.

A 2016 survey conducted by NASBLA revealed that as of November of that year, 22 of the 43 responding States had a $2,000 threshold, 20 had a threshold under $2,000, and two of those 20 were planning to raise their threshold to the federal level. Although most workgroup members were comfortable with the $2,000 threshold because they felt it captured incidents of interest, Coast Guard members were still interested in studying whether the federal threshold should be raised due to inflation, especially as this most recent increase went into effect 17 years ago.

Just before the end of the first phase of this project, the Coast Guard's Boating Safety Division (CG-BSX) recalculated the federal damage threshold using the same methodology applied on the commercial side by the Coast Guard's Office of Investigations and Analysis (CG-INV) [see methodology and related discussions in Marine Casualty Reporting Property Damage Thresholds-Final Rule (3-19-2018)]. The result was that CG-BSX put forward an alternate proposal to the workgroup for an increase in the recreational threshold to $2,800 (the recalculated value), with allowance for the States to retain lower damage thresholds, if desired.

Workgroup members expressed preliminary thoughts about the proposed increase before the first review period commenced Feb. 19. However, instead of making any modifications to the recommendations, the group wanted to gather more information and external feedback on both the current and proposed amounts and the potential implications for reporting. As such, the workgroup released the recommendations with the $2,000 threshold cited in 2.1.2.4 and provided the relevant information on the proposed increase via the Review Document and a previous version of this **Resource Document**.

The feedback from the first comment period—both from the external reviewers and workgroup members—was mixed. While some commenters did not have an issue with the Coast Guard proposing an increase in the threshold amount, they suggested that the amount be significant enough to warrant the change, be an even number, and not be difficult for the public or the officers/investigators to remember. Others were more conflicted as to the reasoning behind such a change and pointed out that there could be unintentional effects associated with such an increase—for example, the potential to lose useful data about incidents such as those associated with operator inattention or inexperience and to make meaningful comparisons over time; or, especially for states with relatively fewer incidents overall, to result in a significant decrease in reportable accidents that could impact their total RBS program and ability to analyze data that might suggest the need for changes in enforcement or educational activities.

As a result of the varied feedback received in the first round, for the second comment period with all of the States, the project workgroup once again decided to retain the recommendation as originally worded, and also provide the information on the proposed increase—this in order to gather more input from a wider range of stakeholders regarding both the current and proposed dollar amounts and the potential implications for reporting and analyzing incident statistics.

Regarding the scope of damages and for the purpose of developing the recommendations presented as 2.1.2.4.1, 2.1.2.4.2, and 2.1.2.4.3, the workgroup had sought guidance on the policies and practices of member States and of various federal entities, including the Federal Railroad Administration (FRA) and the Coast Guard's own CG-INV. Labor costs, environmental cleanup costs, and the value of personal property were all under consideration.

In Wisconsin, for example, the cost to repair is included in its property damage calculation. Wisconsin's statute reads, "Total property damage means the sum total cost of putting the property damaged in the condition it was in before the accident if repair thereof is practical, and if not practical the sum total cost of replacing the property."

The FRA also includes the labor cost to repair in its damage data collection. The agency does not include the cost of environmental cleanup or personal property in its reporting, however. The reporting description reads, “Reportable damage includes labor costs and all other costs to repair or replace in-kind, damaged on-track equipment, signals, track, track structures, or roadbed. Reportable damage does not include the cost of clearing a wreck; however, additional damage to the above-listed items caused while clearing the wreck is to be included in the damage estimate. Examples of other costs included in reportable damage are: 1) rental and/or operation of machinery such as cranes, bulldozers, including the services of contractors, to replace or repair the track right-of-way and associated structures; and 2) costs associated with the repair or replacement of roller bearings on units that were derailed or submerged in water. (Replacement costs include the labor costs resulting from a wheelset change out.)”

CG-INV also includes “the cost of labor and material to restore the property (vessels, shoreline facilities, pipelines, OCS facilities, etc.) to its original condition before the occurrence.” It includes cargo, but does not include the cost of salvage, cleanup, or the damage to natural resources.

Generally, the workgroup suggested that for the purposes of meeting the dollar threshold, damages should reflect the value of property damaged, not the cost to repair. Members expressed concerns about consistency in reporting labor costs as they fluctuate, vary based on geographical location, and likely would depend upon an officer/investigator’s expertise in making that assessment.

The workgroup further recommended excluding environmental cleanup costs (such as fuel spills) in the value of damages because often times these costs are high and do not relate to boating safety.

Finally, although some States currently apply the value of personal property towards the damage threshold, the workgroup recommended that personal property be excluded from the federal threshold due to concerns about consistency in reporting. Members cited the possibility of two incidents involving similar circumstances wherein one involved personal property damage that met the damage threshold but another did not. They questioned the consistency of collecting information on one incident and not the other. One workgroup member suggested that the value of personal property be recorded somewhere in the report (so as to document the full impact of boating incidents on society), but that it should not contribute towards the damage threshold. The Coast Guard representatives recommended that if personal property is excluded for purposes of the national collection, a study be conducted to gauge the impact (for historical comparisons).

2.1.2.5. The vessel is a total loss. "Total loss" is defined by situations where: the vessel is known or presumed to have been destroyed; is presumed to have sunk and its location is unknown; has sunk and its location is known, but it is unrecoverable due to availability and costs; and where it is a constructive total loss, i.e. the vessel is so severely damaged that it is not financially worth recovering and/or repairing.

Current federal regulation (33 CFR 173.55) includes “complete loss of any vessel” as one of the federal report thresholds. This recommendation 2.1.2.5 would amend the language to “total loss” and provide a definition.

In its deliberations, the workgroup considered the origins of capturing data on vessel losses. According to a Final Rule on casualty and accident reporting published in a January 1979 Federal Register Notice, a criterion for “complete loss” was introduced because a previous body recommended capturing data on less expensive vessels that may not meet the damage threshold.

The workgroup discussed what would be the most appropriate wording to capture a total loss in the current recreational boating environment. The phrase “complete loss” ultimately was discarded, as was the term “seaworthy” because some workgroup members said that

State personnel should not have to evaluate a vessel's seaworthiness. The group settled on "total loss," a criterion frequently used in vehicular incidents.

The group also considered whether vessels that were abandoned or left unrecovered should be considered "total losses." The group considered a few scenarios, such as: one where a person refused to recover their kayak because the owner found it easier to buy a new one than pay someone to recover it; and another where a vessel was left adrift in foul weather because it was not deemed feasible to tow the vessel in at the time of rescue. Some workgroup members felt that if the loss was due to availability and cost to recover the vessel, it should not be considered a "total loss" for purposes of incident reporting. Others felt that if the loss were related to a safety issue that education could prevent, the "total loss" should be captured, regardless of whether the vessel was abandoned.

Before coming to consensus on the definition for "total loss," the workgroup considered the Uniform Certificate of Title Act – Vessels (UCOTA-V), which defines hull damage, but does not define loss; and discussed whether the threshold should be tied to an accident type. Ultimately, the suggestion was discarded for the sake of simplicity.

2.1.3. [Incident] Involved at least one of the following:

2.1.3.1. A vessel used for recreational purpose.

2.1.3.2. A State-numbered uninspected vessel.

These conditions align with current federal regulation (33 CFR 173 Subpart C, 173.51) on casualty and accident reporting. The requirements apply to vessels operated for recreational purposes, and that are required to be numbered under that Part. They do not apply to vessels subject to inspection under Title 46 USCG Chapter 33.

In deliberating on these conditions, some workgroup members expressed a desire to add a qualifier to "A State-numbered uninspected vessel" that would exclude commercial fishing vessels from federal reporting. However, the Coast Guard representatives noted that commercial fishing vessels cannot be excluded because they are still covered under applicable regulations. They cannot be passed off to another Coast Guard office at this time because the Coast Guard Commercial Vessel Compliance (which covers commercial fishing) does not have investigators, and the Coast Guard Office of Investigations and Analysis (CG-INV) does not have purview of state-numbered uninspected commercial vessels in their regulation. CG-BSX noted that there may be an opening for CG-INV to investigate state-numbered uninspected commercial vessels.

2.2. Incident should be further evaluated for a federal reporting requirement based on these conditions:

This next series of qualifiers is based on the vessel's operational status as the workgroup deemed operation a relevant framework for defining what should and should not be subject to a federal report. The conditions are not currently specified in regulation, but the recommended scenarios do reflect issues of particular interest to the National RBS Program and its goals.

2.2.1. For docked or moored vessels, a report to the Coast Guard is required if the incident involved one or more of the following events:

2.2.1.1. Carbon monoxide exposure

2.2.1.2. Stray electrical current that was attributed to the vessel

2.2.1.3. Fires/explosions that occurred while fueling or starting the vessel

In evaluating the merits of collecting data on these events, some workgroup members expressed a strong desire to exclude incidents involving docked or moored vessels that

were due to lack of maintenance—one reason why the number of scenarios intended to be captured for docked or moored vessels is limited. The rationale was that maintenance is only minimally touched upon in boating safety education, and unlikely to be regulated. Further, at least one workgroup member expressed concern about being able to differentiate between lack of maintenance, operator error, and fraud.

Conversely, other workgroup members argued that, depending on the circumstances, some incidents involving maintenance *should* be collected. Those workgroup members felt that if the docked or moored vessel were occupied at the time of incident, it should be considered a "reportable incident." Others thought that regardless of the number of people onboard, maintenance incidents should be subject to a report because the data could shed light on equipment problems (such as a certain bilge pump that had problems or a backfire flame arrestor that was not maintained and caused a fire).

Workgroup members discussed a scenario where a vessel took on water for unknown reasons. Members were initially split on whether to collect information on such incidents, but ultimately recommended deeming them "non-reportable."

Workgroup members also discussed a scenario where a vessel broke away from a dock, took on water and sank, or where a person did not moor the vessel properly which caused it to break away. Ultimately, the workgroup recommended excluding these incidents because it might be difficult to prove a person's fault, and a lot of times weather or equipment fatigue is the cause of these cases.

Workgroup members discussed a scenario where an operator forgot to put in the plug and the vessel subsequently took on water after launching while moored to the dock. Workgroup members expressed mixed opinions on whether this scenario should be considered "reportable." Some members noted that the vessel was not in operation at the time, while others noted that the vessel may have been operated (or at least guided to the dock from the trailer). Some felt education may have prevented the situation. Ultimately, the workgroup favored the exclusion of such a scenario.

Some workgroup members also expressed concern about collecting data on stray electrical current and carbon monoxide exposure, but acknowledged that these are issues that the National RBS Program highlights.

2.2.2. For anchored vessels, the list of "Non-Reportable Events" should be consulted (for list, see recommendations under 2.3 below and page 2 of the Decision Matrix in APPENDIX A). A report to the Coast Guard is required if the incident is NOT covered by one of the Non-Reportable Events.

Workgroup members felt that some incidents from anchored vessels should be reported to the Coast Guard because an anchored vessel is in a temporary holding environment.

One workgroup member initially thought that the only anchored vessel incidents that should be reported are those involving a vessel's construction or mechanical failure. There were concerns, however, about differences in interpretation about the role of construction. For instance, some investigators might not focus on the low-profile construction of a vessel that capsized because waves picked up; the investigator might instead focus on the environmental factors as contributors.

In weighing the merits of capturing some incidents involving anchored vessels, workgroup members considered the role that education could play in their prevention. For example, members of the subgroup that drafted the initial version of the Decision Matrix considered whether data regarding falls **on** anchored vessels should be captured, and ultimately recommended in the affirmative because fall prevention could be addressed through education. For instance, boater education would teach a person how to move around in a vessel, keeping a low center of gravity. One workgroup member, however, believed that some incidents could not be prevented through education, citing large raft-ups that cause damage due to winds that push the vessels together.

Regarding incidents involving falls **from** anchored vessels, a workgroup member felt that incidents involving "horseplay" should not be captured. Overall, however, the workgroup did not exclude the capture of falls from anchored vessels because education and outreach efforts could teach boaters situational awareness, and the frequency of cases involving horseplay was low.

2.2.3. For vessels that had an operational status other than docked, moored, or anchored, determination should first be made as to whether the incident was the result of any of the following:

This series of items, associated with known contributors to incidents, is intended to be used to further evaluate whether an incident should be reported to the Coast Guard. A response in the affirmative would lead to one final decision stage—consultation with the "Non-Reportable Events" list. The workgroup did not have any significant differences of opinion regarding the merits of using these contributors to screen the incidents.

2.2.3.1. operation

2.2.3.2. vessel's equipment

2.2.3.3. vessel's construction

2.2.3.4. loading of the vessel

2.2.3.5. vessel's seaworthiness

2.2.3.6. environmental forces

2.2.3.7. vessel's machinery

If the incident met at least one of these criteria, the list of "Non-Reportable Events" should be consulted (for list, see recommendations under 2.3. below and page 2 of the Decision Matrix in APPENDIX A). A report to the Coast Guard is required if an incident is NOT covered by one of the Non-Reportable Events.

2.3. Non-Reportable Events:

Not all incident reports received ultimately are determined by the Coast Guard to be "reportable," whether by regulation or policy. The recommendations associated with 2.1. and 2.2. (above)—in the context of the proposed two-tier system—are intended to guide the decision as to whether or not an incident would require a report to the Coast Guard. This recommendation 2.3, with list of events, is intended to further describe the types of scenarios for which a federal report would **not** be required. Currently, the primary source of examples of incident types that do and do not reflect current Coast Guard national RBS policy is found in the introductory section of the Coast Guard's annual recreational boating statistics publication. The scenarios described in this list could be updated via policy.

Of note: In discussions about possible "non-reportable" events, the workgroup considered incidents involving non-recreational and recreational vessels where the latter are innocent of fault. The general sentiment of workgroup members was that the State would investigate to determine if the recreational vessel involved was at fault. However, if the recreational vessel was docked or moored (for instance, in the case of a commercial tug that lost propulsion, drifted across the channel, and then impacted moored recreational vessels, thus causing damages that met the federal report threshold described in 2.1.2.4.), the incident would **not** need to be captured as "reportable" under this decision process.

2.3.1. Non-Reportable Event. Person voluntarily departed vessel: The first and only event involved a person voluntarily departing a vessel (or departing shore to swim after a vessel).

Before arriving at this recommendation, the workgroup focused on numerous scenarios involving swimming; the following reflect the group's considerations:

The workgroup emphasized the condition “first and only event.” If a person disembarked a vessel that had become grounded and, in the process, slipped and drowned, the incident should be reported to the Coast Guard because the grounding was the precipitating event. The workgroup recommended adding more examples to the “best practices” document that will be developed to accompany the incident Decision Matrix in order to provide greater insight.

The workgroup also considered situations in which a person departs a vessel to swim for various reasons. For instance, if a person departs to swim for pleasure and drowns, most workgroup members felt the incident should be excluded from federal reporting because they viewed the casualty as swimming-related, not boating-related. In the example of an incident involving a person who departs a vessel to retrieve a hat that has flown out of the vessel and subsequently drowns, the workgroup felt this too should be considered a “non-reportable” event because education would not have prevented the incident.

However, if a person departs a **disabled** vessel to swim, some workgroup members questioned whether this scenario should be captured as “reportable.” Some felt, for example, that a victim departing a disabled vessel in an attempt to clear a fouled prop would be “reportable” since the first event was vessel contact with an object. Others felt that a scenario involving a person departing a disabled vessel due to concerns for their safety (lack of communication, lack of others to assist, concerns about weather, etc.) *should* be reported because education could teach the person to stay with the vessel.

If a person simply departs the vessel and is injured (for instance, a person who jumps from an anchored vessel and impacts the cleat, thus causing injury), the incident should be considered “non-reportable.” Workgroup members felt that such a casualty should not be subject to a federal report as the injury was due to activities outside of the vessel.

2.3.2. Non-Reportable Event. <u>Towed watersports injury exceptions:</u> A person suffers an injury while participating in towed watersports (including wake surfing) that wasn’t due to the operation or equipment of a vessel.

The workgroup engaged in lengthy discussion about towed watersports injuries. Some members suggested such injuries should not be reported because their boating safety programs simply could not prevent some watersports incidents. Among the examples described by workgroup members were a wakeboarder who attempted a flip, fell, and twisted a knee, and a waterski club participant that became injured after falling as part of a “ski pyramid.” Workgroup members argued that in both cases the towed participant’s actions alone contributed to the incidents and that their education programs would not have been able to prevent these incidents. Therefore, they recommended adding a non-reportable event for any towed watersports incident that could not be attributed to the operation or equipment of a vessel.

In the course of discussion, alternate proposals were suggested for the content of this exclusion. One suggestion --“the first and only event was a self-inflicted injury of a watersports participant” -- was discarded because “self-inflicted injury” might not reflect the root of the problem. A workgroup member was concerned that the aforementioned waterski team member who fell from the top of a human pyramid and became injured would not be interpreted as “self-inflicted.” Another suggestion-- “while participating in towed watersports, a person suffers an injury that was not due to the operation of the vessel”—was discarded by the workgroup because members felt there could be injuries that should be captured that would not have been due to operational factors. One example is a person who suffers an injury after becoming tangled in the tow line. Reference to a “sports-related injury” also was discarded because some workgroup members felt “boating” ***is*** considered a sport.

Some members questioned whether an exclusionary statement was even necessary since the decision process described in recommendations 2.1. and 2.2. (above and on page one of the Decision Matrix) has the “all other vessel operational statuses” qualifier. That qualifier would seem to exclude the desired towed watersports incidents since operation of vessel, construction, machinery, equipment, loading, and environmental factors would not apply. However, workgroup members expressed interest in including a statement to make clear that some towed watersports incidents could be excluded from federal reporting.

There were, however, some members who still felt that **all** towed watersports incidents should be captured in the name of consistency. They were concerned that an officer/investigator might inadvertently interpret all towed watersports injuries as "excluded" and thus would end up reporting none of them, regardless of the circumstances. They also expressed concerns about the universal interpretation of this "non-reportable" event. If two officers viewed the same towed watersports incident, one might identify a wake as a contributing factor, while the other would not. As a result, only one would report the incident, thus creating inconsistencies in the data collection.

Other workgroup members argued that it might not be immediately apparent what caused an injury, or whether the operation of the vessel was, in fact, a contributor. If two watersports occupants collided with each other, vessel speed could have been a factor. Some workgroup members argued that ultimately these incidents warranted reporting as the data collected could be used to evaluate and refine operator education since the operator is responsible for the boat and safety of its occupants. Further, some members felt that there were parallel cases that did not involve towed watersports that would be considered "reportable" boating incidents. One example was a person who suffers an injury while walking on the deck of a vessel that is underway. The fall was not a result of the vessel's operation or environmental conditions, but was instead due to the occupant's behavior. A workgroup member questioned why one incident involving occupant behavior would be captured whereas another incident involving a towed watersports participant's behavior would be excluded.

Although the group ultimately arrived at consensus on this recommendation, members still expressed mixed opinions about whether some incidents involving towed watersports participants should, in fact, be considered "non-reportable" for federal purposes. Of note is that the majority in favor did not think there would be a drastic reduction in the number of towed watersport incidents reported.

The feedback from the first comment period, however, did not fully resolve the mixed opinions. At least one workgroup member believes that all towed watersports injuries should be reported because there might be "too fine a line" for an investigator to determine if operation or equipment was a contributor. Similar issues were raised by some participants in the Spring 2019 BLA Workshop during a March 1 session on this project. During its discussions on the feedback to date, the project workgroup considered the likelihood that this—and others of these non-reportable events—may involve more of a training issue (which speaks to the need for the best practices document intended to accompany the Decision Matrix). Ultimately, however, the project workgroup decided that for purposes of the second comment period and in the interest of gathering more feedback, that it should retain the recommendation as is and await the additional input and airing of all relevant issues and alternatives.

2.3.3. Non-Reportable Event. <u>Vessel use exceptions:</u> The only vessel(s) involved were used solely for governmental, criminal (activities in the course of a criminal offense, with the exception of impairment and boating safety-related offenses), disaster response, or sanctioned activity (when competing in an organized or sanctioned race or training program approved by a national or international body, or by appropriate permit, and where adequate safety precautions are in place).

In developing this recommendation, workgroup members wanted to differentiate between rescues and disaster response. Members felt that rescues should be reportable, and to make their point, cited a case where a husband and wife kayaked in separate vessels. In the incident, the husband experienced some difficulty and capsized, and when his wife tried to assist him, she also experienced some difficulty, capsized, and became a casualty. The wife, even though she was attempting to rescue another, was still viewed as a participant in recreational boating, and the group felt this incident should be "reportable." Likewise, Good Samaritan rescues still involve recreational vessels and recreational operators, and data from such incidents would benefit operator education about safe loading when assisting occupants in the water.

On the other hand, the workgroup felt that disaster response should be considered "non-reportable." The term "disaster response" is intended to capture events of greater magnitude such as floods, post-storm search and rescue, or salvage. The people involved in such activities would not be viewed as being involved in recreational activity.

In feedback from the first comment period, one of the commenters suggested that the recommendation—especially with regard to the criminal use of a vessel—should be more specific in excluding not only damages causes by the vessels, but also any injuries or fatalities resulting from the activities. In its discussions on the feedback, the project workgroup did not see the need to add the commenter's suggested qualifying language. In this recommendation, if the only vessel involved was used for—and thereby excluded for any of the stated purposes—then any resulting damages, fatalities or injuries (with the exception of the named impairment or boating safety related offenses) would be excluded from federal reporting.

Of note: In a previous iteration of this recommendation, the workgroup also had excluded the reporting of incidents that solely involve state-numbered uninspected "**commercial**" vessels. However, as described on page 13 regarding recommendation 2.1.3.2, the Coast Guard currently cannot exclude such reports because they are included in regulation. If the Coast Guard were able to modify regulation to remove purview of these incidents from CG-BSX to another Office, then they could be excluded from reporting and this "non-reportable event" would be updated to reflect that.

2.3.4. Non-Reportable Event. Self-inflicted injuries: Self-inflicted injuries were the cause (examples include: self-inflicted wounds, ingestion of controlled substances or poison, gunshot wounds).

2.3.5. Non-Reportable Event. Assaults: A person suffers an injury, dies, or is missing as a result of an assault by another person or persons while aboard a vessel.

The project workgroup added this event to the list as a result of feedback received in the first comment period noting the oversight. The Coast Guard's Recreational Boating Statistics report (p.10) currently includes assaults among the federal non-reportable scenarios.

2.3.6. Non-Reportable Event. Medical events: A medical event (does not include physical impairments such as poor eyesight, poor hearing, or mobility difficulties) was involved, when the vessel did not contribute, and when no other reporting threshold was met.

Historically, the term "sudden medical condition" had been used. The workgroup recommended revising this term to "medical event" to reflect a spontaneous, unexpected event versus a pre-existing condition. A comparable modification was subsequently made to a similar term presented in the Contributing Factors/Causes list referenced in recommendation 5.4.5. and included in **APPENDIX G**.

In this "non-reportable event," the condition "no other reporting threshold was met" is important because some incidents involving a medical event might require a report if something else happened that met a federal report threshold. For instance, if an operator went into cardiac arrest, became incapacitated, grounded the vessel and sustained $16,000 in damages, then the incident would be a "reportable incident" and require a report to the Coast Guard. If the operator just went into cardiac arrest and nothing else happened to the vessel or other people, it would be considered a "non-reportable" incident and would not require a report to the Coast Guard.

However, workgroup members initially held differing opinions as to whether "no other reporting threshold was met" really should be included in this "non-reportable" scenario. Some felt that such incidents could not be positively impacted through education or regulation, whereas at least one workgroup member suggested that a State could prevent it by recommending in boating safety education that people with pre-existing medical conditions have a backup plan for operation if the person were to become incapacitated.

Workgroup members noted that a death or injury associated with the medical event should not be captured in an incident report if the vessel did not contribute to the medical event. An example is an operator who dies due to a medical event and grounds the vessel causing damages in excess of the reporting threshold. In the incident report, the grounding (with damages) would be captured, but a death record for the person who died from natural causes while onboard the vessel would not be entered. The workgroup recommended clarifying this in the "best practices" document that will be developed to accompany the incident Decision Matrix.

2.3.7. Non-Reportable Event. <u>Watercraft not a "vessel"</u>: The only watercraft involved were not considered "vessels" (examples include: a pool float toy, innertube, float tube propelled by feet or fins, surfboard, submersible, diving propulsion aid, stock tank, air mattress, fish box, floating dock, unmodified log, snowmobile, and/or seaplane).

*** Per recommendation 4.1.1., "For purposes of the national RBS program and casualty reporting, the parameters for a "Vessel" should be a watercraft—capable of holding at least one person—that is intended to be propelled through the use of a paddle, motor, sail, etc., as a means of transportation on the water."**

This non-reportable statement recommended by the workgroup aligns with related recommendations made regarding Vessel Determinations (see items under **Section 4.1 Determining which watercraft are vessels,** and especially recommendation 4.1.3.). The definition of "vessel" from recommendation 4.1.1. was added as a result of the project workgroup's consideration of feedback received during the first comment period. The workgroup agreed with commenters' suggestions that references to definitions—whether presented in other recommendations or in U.S. Code or CFR—should be made as needed throughout the package of recommendations.

2.3.8. Non-Reportable Event. <u>Foreign flag vessels</u>: The only vessel(s) involved were foreign flag vessels.

Workgroup members recommended this statement since States would not have authority to investigate incidents involving foreign flag vessels.

2.3.9. Non-Reportable Event. <u>Natural phenomenon:</u> A natural phenomenon was involved (such as interaction with marine life (e.g., carp causes injury to person) and interaction with nature (e.g., mountain side falls onto vessel causing damage)) when no other event occurred and when no other reporting threshold was met.

In this recommended "non-reportable event," the qualifiers "when no other event occurred" and "when no other reporting threshold was met" are important because some incidents involving natural phenomenon would be subject to a report if a secondary event occurred and at least one of the reporting thresholds was met. For instance, if an operator was distracted because he was hit by a leaping sturgeon, which in turn caused him to crash into mangroves and cause an additional injury, it would be considered a "reportable" boating incident and a report would be required to the Coast Guard. However, if the incident solely involved an operator being hit by a leaping sturgeon causing an injury that met the threshold, and nothing else happened, a report would not be required to the Coast Guard. If a person was bit on the finger by a fish resulting in an injury that met the threshold and nothing else occurred, the workgroup members felt the incident should be considered a fishing incident, not a boating incident.

The question arose as to whether this exclusion scenario, as written, encapsulates all desired events. For example, one member described an event in which a whale was harpooned and hit the vessel, sinking it. While acknowledging that another event occurred—the vessel sank—the member did not feel the incident should be reported because the whale was the cause of the sinking. Other members argued that the people onboard were at risk as a result of the vessel sinking, one solid reason it could be considered "reportable." Though it would most likely be difficult to predict a whale strike, they suggested that boaters could still be educated about the possibility, just like boaters could be educated about a possible fish strike while traveling up a river known for leaping sturgeon.

Beyond whether boaters can be *educated* about such events, however, is the question of whether incidents involving natural phenomena can be *prevented*. Historically, the Coast Guard has tracked some incidents involving natural phenomena to match the practices of other federal agencies. For instance, the highways program administered by the National Highway Traffic Safety Administration (NHTSA) has collected information on incidents involving cars hit by tumbling cliff rocks, and has attempted to prevent these incidents by posting warning signs of "falling rocks." Likewise, the Coast Guard has witnessed incidents where tumbling rocks impact a vessel. The prospects of changing behavior based on a sign was met by skepticism by at least one workgroup member who, as a driver, said that changing behavior (driving faster or slower to avoid the posted hazard) could inadvertently cause an accident. On the other hand, another member pointed out that warning signs of the risk of

"hazardous waters ahead" sometimes prevents boaters from approaching a waterway, thus averting danger. However, while signs can warn people of *known* dangers ahead, other events may occur with little to no warning.

In the first comment period, one of the commenters relayed a fatality scenario involving a boater's failure to heed a tornado warning; his question was whether such an event would be non-reportable under this "natural phenomenon" description. After discussing this and other weather-related scenarios, the workgroup agreed to retain the recommendation as currently stated for purposes of gathering additional feedback in the second comment period. However, the group also agreed that further explanation of how to handle weather-related circumstances should be provided in the best practices document that will need to be developed to accompany the Decision Matrix.

2.3.10. Non-Reportable Event. Launching/recovery injuries, fatalities, damages: Launching or recovery when the vessel is not on the water and capable of use (free from the apparatus from which it is being launched).

2.3.11. Non-Reportable Event. Embarking/disembarking injuries, fatalities: A person suffers an injury while embarking or disembarking a docked, moored, or anchored vessel, when no other event occurred and when no other reporting threshold was met.

In this recommendation, the mentions of "docked" and "moored" are not really necessary because, according to the criteria in the Decision Matrix, there are only three events associated with docked or moored vessels that would require a report to the Coast Guard: carbon monoxide exposure, stray electric current from a vessel, and specific fires/explosions. However, the workgroup named them in this recommendation to reinforce their exclusion.

The qualifiers "when no other event occurred" and "when no other reporting threshold was met" are important because some incidents involving embarking or disembarking would be considered "reportable" if a secondary event occurred and a threshold was met. For example, if as a secondary event a person is struck by the vessel and suffers an injury, then a report would be required. However, if the person just pulled a hamstring while trying to enter the vessel, or if a swimmer kicked a non-moving propeller while attempting to board from a ladder, the incident would be considered a "non-reportable" event.

Another example involves people swimming from an anchored vessel and trying to climb in from the side, causing the vessel to swamp. The workgroup recommended that this scenario be considered "non-reportable" because proper boarding methods are not taught in boater education. One workgroup member noted that construction was not necessarily a factor, since there are not many vessels designed to be boarded from the side.

2.4 Best Practices should be developed to accompany the Recreational Boating Incident Report Decision Matrix (see APPENDIX A for this graphical representation).

The Matrix—the graphic representation of the decision criteria presented under recommendations 2.1. and 2.2. above—was developed with the intent of providing an easy reference for an officer/investigator to use to determine whether an incident will require a report vice reviewing a lengthy list of statements such as those that currently appear in the introductory section of the Coast Guard's annual recreational boating statistics reports (see, for example, pages 9-11 of the 2017 statistics publication). The "non-reportable events" section of the Decision Matrix (presented as recommendations 2.3.1 through 2.3.11 above) was designed to weed out those incidents that could not be prevented through education, enforcement, or regulation.

In an initial draft version, the Matrix also included information about the State Reporting Authority's reporting responsibilities and projected timelines associated with those responsibilities. However, the workgroup decided that it would be preferable to create a second quick reference sheet that would focus on key programmatic issues such as reporting timeframes, bridge allision notifications, and safety defect notifications. Associated "best practices" will be created in Phase 2 of this collaborative policy project.

The workgroup further recommended that the next-generation reporting system—specifications also to be drafted in Phase 2 of the project—should have the "best practices" document(s) and Matrix available as reference files.

It is worth noting that despite the overall consensus of the workgroup that the Decision Matrix will be a useful tool, some members reminded the group that it might not cover all events that will arise, and others had varying opinions about who would employ the Matrix. Some thought that States might want to widely distribute it for officers to use in the field, while others thought that it might be kept more centralized at the State Reporting Authority level. The differences centered in part on speculation about which method would most likely result in consistent application and interpretation: some members felt that if the Matrix were distributed widely to officers, it might lead to differences in interpretation, whereas if it were centralized, there might be more consistent interpretations. Ultimately, however, the combination of "best practices" and training—and, eventually, the creation of an electronic version of the Matrix that would prompt the user at each stage of the process—should assist the States in achieving effective, accurate, and consistent application of the decision criteria.

3. GATHERING DATA, REVIEWING, AND SUBMITTING FINAL REPORTS

RECOMMENDATIONS (see detail below)

Within 60 days of notification of an incident, the State Reporting Authority should submit all available information on that incident to the Coast Guard. *[The recommended data elements associated with "all available information" – whether for mandatory or voluntary collection nationally—are presented under **Section 5. Incident Report Data Elements, Fields and Definitions**.]*

There should be a requirement for the State Reporting Authority to review the final incident report (containing all available information).

The Coast Guard should review and accept the final report from the State Reporting Authority as is or request clarification on missing or confusing information within the report.

BACKGROUND

As previously described, current federal regulations require the operator to submit the casualty or accident report in cases where the reporting thresholds are met (33 CFR 173.55), within set timeframes, and to provide all of the detailed report information requested in 33 CFR Part 173.57. The State Reporting Authority, in turn, is required to forward the report to the Coast Guard within 30 days of receipt of the report. The recommendations under **Section 1. Incident Reporting Structure: Initial notification of and follow-up on recreational boating incident** described the revised collection of information in the context of initial notification within the two-tier reporting system, and would update current regulatory provisions to accommodate a 15-day timeline from notification for the State Reporting Authority's submission of the preliminary data to the Coast Guard. The recommendations below, which also would require revisions to current regulations, describe a modified timeline for submitting final ("all available") report data on an incident as part of the second (investigative) tier; present a preliminary look at the review requirements and relationship of these activities to determine a State's compliance; and describe the terms of the Coast Guard's review and acceptance of an incident report. The proposed data elements associated with "all available information" can be found under **Section 5. Incident Report Data Elements, Fields and Definitions**.

3.1 Within 60 days of notification of an incident, the State Reporting Authority should submit all available information on that incident to the Coast Guard.

The workgroup specifically added the words "***of notification***" to the 60-day timeframe to ensure that States would not be "on the hook" for submitting information on incidents for which they received late notification. The words "all available information" are associated with the proposed data elements for the final report (see recommendations under **Section 5. Incident Report Data Elements, Fields and Definitions**) and acknowledges that certain information associated with an incident, such as laboratory results or medical examiner's determinations, may take time to process.

During the first comment period, questions were posed as to whether the recommendation needed to be more specific regarding the mechanism(s) for submitting the information to the Coast Guard, and whether a newcomer to the reporting process and responsibilities might unnecessarily assume that the submission would need to include all of the reports and documentation created as part of an investigation.

In taking up these questions, the workgroup's discussions revolved around two issues—first, the mechanism for report submissions, and second, the need to familiarize new BLAs with their roles and responsibilities regarding the reporting process. A Coast Guard member of the workgroup said that the intent is to go all electronic with report submissions, and that what "reporting" or a "report" is will need to be defined in regulation. The workgroup further acknowledged that the reporting process should be covered in multiple ways with new BLAs (e.g., via the best practices to be developed per this project; in accord with the NASBLA strategic plan and intent to develop a resource on the BLA's national responsibilities; and as a possible NASBLA Leadership Academy session). With those things in mind, the workgroup agreed to retain the recommendation as currently stated, and continue to gather more feedback during the second comment period.

3.2 There should be a requirement for the State Reporting Authority to review the final incident report (containing all available information). The outline below reflects initial Coast Guard thinking, shared with the workgroup in response to concerns expressed by State members about setting timelines for the review and uncertainties about the relationship to measures of "compliance." Formal language on compliance will not be drafted by the Coast Guard until consensus is reached on the final recommendations.

While formal language on "compliance" cannot be drafted until the final recommendations from this project achieve consensus among the stakeholders, the Coast Guard representatives to the policy workgroup shared **basic concepts from their initial, internal discussions:**

- At the end of the 60 days of notification of an incident, the State Reporting Authority would be required to enter all available information, along with any caveats about outstanding information (such as coroner's or laboratory reports). The "clock" would stop at that point, and the Coast Guard would use the information gathered within 60 days as a mark of compliance.

- If more information were to become available on an incident, the record could be updated, and should be updated before data are pulled for the annual, national statistics publication.

- Regardless of whether updated data would be used in the annual statistics publication, the State would still be expected to update its record(s). However, an update would **not** be used by the Coast Guard as a measure of compliance.

- To facilitate this process, the future reporting system should accommodate the incident record status so that the State Reporting Authority can indicate whether all available information was reviewed and expected as final or whether information was reviewed but was not yet final due to outstanding information.

The Coast Guard expressed a desire to set up a timeline for a final review for the sake of accountability. State members, however, expressed concerns over extenuating circumstances (for example, the availability of people to review a report in a chain of command, the timeliness of reporting and updating reports based on input from agencies that are not under the State Reporting Authority's command, and the holdup of lab or other medical reports that are needed in order to complete a review) that might affect a timeline for review and the use of timelines as a compliance measure.

Some workgroup members requested that the deadline for the final review of reports be the end of the reporting cycle. The Coast Guard representatives expressed concern about having the timeline at the end of the reporting cycle because it could burden their agency. If a lot of reports were submitted at the very last opportunity, the Coast Guard would be at a severe disadvantage to process all information and produce the annual national recreational boating statistics publication in a timely manner.

3.3 The Coast Guard should review and accept the final report from the State Reporting Authority as is or request clarification on missing or confusing information within the report.

In making this recommendation, workgroup members further expressed a desire that the Coast Guard accept the state's determination of whether an incident should be reported. Some members also expressed a desire for the final statistics to match so that States do not have to entertain questions about any differences between their counts and what the Coast Guard publishes in the national boating statistics report. The expectation is that with the implementation of the incident report Decision Matrix, there will be fewer, if any, discrepancies between the States' numbers and the Coast Guard's.

4. VESSEL DETERMINATIONS

RECOMMENDATIONS (see detail beginning p. 24)

For purposes of the national RBS program and casualty reporting, the parameters for a "Vessel" should be a watercraft—capable of holding at least one person—that is intended to be propelled through the use of a paddle, motor, sail, etc., as a means of transportation on water.

At the national level, the Coast Guard determines whether certain watercraft are "vessels." There should also be a list of the watercraft that are determined NOT to be "vessels."

Examples of watercraft that the Coast Guard should classify as NOT being "vessels"—for purposes of the national RBS program--include: a pool float toy, innertube, float tube propelled by feet or fins, surfboard, submersible, diving propulsion aid, stock tank, air mattress, fish box, floating dock, unmodified log, snowmobile, and/or seaplane.

Currently, vessel determinations are made by the Coast Guard on an as-requested basis. In the future, a standing group of State and Coast Guard representatives and other stakeholders as may be identified should be formed to help make vessel determinations periodically.

Following are recommendations regarding certain vessel determinations already issued by the Coast Guard:

"Paddleboard" and "Kiteboard" have both been deemed by the Coast Guard to be vessels when "outside the narrow limits of a swimming, surfing or bathing area."

- **Recommendation:** "Paddleboard" and "Kiteboard" should be retained on the current list of vessel determinations pending the Coast Guard's internal review of the entire vessel determination process.

"Argo Amphibious ATV" is a device equipped with 6x6 or 8x8 wheel drives capable of land speeds up to 22 mph and floating on water with speeds up to 2.5 mph, using tire treads to propel through the water; some models also may be equipped with an outboard motor. While on the water, the device is considered by the Coast Guard to be a vessel.

- **Recommendation**: This vessel determination—the vessel term "Argo Amphibious ATV" and its definition—should be revised so that it is more representative of all amphibious craft and not just specific to one manufacturer.

"Gold dredge" is a device of traditional hull types (e.g., monohull, pontoon, etc.), propelled by propulsion machinery (typically outboard motors) used to mine gold off the ocean floor. The devices have been deemed vessels by the Coast Guard.

- **Recommendation:** "Gold dredge" should be retained on the list of devices the Coast Guard has determined to be vessels.

"Float tube" is a tube (typically encased rubber inner tube(s) or a hard-plastic tube) that has a built-in seat, with the operator's legs sticking through the seat and dangling in the water below the tube. They often have small storage compartments for fishing or gear. The operator, typically a fisherman, wears swim fins to manually steer and/or propel the craft, and often wears chest waders to maintain heat and stay dry. Non-motorized float tubes are propelled by the use of the swim fins; motorized float tubes are propelled by an electric or hand pump motor, with the operator using the swim fins to steer the craft and sometimes to assist in its propulsion.

- **Recommendation:** A "Float Tube" that is propelled by feet or fins should not be considered a "vessel" as it is similar to an unmodified innertube. A motorized "Float Tube," on the other hand, should be considered a "vessel" (i.e., it would be designated as an "Open Motorboat").

BACKGROUND

1 U.S.C. § 3 provides the foundation for the definition of a vessel. It is broad, encompassing "… every description of watercraft or other artificial contrivance used, or capable of being used, as a means of

transportation on water." 33 CFR Part 183, which prescribes standards and regulations for the manufacturing of boats and associated equipment, provides a definition of a boat that is not used for boat incident reporting purposes.

The recommendations below, which do not propose to modify the aforementioned statutory and regulatory definitions, are associated with the determination of which watercraft are "vessels" for purposes of the requirements of the Coast Guard's recreational vessel incident reporting program.

Currently, the Coast Guard prepares vessel determinations whenever there is a request to do so. Usually, the request originates from a State Boating Law Administrator (BLA). The Coast Guard uses guidance from its Legal Department for these determinations, focusing on whether existing regulations apply to a vessel, whether a vessel is "practically capable" of being used as a means of transportation, and whether the National RBS Program would be able to make a difference in the operation of such craft (for instance, through education).

4.1. DETERMINING WHICH WATERCRAFT ARE "VESSELS"

4.1.1. *For purposes of the national RBS program and casualty reporting*, the parameters for a "Vessel" should be a watercraft—capable of holding at least one person—that is intended to be propelled though the use of a paddle, motor, sail, etc., as a means of transportation on water.

In recommending criteria for watercraft that should be identified as "vessels" for purposes of the National RBS Program and incident reporting, the workgroup focused on the craft's capability for holding a person, the ability to navigate, and having a means of propulsion.

The condition of being "capable of holding at least one person" would rule out devices that are meant to serve solely as propulsion aids while a person is in the water. An example is a handheld water device that propels a swimmer. Boater education would not address such a device or its use.

The ability to navigate is addressed with the criterion that the watercraft be propelled through the use of a paddle, motor, sail, ***etc***. as a means of transportation. In the first comment period, one of the commenters suggested that such a definition should not have an "etc." in it because that raises more questions. The workgroup appreciated the intent behind the comment, but ultimately decided to leave the means of propulsion open ended in this way and gather more feedback on the recommendation during the second comment period.

In considering propulsion, the workgroup weighed whether **the intent** of propulsion should factor into the definition. For example, there could be instances where a person takes a craft out without a means of propulsion (an alcohol-impaired person pushes a rowboat off the shore and realizes too late that they do not have an oar) or where a person loses their means of propulsion (drops a paddle while in rough waters). The workgroup thought that such watercraft would still be considered "vessels" because a means of propulsion was "intended" to be present on the watercraft. On the other hand, it would exclude craft like a surfboard that moves by force of a wave.

4.1.2 At the national level, the Coast Guard determines whether certain watercraft are "vessels." There should also be a list of the watercraft that are determined NOT to be "vessels."

4.1.3 Examples of watercraft that the Coast Guard should classify as NOT being "vessels"—for purposes of the national RBS program--include: a pool float toy, innertube, float tube propelled by feet or fins, surfboard, submersible, diving propulsion aid, stock tank, air mattress, fish box, floating dock, unmodified log, snowmobile, and/or seaplane.

This list represents the workgroup's consensus as to the types of watercraft that even if used on a navigable waterway, should **not** be considered a "vessel" for federal reporting purposes because the National RBS Program would not be able to impact these users. The intent of manufacturing was discussed and then discarded as a factor.

In further discussions, however, the workgroup considered whether the presence of propulsion on any of the named watercraft would change their status from “not being a vessel” to a “vessel” for reporting purposes. The workgroup suggested that it would be circumstantial. If a float tube were taken out on the water with a paddle, the workgroup still would not recommend that watercraft be deemed a “vessel.” However, if a piece of board were modified to place a motor on the back, thus prompting the state to issue a HIN, the watercraft could be considered a vessel. Additional guidance in a “best practices” document would assist the Coast Guard and the States in determining when such a device would become a “vessel” based on certain modifications.

While there was consensus on this recommendation, one workgroup member noted that some States may have difficulty adhering to the recommended list of watercraft not considered vessels. For example, California’s Legal Department considers innertubes to be “vessels” because they are used as a means of transportation from point A to point B. The State Reporting Authority would still need to continue to keep track of incidents involving them. A Coast Guard member on the workgroup noted, however, that a State could consider an innertube or any other device on the list a “vessel” for State reporting purposes, even if federally, the Coast Guard would not.

4.1.4 Currently, vessel determinations are made by the Coast Guard on an as-requested basis. In the future, a standing group of State and Coast Guard representatives and other stakeholders as may be identified should be formed to help make vessel determinations periodically.

In the first comment period, one of the commenters reminded that while the States would make recommendations to such a standing group, the Coast Guard would have the final say on the vessel determinations. The project workgroup understood the concern, but did not modify the recommendation as members thought that the phrase “help make” was sufficient to convey that the standing group would not be making the ultimate decisions.

4.1.5 Following are recommendations regarding certain vessel determinations already issued by the Coast Guard:

4.1.5.1 “Paddleboard” and “Kiteboard” have both been deemed by the Coast Guard to be vessels when “outside the narrow limits of a swimming, surfing or bathing area.”

Recommendation: “Paddleboard” and “Kiteboard” should be retained on the current list of vessel determinations pending the Coast Guard’s internal review of the entire vessel determination process.

When the workgroup first reviewed the conditions of the current vessel determinations for paddleboards and kiteboards, members’ initial reaction was to recommend striking the words “outside the narrow limits of a swimming, surfing or bathing area.” The sense of the group was that location should not determine whether a watercraft is a vessel. Several thought that the manufacturing or design would be more important to consider than the location in which the craft is used.

With regard to the stated parameters, some workgroup members argued that “swimming areas” are not always marked, although a Massachusetts member noted that even while a swimming area may not be marked, the State has a rule whereby a vessel is not supposed to operate within 150 ft of the shoreline, a parameter that could be considered a swimming area. Between 150 and 300 ft, a vessel is supposed to travel at headway speed.

However, upon further internal consideration, the Coast Guard members expressed concerns to the rest of the workgroup over removal of the phrase “outside of a swimming, surfing, or bathing area,” notably for how it relates to life jacket carriage requirements. There was concern, for example, that standup paddleboarders in a surf zone would be required to carry a life jacket if their craft were considered to be a vessel in all situations. A person using a standup paddleboard in that zone should not be wearing a life jacket as it would hinder their ability to swim into the crashing waves. In order for the Coast Guard to support the original recommendation, it would need to obtain a life jacket carriage exemption for certain craft when inside a swimming, surfing, or bathing area.

Other group members made some suggestions for how the vessel determination could be worded. One was to consider the craft to be vessels in all circumstances but to base carriage requirements on location; another was to consider them vessels in all circumstances but to exclude them from casualty reporting based on location.

Ultimately, the group decided to abstain from a recommendation for modifying the current determinations. However, the group did recommend, upon counsel of the Coast Guard members, that the Coast Guard use these issues as a starting point for figuring out a new process for making vessel determinations.

4.1.5.2 "Argo Amphibious ATV" is a device equipped with 6x6 or 8x8 wheel drives capable of land speeds up to 22 mph and floating on water with speeds up to 2.5 mph, using tire treads to propel through the water; some models also may be equipped with an outboard motor. While on the water, the device is considered by the Coast Guard to be a vessel.

Recommendation: **This vessel determination—the vessel term "Argo Amphibious ATV" and its definition—should be revised so that it is more representative of all amphibious craft and not just specific to one manufacturer.**

4.1.5.3 "Gold dredge" is a device of traditional hull types (e.g., monohull, pontoon, etc.), propelled by propulsion machinery (typically outboard motors) used to mine gold off the ocean floor. The devices have been deemed vessels by the Coast Guard.

Recommendation: "Gold dredge" should be retained on the list of devices the Coast Guard has determined to be vessels.

For this watercraft, the Coast Guard noted that the vessel determination had originally been made with respect to carriage requirements, not casualty reporting requirements. While some workgroup members recommended completely removing the vessel determination for "gold dredge" because it reflected an activity and not a vessel type, others recommended retaining the vessel determination because there would be no apparent harm in doing so, there are few incidents involving them, and its impact is very narrow (thus far, affecting only Alaska). However, the workgroup recommended that a "best practice" be developed to encourage selection of a traditional vessel type (such as pontoon or open motorboat) when capturing data on an incident involving a "gold dredge."

4.1.5.4 "Float tube" is a tube (typically encased rubber inner tube(s) or a hard-plastic tube) that has a built-in seat, with the operator's legs sticking through the seat and dangling in the water below the tube. They often have small storage compartments for fishing or gear. The operator, typically a fisherman, wears swim fins to manually steer and/or propel the craft, and often wears chest waders to maintain heat and stay dry. Non-motorized float tubes are propelled by the use of the swim fins; motorized float tubes are propelled by an electric or hand pump motor, with the operator using the swim fins to steer the craft and sometimes to assist in its propulsion.

Recommendation: A "Float Tube" that is propelled by feet or fins should not be considered a "vessel" as it is similar to an unmodified innertube. A motorized "Float Tube," on the other hand, should be considered a "vessel" (i.e., it would be designated as an "Open Motorboat").

5. INCIDENT REPORT DATA ELEMENTS, FIELDS, AND DEFINITIONS (see also summary chart in APPENDIX B, and specific report category lists in APPENDICES C, D, E, F, and G)

BACKGROUND

Current federal regulation (33 CFR 173.57) details the collection of information on a recreational boating incident report that is then submitted by the State Reporting Authority to the Coast Guard according to the

requirement in 33 CFR 173.55. Over the years, additional incident data elements, beyond what are prescribed in regulation, but still within the scope of the National RBS Program, have been included for collection in support of the goals and strategies of the Program. The compilation is then presented by the Coast Guard in its annual recreational boating statistics under the authority of 46 U.S.C. § 6102.

Recommendations presented thus far outlined the gathering and submission of preliminary information following notification of an incident (recommendation 1.9) and the projected timeline for the State Reporting Authority to submit "all available information" about that incident to the Coast Guard (recommendation 3.1). In developing the following series of recommendations as to what should constitute "all available information," workgroup members weighed the most critical components of a final report to the Coast Guard—that is, the data "elements" or broad categories of data that the group would recommend for national collection along with the related "fields" or descriptive selections for each element.

In this task, the group reviewed and evaluated the relevance and utility of the data currently prescribed in 33 CFR 173.57 and on the Coast Guard Boating Accident Report form (CG-3865). Elements were identified for retention, modification, deletion, or in several cases, were identified as worthy of new collection. The proposed data elements are presented in this section and are also summarized in the chart in **APPENDIX B.** When there is a large volume of information, the detail is not presented in the recommendation, but instead appears in one of the lists contained in **APPENDICES C, D, E, F, and G**. Unless otherwise noted as optional/ voluntary/at the State's discretion, the recommendations are for mandatory collection nationally, with all jurisdictions employing the same terms and definitions for the sake of consistency and accuracy; for easier analysis of factors associated with boating incidents; and to help inform development of national- and State-level safety policies, programs and campaigns. The expectation is that while the incident report data collection form would be referenced in an updated regulation, the actual data items would be incorporated into a policy document that could be refreshed more frequently to adapt to changing recreational boating safety issues and needs.

The data elements are presented under broad categories of Environmental/External (5.1), Where and When the Incident Occurred (5.2), Vessel Characteristics (5.3), Incident Details (5.4), Damages to Vessels and Other Property (5.5), and People Associated with the Incident (5.6).

5.1 ENVIRONMENTAL / EXTERNAL

5.1.1 Data on the Overall Weather Conditions should continue to be collected, with preference for the following basic options: Clear, Cloudy, Foggy, Hazy, Raining, Snowing, Other. Consideration should be given to providing guidance for the selections in a Best Practices document.

Some workgroup members felt that since "foggy" and "hazy" could be similar, it would be beneficial to develop additional guidance in a "best practices" document.

In other discussions on this element, some workgroup members suggested adding a question about whether the weather at the time of the incident was "as forecasted," citing concerns that often times the weather can change in the blink of an eye.

5.1.2 Data on Visibility should continue to be collected, with preference for the following basic options: Good, Fair, Poor. Consideration should be given to developing parameters or other guidance in a Best Practices document to help better define these Visibility options.

In discussions on a possible ready-made source for parameters, one workgroup member suggested consulting existing guidelines from NOAA.

5.1.3 Data on Wind should continue to be collected, with preference for the following options: no wind (0 mph), light (1-6 mph), moderate (7-14 mph), strong (15-25 mph), stormy (>25 mph), and an additional option of "unknown."

5.1.4 Data on Air Temperature should continue to be collected, but with the following changes: mandatory selection from a range of air temperatures (in Fahrenheit) defined as "Under 30,

30-39, 40-49, 50-59, 60-69, 70-79, 80-89, 90-99, 100 and above, and unknown"; and a field for voluntary reporting of an actual/estimated temperature (in Fahrenheit).

The workgroup modified the categories used in the Coast Guard's annual statistics publication to reflect a broader range of air temperatures (to accommodate southern and southwestern states). A look at five years of data in the U.S. suggested air temperature ranges between 0 to 121 degrees Fahrenheit.

Some workgroup members felt that a range would facilitate reporting of temperature because often times the exact or appropriate temperature may not be known by the State Reporting Authority as a result of late notification or varying temperatures over an area. Members thought that the introduction of ranges would encourage a response. Further, some felt that reporting a range vice an actual/estimated figure would not result in the loss of any crucial information.

On the other hand, some members wanted the opportunity to report actual or estimated temperature. They argued that the "low" and "high" of the range could be significant enough to merit distinction. In this regard, group members discussed the possibility of creating smaller ranges such as 40-45 degrees instead of a proposed 40-49, but discarded this suggestion noting that there would be too many categories.

Workgroup members also considered documenting whether it was "hot" or "cold." Ultimately, this suggestion was discarded as members felt it would be too subjective and not necessarily provide useful comparative information; individuals in Alaska and Texas, for example, may have widely differing opinions on what constitutes "hot."

5.1.5 Data on Day and Night as light conditions should continue to be collected, but with better definition (considering sunrise to sunset--inclusive of dawn and dusk--as "Day" and adding a check box for "twilight").

One suggestion would define "twilight" as 30 minutes before sunset and 30 minutes after sunset. A few members suggested adding the field to correlate it to the use of navigation lights.

5.1.6 Data on Overall Water Conditions should continue to be collected, with preference for the following options as defined (and from which there could be multiple selections): calm (waves 0 to 6"), choppy (waves >6" to 2'), rough (waves >2' to 6'), very rough (waves >6'), strong current, other, and unknown.

In its discussions on this element, the workgroup considered adopting the Douglas Sea Scale, but ultimately discarded the suggestion due to a desire for simpler ranges.

Some workgroup members expressed concern about the introduction of the term "other" and whether it would be misused (instead of selecting a standardized category). However, this concern was discarded as some workgroup members felt "other" could be used to describe specific environmental situations that they would want to document, such as flood waters or heavy surf.

5.1.7 Data on Water Temperature should continue to be collected, but with the following changes: mandatory selection from a range of water temperatures (in Fahrenheit) defined as "Under 28, 28-39, 40-49, 50-59, 60-69, 70-79, 80-89, 90 and above, and unknown"; and a field for voluntary reporting of an actual/estimated temperature (in Fahrenheit).

The workgroup modified the ranges used in the Coast Guard's annual statistics publication to add a category reflecting the freezing water temperature of salt water (a reference on NOAA's website indicates saltwater freezes at 28.4° F; see https://oceanservice.noaa.gov/facts/oceanfreeze.html) .

5.2 WHERE AND WHEN THE INCIDENT OCCURRED

5.2.1 The collection of Coordinates for the incident should be mandatory IF the future reporting system can facilitate documentation based on existing geographical information when the coordinates are not otherwise readily available. Appropriate, related guidance and a standard format for entering the data should be developed.

The recommendation for mandatory collection of coordinates is dependent on a future reporting system that can facilitate the documentation in a manner that is not burdensome or difficult for the States. Ideally, if coordinates were not readily available, the system would automatically zero in on a location on a map based on existing geographical information within the record (state, county, body of water). The system user could then pinpoint the area of incident, which would then populate coordinates back into the report. The level of confidence with the coordinates and the source of the information (handheld GPS, report system, etc.) could be documented as well. This reporting system concept would be designed in Phase 2 of this policy project.

Some workgroup members expressed other, more general concerns about collecting coordinates, such as being able to accurately document them in a standardized format and validating them. Members whose States already collect coordinate cited some glitches, noting that their officers will sometimes inappropriately record them, pushing a button that records the location of their home or duty station instead of the site of the incident. Others said they would not use the information, citing open records requests that usually focus on a name of body of water or town. Those members suggested a number of alternatives, including using other geographical information (state, county, body of water) to produce a plot on a map. However, there were issues with this suggestion because some States have oddly-shaped bodies of water with a lot of arms, thus making it difficult to plot accurately. Another suggestion was to have an "either/or" option so that States could either report coordinates or the other geographical information (county, body of water, etc.). The Coast Guard expressed concern with the "either/or" option given that sometimes coordinates are incorrect. Having the accompanying geographical information can validate a coordinate, which is important because the Coast Guard plots fatal accidents in the annual statistics publication.

Some workgroup members noted that they already mandate coordinates in their data collection, while others thought that they would be able to implement mandatory coordinate collection in the near future. Some members also thought that the collection of coordinates would be especially useful in public-facing projects like the NASBLA Boating Safety Dashboards.

5.2.2 Other elements associated with location, including names of the County, State, Body of Water, and Type of Body of Water, should be collected.

Workgroup members recommended "hard-coding" the type of body of water when the information is entered into the reporting system. For example, if Lake Superior were entered as the body of water, the *type* of body of water would automatically reflect "Great Lakes" based on a previous type assignment provided by the State.

The workgroup generally felt that the current field accommodating "**Location on Water**" should be retained, but that no attempt be made to try to standardize entries (see also, discussion on Coordinates in 5.2.1, above).

The group briefly discussed other possible geographical fields, such as distance from shore, whether an incident occurred inland or offshore, and Coast Guard jurisdiction (District and Sector). Ultimately, however, the discussion did not amount to any collection recommendations.

5.2.3 Data on the Nearest City/Town should be retained for voluntary collection.

Workgroup members hosted a lengthy discussion about whether the nearest city/town should be collected. Some members were concerned about the accuracy of the data, citing difficulties with determining the nearest city/town for an incident on a coastal waterway. Others expressed the difficulty of identifying meaningful information (for example, should Clark's Point, population 12, or Dillingham, which has a larger population, be documented?). Others found the information to sometimes be ambiguous. Ultimately, the group recommended retention of the element, but with response on a voluntary basis.

5.2.4 The Date and Time of the Incident should continue to be collected, but issues currently associated with the recording of midnight need to be resolved. Consideration should be given to 24-hour time and the ability to mark a time as "unknown."

5.2.5 There should be an element and field that accommodates the State's recording of the Date the State Reporting Authority was notified of the incident.

Feedback from the first comment period suggested that the element and field should accommodate recording the date that the State Reporting Authority was notified of the incident, provided it is not interpreted that news articles via the BADs reports count as notification.

Discussion among State members of the workgroup revealed, however, that some *have* used the BADs for the notification (not having learned of the incident(s) in question through any other means). One State member specifically indicated that in such cases, the date the BAD report came to the State was used, **not** the date of the incident as might have been noted in the media report. As in prior discussions about notification (that resulted in recommendations 1.4 as to acceptance of notification, and 1.7 as to the means of collecting the preliminary information associated with notification), members drew the distinction between the incident date and the date on which the State becomes aware of the incident (and the sometime significant lag time between the two). To make clearer that the recommendation is toward the State's determination and recording of the notification date, the workgroup agreed to modify this recommendation to specify "the State's" recording of the date.

5.3 VESSEL CHARACTERISTICS

5.3.1 The Number of Vessels involved in the incident should continue to be collected.

Even though the future reporting system should be designed to automatically calculate the number of vessels involved based on the number of vessel records entered, workgroup members recommended a field to manually enter the "number of vessels" to ensure a check and balance with the officer doing data entry. Workgroup members noted that sometimes an officer will skip a vessel record entry (for example, a hit and run) when there should be one. Having the field "number of vessels" would help validate the number of vessel records entered.

5.3.2 The Name, Make, Model, Model Year, HIN, Registration Number and Document Number (if available) should be collected.

5.3.3 The Ownership Status of the Vessel should continue to be collected. The preferred options are Owned, Rented, and Borrowed, with the addition of an "Other" field.

Workgroup members from States with large rental markets advocated for retaining the term "rented." Other members supported the addition of the term "borrowed" because having the information supported their boater education laws.

The workgroup considered adding "unknown," an option that could be used in a hit and run where the ownership status of the vessel that fled the scene might not be known. Ultimately, workgroup members discarded this suggestion, noting that "other" could be used to describe the reason for the "unknown," and could also be used to describe a stolen vessel. During the first comment period, in response to a question posed by a commenter as to what else might fall into the "other" field, another commenter noted that it could involve a leased vessel.

5.3.4 The Number of Engines should continue to be collected.

5.3.5 The collection of Engine Manufacturer data should only be mandatory if the engine is determined to be a factor in the incident. If the engine manufacturer data is not available (e.g., if the engine is not recoverable), then that should be documented in the system.

The workgroup recommended collecting data on the engine manufacturer only if the engine were determined to be a factor in the incident. Otherwise, group members questioned the ease of identifying the manufacturer due to engine modifications, rebuilds, and cosmetic work.

5.3.6 The collection of the Engine Serial Number should be mandatory only if the engine is determined to be a factor in the incident. If the serial number is not available (e.g., if the engine is not recoverable), then that should be documented in the system.

As with the Engine Manufacturer information, workgroup members recommended collecting the serial number only if the engine were determined to be a factor. There was some variation among members as they speculated how easy it would be to obtain the serial numbers (beyond States that title boats and engines). Members suggested the development of guidance in "best practices" to address when and how to document this information.

5.3.7 The Engine Drive Type should continue to be collected, with drop-downs for the CFR-authorized options to incorporate additional engine styles. The options should be Inboard, Outboard, Pod Drive, Sterndrive, Unknown, and Other. Airboat Engine should be included in a drop-down for Inboard. Shallow / Surface Drive should be included in a drop-down for Outboard. All of the engine drive types should be more clearly described in Best Practices.

5.3.8 Horsepower/CCs/Pounds of Thrust should be collected. If the data is not available, then that should be documented in the system.

While the workgroup discussed whether horsepower should even be collected, it ultimately was recommended for retention as it is among the CFR-required contents of the incident report and used for compliance purposes. That said, workgroup members recommended adding CCs and pounds of thrust as measures since sometimes motors are not described in horsepower.

5.3.9 There should be mandatory collection of data on Overpowering if it was a factor in the incident. There should be a checkbox to indicate overpowering and a text field to document the rated horsepower.

"Overpowering" arose as part of the discussions on horsepower (recommendation 5.3.8 above). Originally, the workgroup considered adding overpowering as a cause of incident. However, because there were concerns about validating the information for a vessel that did not have a capacity plate, the workgroup only recommended documenting overpowering in the horsepower section of a data collection form, whereby both rated and actual horsepower would be documented.

5.3.10 The Fuel Type should continue to be collected, with the following options: the CFR-authorized Gas, Diesel, Electric, and Other. Additional fields should include No Fuel and Unknown.

5.3.11 The Hull Material Type should continue to be collected, with the following options: the CFR-authorized Fiberglass, Aluminum, Plastic, Rubber/vinyl/canvas, Steel, Wood, Other, and Unknown. Only one selection should be made for each vessel so that data will match VIS/SNS. There should be guidance in the Best Practices document as to which primary hull material type should be selected in the event a vessel is constructed with more than one material.

Before coming to consensus on this recommendation, some workgroup members expressed a desire to select multiple hull material types. However, the Coast Guard recommended that the selection of hull material be limited to just one so that data would match the Vessel Identification System (VIS) and Standard Numbering System (SNS), and would facilitate reporting out on the information in the Coast Guard's annual statistics publication.

Workgroup members considered adding a hull material "composite" to reflect a vessel where the primary hull material was not identified by the officer/investigator. The suggestion was discarded because some group members felt it would result in a loss of information. Ultimately, the group recommended that "best practices" address the selection of a primary hull type when the vessel was constructed with more than one hull material.

5.3.12 The list of Vessel Subtypes that was approved by NASBLA membership in 2013 as part of the NASBLA/ERAC and USCG Terms and Definitions Project and that roll up into the primary vessel types mandated in CFR should be made available for the States' use as part of the anticipated revamp of the reporting system. The States' collection of data on these subtypes would be voluntary; however, if a State chooses to record vessel subtypes, it

should select from the subtype options on this list. (See APPENDIX C for original approved list with markups and notes reflecting workgroup's recommendations)

In the process of developing this recommendation, there had been lengthy discussion about the issue of mandatory vice voluntary collection of the subtypes. Coast Guard representatives expressed hesitation with mandating their use because such a change would affect multiple reporting systems, including the current BARD, VIS, and SNS. The Coast Guard also expressed concern about correlating vessel subtype data from incident reports to survey data and questioned whether the public responding to a survey would be able to identify their vessel subtype. Even a few State members expressed hesitation, feeling the information would not be useful for outreach purposes. Other members, however, felt that the subtype information could be useful for manufacturing studies, particularly when studying hull design. Having a vessel subtype coded in incident reports would provide quicker access to hull design information than having to analyze accompanying vessel information.

Ultimately, the workgroup members came to consensus with the following qualifications: that the subtypes be available on a voluntary basis as drop downs to the main types in the future reporting system; that if a State records subtypes it should use those in the list; if a State wants to introduce a new subtype term, it would be able to do so in the "other"/"unspecified" categories; and finally, although the Coast Guard would not report out on vessel subtypes at the national level in its annual statistics publication, the agency would accommodate requests for the data.

In the first comment period, two commenters said that while they agreed overall with the recommendations in this section, they still thought that the vessel subtypes should be a mandatory, not voluntary collection. With the consent of the State member who still advocated for that aspect of the recommendation, the project workgroup agreed to move the recommendation as currently worded forward to this second comment period in order to gather more feedback from the States.

5.3.13 The Vessel Types (included as authorized and defined per the Coast Guard's 2012 Final Rule on SNS, VIS, BARD; 33 CFR 173.3 and 173.57), should be modified to remove one of the authorized types---"Inflatable Boat." If such a CFR change occurs, then the Vessel Subtypes list from the 2013 NASBLA/ERAC and USCG Terms and Definitions Project referenced above should also be modified to move "whitewater raft" (which is currently a subtype under Inflatable) to the vessel type "Rowboat." (See APPENDIX C for original approved list with markups and notes reflecting workgroup's recommendations)

5.3.14 Whether or not "Inflatable Boat" is ever removed as one of the Vessel Types authorized in CFR, there should still be a separate check box on the report form to record Inflatable Construction. [See APPENDIX C]

5.3.15 The Overall Length of the Vessel (in feet) should continue to be collected.

5.3.16 The data elements Depth from transom to keel and Beam width at widest point, both currently written into regulation, should be removed from regulation and future reporting requirements.

Workgroup members recommended regulatory change to remove these data collection elements currently identified in CFR, because they are not often reported and available data is not used. Further, the information is difficult to document when the vessel is in the water. One workgroup member noted, however, that the information could still be useful in an overpowering situation, if the hull design or size was a factor in the incident, or if the incident involved a paddlecraft.

5.3.17 There should be mandatory collection of Safety equipment/gear recorded at the scene of incidents involving paddlecraft. This should help in determining whether the equipment carried/available was appropriate for mitigating the risks involved with the specific type of vessel(s) and activity.

The specialized lists of items should be:

- **<u>Standup paddleboard</u>: Wet suit; Drysuit; Paddle (whether it was appropriate for vessel, and whether it was intact); Leash; Helmet; Communications Device (with text field to describe).**
- **<u>Canoe</u>: Wet suit; Drysuit; Paddle (whether it was appropriate for vessel, and whether it was intact); Helmet; Communications Device (with text field to describe).**
- **<u>Kayak</u>: Wet suit; Drysuit; Paddle (whether it was appropriate for vessel, and whether it was intact); Helmet; Spray skirt; Dewatering Device (note if not applicable); Communications Device (with text field to describe).**

This collection of information was introduced because the workgroup felt it could help in developing educational messages for paddlecraft participants. The collection would depend on the design of an electronic reporting system that could isolate incidents involving paddlecraft and prompt an officer/investigator for these items. The focus would be on whether the items were "available" and "used." All would include an option for indicating if the availability and/or use of the gear/equipment is "unknown." Workgroup members recommended that examples, and especially the definitions of "Communications Device," "intact," and "appropriate for vessel," be included in "best practices."

Before arriving at consensus on this recommendation, the group discussed documenting available equipment/gear for **any** type of vessel involved in an incident. There was an idea to launch what would have been a lengthy data collection focusing on vessel safety check items such as visual distress signals, sound producing devices, fire extinguishers, navigation lights, and marine radios. Additional fields for consideration included dewatering devices, anchor lines, first aid kits, charts, boarding ladders, wet suits, whistles, compasses, GPS, flashlights, and water bottles.

Workgroup members felt that such data collection would be too involved, and further expressed concern about the ability to document gear for incidents where gear may have been lost due to capsizing, sinking, or other events. Members noted that incidents do not involve static scenes, and particularly with paddlecraft involved in capsizings, the collection could be problematic. Ultimately, however, there was support for the narrower focus on paddlecraft because of the rise of paddlesports incidents involving ill-equipped participants, and support for a pared-down set of lists.

Initially, there was discussion about making this data collection section mandatory only if the gear/equipment or lack thereof might have played a factor in the incident. Ultimately, workgroup members recommended collecting the information for **<u>all</u>** paddlecraft incidents so that there would be a universe of cases to evaluate. Members were agreeable since they noted that the future reporting system—with anticipated design changes--should facilitate collection of the information because the options would only be presented if pertinent to the paddlecraft vessel type. Additionally, some members expected the additional data collection would not be burdensome due to the relatively low number of paddling incidents in their respective States.

However, some concerns were expressed about the investigators' ability to determine the "appropriateness" of paddles. Although group members admitted they have not seen many incidents due to a paddle (lack of paddle, inappropriateness of a paddle, paddle not intact, etc.), they realized the data collection might be relevant, particularly in whitewater situations. In response to concerns, the group recommended developing and presenting "best practices" guidance for investigators.

In finalizing the lists, the group considered and then discarded other fields including: re-boarding mechanisms, float bags or other flotation added to the craft, paddle bags, throw bags, and inflatable pumps. Ultimately, the group decided to keep the list short, acknowledging that some items like an inflatable pump would not likely be onboard the vessel at the time of incident and others, like a throw bag, lacked standards.

The workgroup also considered whether it would be useful to collect information as to the presence of a Vessel Safety Check sticker. Ultimately, the group decided to forego collection because the sticker would only reflect compliance with carriage equipment on the day that it was issued.

Finally, the workgroup considered whether any other safety equipment questions should be posed as part of collecting information on paddlecraft incidents. One member suggested asking whether

a life jacket was worn at the time of the incident and after the incident. Another posed questions as to whether required safety equipment was met, and if not, what were the missing elements? This suggestion prompted concerns that required safety equipment might differ by jurisdiction, thus making the resulting data difficult to present nationally. While the collection could focus on federally-required carriage equipment items (of use in studying owner/operator compliance), the final recommendation from the workgroup was to omit the element in this collection.

5.4 INCIDENT DETAILS

5.4.1 The Number of People Onboard and Number of People Towed should continue to be collected, but there should also be a field for Total People based on these entries. The purpose would be to help ensure against the double counting of any person(s) who had been onboard the vessel, but were being towed at the time of the incident. The future reporting system should accommodate an automatic calculation of the Total; however, it should also feature an override to allow manual entry of Total People in case the breakdown of number of people onboard and number being towed is unknown, but the Total People is known.

5.4.2 The Accident Types/Events list approved in 2012 by NASBLA membership as part of the NASBLA/ERAC and USCG Terms and Definitions Project--and as modified during workgroup discussions in March 2018 and again in March 2019 following the first external review and comment period --should be adopted for national data collection. As part of this, the report category title should be changed to "Incident Events." (See APPENDIX D for original approved list with markups and notes reflecting workgroup's recommendations)

The workgroup based its discussions off of the previous body of work on incident event terms and definitions that was developed by NASBLA/ERAC and the Coast Guard and approved by NASBLA membership in September 2012. Recommended modifications to this report category are summarized here; specific modifications to the list of entries are presented in **APPENDIX D**.

One of the first modifications recommended by the workgroup was to change the report category label from "accident events" to "incident events" to reflect that not all reports involve "accidents" which are often defined as unexpected events or events that may have unknown causes.

The workgroup also recommended documenting incident events from two perspectives: 1) recording the series of events in the overall incident, and 2) recording the series of events for each vessel involved in the incident.

Finally, the workgroup recommended documenting whether a fire/explosion was fuel-related and then further, if known, whether it was propulsion-related. Some workgroup members expressed reservations about their ability to document whether a fuel-related fire was propulsion-related because often there is not enough evidence. The workgroup recommended that the reporting system to be designed in Phase 2 of this policy project facilitate the recording of this information.

As a result of feedback received during the first comment period, the workgroup made additional format modifications to the **Fire/Explosion** entries. They include a new, combined term "**Fuel-related Fire/Explosion**" with check boxes for options **Engine (propulsion)/generator-related**, and N**ot engine (propulsion)/generator-related**. Upon selection, there would be additional prompting for the source of the suspected leak. For the "Non-Fuel" related entry, no changes would be made to the term or definition, but examples would be provided. See detail on pp. 2-3 of **APPENDIX D**.

5.4.3 The Operation of the Vessel list approved in 2013 by NASBLA membership as part of the NASBLA/ERAC and USCG Terms and Definitions Project--and as modified during workgroup discussions in March 2018 -- should be adopted for national data collection. (See APPENDIX E for original approved list with markups and notes reflecting workgroup's recommendations)

The workgroup based its discussions off of the previous body of work on operation terms and definitions that was developed by NASBLA/ERAC and the Coast Guard, and approved by NASBLA

membership in September 2013. Recommended modifications to this report category are summarized here; specific modifications to the list of entries are presented in **APPENDIX E**.

The workgroup recommended some changes to the propulsion and speed aspects associated with the Operation framework. Those recommendations are on pages 1 and 4 of **APPENDIX E.**

With regard to **propulsion used at the time of the incident**, the workgroup recommended documenting both the type of propulsion available and of propulsion used. All of the term and definition options in the list would be retained, and water jet and air thrust would be added.

With regard to **speed at the time of incident**, the workgroup recommended retaining all of the term and definition options, and adding "not making way" to reflect a vessel that was drifting (which would be considered underway but not making way).

Finally, after a lengthy discussion about speed, the group recommended voluntary data collection on "estimated speed" in mph. Since not all vessels have speedometers, some workgroup members questioned the validity of the information. Other members countered, however, that speed could be obtained from a GPS or TAC download in some cases. Several members agreed that documenting speed could be important for analyses and educational purposes.

5.4.4 The Activity--Use of the Vessel/Immediate Activity at Time of Accident list approved in 2013 by NASBLA membership as part of the NASBLA/ERAC and USCG Terms and Definitions Project--and as modified during workgroup discussions in March 2018 -- should be adopted for national data collection. (See APPENDIX F for original approved list with markups and notes reflecting workgroup's recommendations)

The workgroup based its discussions off of the previous body of work on activity terms and definitions developed by NASBLA/ERAC and the Coast Guard, and approved by NASBLA membership in September 2013. Recommended modifications to this report category are summarized here; specific modifications to the list of entries are presented in **APPENDIX F**.

In taking an overall look at activity, the workgroup considered the merits of documenting the general purpose of the trip since it may differ from the immediate activity at the time of incident. Knowing the general purpose could help boating safety professionals better understand the boating population(s) involved in incidents. The workgroup recommended establishing a means to document general purpose in Phase 2 of this policy project.

The workgroup made several recommendations for changes to the original approved list.

Under the "**Use of the Vessel,**" the workgroup recommended the following modifications: 1) relabel "commercial" as "profit making activity" and establish parameters that such activity would include, for example, a boat owner who hires an operator, and a fishing guide who is hired to take people fishing; 2) to the "profit making activity" definition, add "state-numbered" to describe the vessel to which it applies; and 3) relabel "occupational" as "official public service" so as not to confuse "occupational" with profit making activities. Members also recommended establishing parameters that occupational would include, for example, a research vessel associated with a state-run university, but not one associated with a private university.

Under the "**immediate activity**," the workgroup recommended collecting the immediate activity for both operator and victim because different people onboard the vessel could be performing different activities. For ease of selection, one master list of activities should be constructed.

Also, under "immediate activity," the workgroup recommended the following modifications: 1) strike "towing a watersports participant" because it is not easily understood, would likely rarely be used, and could be covered by "riding in or on vessel;" 2) add examples to the definitions of "assisting in docking vessel" and "assisting in leaving dock" to make it clear that these terms reflect physical interaction with a vessel, such as handling lines, grabbing a pole, or holding the side, and that the person's location (in boat, on dock, etc.) does not factor in to their application; 3) add language to the definition of "towed watersports participant" to make it clear that this term also applies to wake surfers. The group also recommended clarifying whether a person in a jetlev was considered a

participant or the operator, depending on whether the person was controlling both thrust and direction of travel; 4) add a new term (and definition for) “whitewater sports operator” that would mirror “whitewater sports participant”; and 5) eliminate the activity “operating vessel” because of redundancy—the operator can be identified in the system by their operator record, and “riding in or on vessel” can be selected if operator was not engaged in any other activity at the time of the incident.

In its discussions, the group also considered whether the term “departing vessel” is necessary given that another recommendation (2.3.1) would deem as “non-reportable” any incidents in which the first and only event involved a person voluntarily departing a vessel. Ultimately, the workgroup recommended retaining the term because it would be appropriate to describe activities where a person departed a vessel because it was on fire, departed a vessel to step off onto the dock (when an incident occurs), or departed a vessel and some other “reportable” event occurs.

Finally, the group recommended that Phase 2 of this policy project design an efficient means to document all of the activity information.

5.4.5 The Contributing Factors/Causes list approved in 2012 by NASBLA membership as part of the NASBLA/ERAC and USCG Terms and Definitions Project--and as modified during workgroup discussions in March-April 2018-- should be adopted for national data collection. (See APPENDIX G for original approved list with markups and notes reflecting workgroup’s recommendations)

The workgroup based its discussions off of the previous body of work on contributing factor/causes terms and definitions developed by NASBLA/ERAC and the Coast Guard, and approved by NASBLA membership in September 2012. Recommended modifications to this report category are summarized here in the order in which the items appear in the list; specific modifications to the list of entries are presented in **APPENDIX G**.

For the factor “**Improper Lookout/Inattention,**” the group recommended mandatory collection of the accompanying operator distraction codes due to concerns that voluntary collection would result in gaps in the data, something that would hinder analysis of the increasingly important issues surrounding distractions. The group made a similar recommendation for mandatory collection of the inexperience codes associated with the “Operator Inexperience” factor.

Regarding the “I**mproper Lookout/Inattention**” **distraction codes**, the workgroup recommended the following updates: 1) Revise “Onboard electronics or equipment” to remove the current reference to mobile phones (to distinguish onboard electronics from handheld devices), and create a new distraction code “Wireless communication devices” specific to cell phones, tablets, and other handhelds. Workgroup members recommended the differentiation so that they could easily query data in the event that their legislature decided to consider restrictions on cell/tablet use. 2) In response to a suggestion from the NASBLA Paddlesports Committee, include “pets” under the distraction code “Operator or occupant activity.” Pet movement within a vessel may affect vessel stability, and could contribute to an incident. Members saw no need for a separate distraction code, instead lumping pets (as vessel “occupants”) together with humans in this distraction code. Even though the pets cannot be “educated” in boater safety courses or outreach, the operator who has responsibility over the pets and humans onboard can be impacted by education.

Workgroup members discussed the necessity of the cause “**Towed Watersport Participant Behavior**” in light of the recommendation to consider “non-reportable” those towed watersports incidents that were not a result of the operation of vessel or its equipment (Section 2.3.2). Members recommended retaining the cause because it may be applicable for situations in which a participant caused a distraction that contributed to an incident.

Regarding the factor “**Equipment Failure**” and the list of selections to indicate which piece of equipment failed, the workgroup recommended the following updates: 1) Split the term “Auxiliary or accessory equipment failure” so an investigator could indicate whether the failure was of portable equipment brought onboard or of equipment installed by a manufacturer or marine yard. The workgroup recommended the differentiation to educate or potentially regulate these different groups; 2) Remove the option of “Communication equipment failure” due to expectations that it

would see limited use, and that such a failure might relate more to a rescue or recovery issue vice being the cause of an incident; 3) Remove the term “Day Shapes or Flags” since, as defined, it does not reflect an “equipment” failure. If an operator failed to display an appropriate flag, selection of a navigation rules-related factor would be more appropriate; 4) Fine-tune the definition of “Fire extinguisher failure” to limit it to the failure of an extinguisher that was considered to be serviceable (the addition of language about “serviceable” was deemed important because often times boaters do not have a serviceable extinguisher onboard). While the failure of a fire extinguisher is unlikely to be the cause of an incident, it could contribute to an ongoing fire; 5) Remove “Life jacket failure” due to expectations that it would see limited use; 6) Fine-tune the definition of “Navigation equipment failure” to note that it is more likely to be used as a secondary contributing factor. Some workgroup members expressed concern about how the inadequate calibration of equipment or misinformation from equipment (mainly the various GPS tools) would factor into navigation equipment failure. Some felt such a failure would be more appropriate as a secondary or tertiary cause because even if the navigation equipment had failed, the operator would still have been required to maintain a proper lookout. In that case, the factor “Improper lookout/Inattention” would likely be a more appropriate primary cause; 7) Rename and fine-tune the definition of “navigation light equipment failure” so that it represents a failure of the navigation lights (blown fuse, faulty wire, etc.). A faulty light switch for navigation lights would fall under this category vice a “Machinery Failure”; 8) Remove the term “Sail dismasting” due to expectations that it would see limited use; 9) Alter the definition of “Sound producing device” so that it is limited to the failure of the equipment, not its lack of use or lack of carriage; and 10) Add “Other” as a selection to accommodate any equipment failure that did not fit an established category.

The workgroup considered whether Automatic Identification System (AIS) should be listed as a subcategory under equipment failure, but ultimately discarded it, noting that AIS is not required of recreational boaters, is not monitored, and AIS is not a collision avoidance, just a tool for position awareness. It usually is used in concert with radar or some other tool, and probably would not play a factor in recreational boating incidents.

For the factor “**Hull Failure**,” the workgroup recommended adding “lack of or inadequate vessel flotation” to the definition. This addition was made in the wake of related group discussions on vessel and hull design characteristics as possible contributors to an incident (see recommendation 5.4.6).

For the factor “**Machinery Failure”** and the list of selections to indicate which part of the machinery failed, the workgroup recommended fine-tuning the definition of the selection “Propulsion system failure” to include failure of a “water jet braking system.”

Regarding the factor “**Off-Throttle Loss of Steering**,” the workgroup considered whether it was a candidate for elimination since often times it is an operator’s inexperience with a propulsion system that is the reason for the incident. Ultimately the group felt it should be retained because it captures a specific issue.

For the factor “**Ignition of Fuel or Vapor**,” the workgroup recommended fine-tuning the definition to reflect “ignition of combustible gases, vessel fuels, or fuel vapors.” The group discussed whether “fuel” needed to be retained since fuel vapor is usually the source of ignition; ultimately, members thought it should be retained because liquid fuel could ignite in a leak. The group added “combustible gases” to the definition since some equipment runs off of propane gas.

Regarding the factor “**Hazardous Waters**,” the workgroup recommended revising the definition to incorporate “unseen underwater hazards,” and requiring a mandatory selection of one of three, unique subcategories to detail the officer’s selection of the factor. The three subcategories are: 1) weather-related hazardous waters (for example, currents and wave height); 2) hazardous waters inherent to the location (for example, whitewater, oyster beds, reefs, sunken vessels, strainers); and 3) a hazard in the water. Some members expressed reservations about using the factor to reflect hazards in the water when traditionally it had been used to reflect conditions due to vertical or horizontal movement of water. Other considerations by the workgroup were: areas that were inherently an obstacle to navigation (oyster beds, reefs, and strainers), areas that could create hazardous water conditions (dam), and other factors that could pose obstacles to navigation (tides that affect water level, droughts that affect water level, and unseen hazards in the water). The

workgroup considered having a free-entry text field that would allow the investigator to indicate the type of hazard, but the idea was discarded over concerns that analysis would be problematic due to lack of standardization.

For the "**Weather"** factor, members recommended fine-tuning the definition to direct the officer/ investigator to the "**Hazardous Waters**" factor (with subcategory "weather-related hazardous water conditions") if water conditions were caused by weather.

For the factor "**Wake**," members recommended modifying the term label and definition to the more inclusive "**Wake/Wash**."

Regarding "**Missing or Inadequate Navigation Aids,"** the workgroup recommended altering the term label to "**Authorized Navigation Aid Failed or is Missing**" to clarify that it reflects off station or malfunctioning physical or virtual aids, not the absence of a recommended aid. An example of a malfunctioning virtual aid would be a one that failed to provide a signal which in turn failed to alert the operator of a grounding hazard while navigating at night. Other considerations by the workgroup were: 1) failings of electronic navigation or sound signals (whistles, bells, gongs); 2) absent, ineffective presence, or off station or missing physical or virtual aids; and 3) malfunctioning items. However, workgroup members discarded the lengthy list in favor of describing aids that were implemented (authorized) by federal, state, or local authority.

For the factor "**Language Barrier**" the workgroup deliberated whether to recommend retention, as other causes such as a navigation rules violation or operator inexperience could likely be coded for an incident in which the participants did not understand navigation rules, aids, laws, or instructions. Ultimately, the group felt there were enough boaters from non-English speaking countries that there would be merit to retaining the factor.

Regarding the factor "**Medical Condition**" (which, when accepted by NASBLA membership in 2012 was to replace the existing term "Sudden medical condition"), the workgroup recommended revising the term label again to "**Medical Event**" and clarifying the intent as a spontaneous, unexpected event as opposed to a pre-existing condition. The modifications are in line with the terminology used in recommendation 5.4.6 regarding non-reportable medical events.

Regarding selection of the options "**Other**" and "**Unknown**" that were included in the 2012 list of revised contributors, the workgroup recommended requiring an explanation if either were selected.

Before leaving the discussions on contributing factors and causes, the workgroup discussed other factors not on the 2012 list. One of those was "Careless/Reckless Operation," a term that was removed from the Coast Guard's Boating Accident Report form (CG-3865) and national statistics report in 2008, but is still in use in some States. The term was not included in the 2012 list of revised contributors because the consensus was that careless/reckless implies a conclusion, not a contributing factor. The direction to users of the revised list was to focus instead on determining the factor(s) that led to such a conclusion. Ultimately, the current workgroup gravitated toward the same rationale: other contributors could better detail what led to the incident. For instance, if the operator were barreling down the lake while arguing with a passenger who refused to stay seated, then—under the revised terminology— "Speed Too Fast for Conditions," "Improper Lookout/ Inattention," and "Occupant Behavior" would all be candidates for consideration as contributors in the event of an incident. Determining these as factors in the incident would not preclude using "careless/reckless" as a chargeable criminal event.

The workgroup also considered whether carriage requirements should be documented in the event they play a role as potential contributing factors in an incident, and if so, how and where they should be recorded. Ultimately, the group discarded carriage requirements as a collection element because of the questionable utility of the data. Members thought that while carriage equipment could contribute to the response to a boating incident, it would be rare for the equipment to contribute to a boating incident or casualty (one such rare scenario would be a life jacket that spontaneously inflates, creating an operator distraction which leads to an incident). The failure of a carriage item (such as a life jacket) would not likely be the cause of a boating incident, but could contribute to a casualty. A sound producing device probably would not cause an incident (unless it

failed to adequately sound, in which case the failure could be documented under “Equipment Failure”) or casualty, but the use or lack of use of it might affect response to an incident.

Finally, members discussed the possible addition of a question that would prompt investigators for a statement as to what they believe could have prevented the incident. Ultimately, the workgroup discarded this idea because they did not feel investigators would want to be held accountable for making such statements, even if a caveat taking them “off the hook” were added to the form.

5.4.6 Regarding <u>vessel design or hull characteristics that might have contributed to an incident</u>, a question should be added for mandatory data collection. *"Is there a possibility that any features or design characteristics of the vessel may have contributed to this accident? ___" A check-off in this field would indicate “yes,” and require follow-up description in the narrative.* Appropriate examples and guidance should be developed and included in a “best practices” document for the officer/investigator to consider in responding.

This recommended question had its origins in the work of a NASBLA/ERAC 2016-2017 charge team that was assigned the task of identifying the most effective way of collecting viable information on hull design characteristics (for example, a specific hull type that might have contributed to an incident). Since currently there are no data points that can isolate a specific hull feature or vessel design characteristic in the reporting system, the desire was to introduce a data collection element that could be queried and facilitate an easier, quicker way of identifying possible issues that would be described in a narrative.

The charge team settled on a “yes/no” question as to whether any features or design characteristics might have contributed to an incident, with follow-up in the narrative. Massachusetts became the first pilot State to test the method for the charge team, and the State has not had any affirmative responses to the question to date (since Massachusetts has a limited number of accidents, and the profile of accidents has tended to lean towards paddlecraft and incidents due to operator inattention). However, the workgroup member from Massachusetts believes that the presence of the question puts the issue on an investigator’s radar.

Some workgroup members expressed concerns about gathering this information. Members were concerned that an officer might not have the experience to answer such a vessel design question, or may be reluctant to do so. A member also felt it might be difficult to untangle operator negligence from any vessel design issues. Finally, some members felt that the question’s appearance on a report form could unnerve manufacturers. Ultimately, the workgroup’s discussion revealed more safety benefits than not in capturing potential vessel design issues.

Of note, though, is that the workgroup did take steps to address potential issues that an officer/ investigator might have in answering the question. Originally, the response to this question was a “yes/no.” Workgroup members recommended removing “no” as a potential selection because they were concerned about officer culpability—that is, if an officer entered “no” when further examination of the investigation detail suggested that the answer should have been “yes,” the officer’s training might be questioned. Apart from altering the yes/no response, the workgroup considered other possibilities such as adding introductory language to the question such as “Based on the officer’s training,” “Based on the officer’s limited training in hull characteristics…,” or “In the officer’s opinion…”. Ultimately, the workgroup decided that these introductory words were unnecessary because the question, as framed, already reflects a degree of uncertainty by using the words, “is there a possibility.” Officers would not be held liable for their responses.

5.4.7 Retain the current Incident Description or Narrative for submission to the Coast Guard, but change the label to <u>Synopsis</u> or Executive Summary to distinguish it from a detailed narrative

Currently, federal regulation on the contents of the report (33 CFR 173.57) require a “description of the vessel casualty or accident.” The current Coast Guard BAR form refers to this as the “accident description,” while the more common reference is to a “narrative.” Workgroup members were favorable toward retaining the requirement to submit a description, but recommended that the label for this data element be a “synopsis” or “executive summary” of the incident vice the narration of every detail (that is, notification, response time, recovery of victim/vessel, investigative steps, etc.).

5.5 DAMAGES TO VESSELS AND OTHER PROPERTY

5.5.1 There should be a mandatory data collection on each vessel and total non-vessel property damages, with States having the option of submitting actual/estimated dollar amounts and/or using the following four ranges (referred to here as "buckets") for this purpose: <$2,000,* $2,000-<$5,000, $5,000-<$10,000, and ≥$10,000. There should be a description/definition of what "non-vessel property" means in the Best Practices document to be developed.

REMINDER: An alternate proposal from the Coast Guard to increase the threshold to $2,800 is on the table; see **Section 2. Determining Which Incidents Require a Report to the Coast Guard discussion on pages 10-12, pertaining to recommendation 2.1.2.4. Workgroup is seeking feedback.*

The workgroup recommendation regarding the dollar amount of the federal report threshold for property damages and related qualifications was outlined in 2.1.2.4. This recommendation and the follow-up guidance recommendations 5.5.2 through 5.5.5 are regarding how the damages data would be captured and reported out for vessel and non-vessel property damages.

"Buckets" – or dollar ranges – were introduced as a collection mechanism given significant concerns about an officer's ability to obtain damage values or estimates in a timely manner. Workgroup members noted that often times, an officer's training, availability of resources, and damage cost variations (even within a State) make it difficult to accurately document damages. Unless there were national guidance, it would be difficult to arrive at actual damages unless they could be obtained from reliable sources such as boat yards and mechanics. In seeking out options for data capture, the workgroup uncovered an outdated damage guide authored by NASBLA's Boating Accident Investigation, Reporting, and Analysis Committee (BAIRAC), predecessor to ERAC, for consideration. It provided calculations of damage per linear foot based on the age, size, and type of vessel. However, there was a concern that such a guide would quickly become dated because of price changes, and that prices based on locality might differ widely as well. In general, the workgroup was concerned about the administrative burden to collect actual damages.

Further, at least one State does not currently provide damage estimates in their incident reports out of genuine concern that the credibility of officers would be diminished if it were brought to light in court that an estimate captured on an incident report was incorrect. As a result, that State only enters a damage amount if received from the owner or operator.

Apart from concerns about the officers' abilities to record actual or estimated damages, there were concerns about validating information received from vessel owners. Under the current reporting structure, some workgroup members stated that they often receive damage estimates from two different sources that vary widely, and that reconciling the values is difficult.

In considering the "bucket" option, the workgroup members discussed their reliability, and whether their use would allow the national RBS program to report out more accurate damage data. The Coast Guard representatives on the workgroup noted that the agency is wary about the current damage figures it has received as some personnel may just enter the minimal $2,000 to indicate the damage threshold was met or they may not estimate correctly; the buckets, they thought, might actually be a more reliable means to collect damage data and perhaps more data.

The recommended buckets were developed in the following manner: for the period 2005-2011, the Coast Guard filtered for any damage-only incidents that involved some damage per vessel. There were 7,377 records. The Coast Guard then evaluated the frequency of vessels by damage amount to see if there were any "natural breaks" in the damage amounts.

The mode (what appears the most frequently) was $2,000; the median (the middle of all values) was $3,000; and the mean (average) was $8,880.20. The low value was $10, and the high value was $1,700,000. The total value of damages associated with these vessels was $65,509,266.16.

The Coast Guard assigned a value to the buckets to see how they would play out if applied to the current data. Usually, the assigned value was close to the midpoint of the bucket parameter. For

instance, the bucket <$2,000's "midpoint" was $1,000, and $2,000-<$5,000's midpoint was assigned $3,500. The assigned value was multiplied by the number of vessels in that bucket to obtain the estimated damages. When tallied, the assigned values of $65,508,700 came close to the actual amount reported.

The workgroup was amenable to the number of buckets offered, and felt that an officer could easily select one. Members recommended selecting a bucket for each vessel, and a single bucket for all non-vessel damages (see recommendations 5.5.2 and 5.5.3 below). Regarding damage documentation, the workgroup recommended having the ability to use buckets and damage estimates; that way, if an officer had an estimate for one vessel damaged but not for a second vessel, the officer could use a bucket for the latter. When the Coast Guard reports out on damages, the agency may use the "actual amount" for any damages reported, and the assigned value for any damages for which a bucket was used.

Among various concerns that surfaced during discussions about the use of buckets and were subsequently resolved to the satisfaction of the workgroup were: 1) the Coast Guard's ability to use buckets for regulatory purposes. After consulting with a staff economist, the Coast Guard workgroup members learned that the use of such buckets would not hinder the agency's ability to regulate; 2) the possibility of over-inflating damages if the highest bucket were selected. In the grand scheme of data collection, over-inflation would not be a major concern; 3) whether a state legislature would accept damage estimates. Some workgroup members felt that over time, legislators would become accustomed to the concept as implemented; and 4) whether the use of buckets would negatively impact other stakeholders' use of the data. Approximately 25 people on a distribution list receive data every year from the Coast Guard. The recipients are from manufacturing, boat history sites, universities, news outlets, and boating safety non-profit organizations. The Coast Guard was not aware of anyone specifically interested in damage data.

Before achieving consensus on the "buckets approach," the workgroup had lengthy discussions about a few other methods, including whether an estimate could be derived based on the value of the boat and severity of damage. Hypothetically, States could use two categories to come up with a damage estimate whereby an officer would be asked to identify the level of damage (using the National Highway Traffic Safety Administration's (NHTSA's) categories of no damage, minor damage, functional damage, and disabling damage) and the face value of the boat. The value of damage would be populated based on these two fields.

For instance, no damage would be $0 off the vessel's value, minor damage would be considered a deduction of 10 percent of the vessel's value, functional damage would be considered a deduction of 30 percent of the vessel's value, and disabling damage would be considered a deduction of 50 percent of the vessel's value.

Workgroup members expressed concerns with this approach and the validity of the face value estimate. Though there are numerous websites that could provide a sales value for a boat, these websites would not reflect homemade vessels or vessels that have had specific modifications post market. Determining the value of the boat would be time-consuming and likely subjective, so this approach was discarded.

Some workgroup members liked an alternate idea of documenting the level of damage, noting that it could be more valuable from a reporting perspective, offering a better idea of the extent of damage vice a dollar amount bucket. There was a discussion, for example, about whether damages should only reflect "functional damage." One member gave an example of a vessel that suffered $1,500 damage to a gelcoat and $1,500 in boat wrap damage. It became a "reportable" accident even though not all of the damages reflected "functional damage."

In the first comment period, two workgroup members and two other State reviewers addressed the option for States to submit the actual/estimated dollar amounts instead of using the buckets. While only one disagreed completely with the bucket approach (suggesting that unless dollar amounts are reported as close as possible, total damages for the annual report would not really be known), the others suggested their States would likely continue to use the actual/estimated dollar amounts. Ultimately, the project workgroup retained the recommendations in their current form, with the intent of gathering more widespread feedback from the States during the second comment period.

5.5.2 For the mandatory collection of vessel damage, an actual/estimated dollar amount should be submitted or a bucket should be selected for each vessel (<$2,000, $2,000-<$5,000, $5,000-<$10,000, and ≥$10,000).

5.5.3 For the mandatory collection of non-vessel property damage associated with the incident (e.g., boating infrastructure that's been damaged, etc.), an actual/estimated dollar amount should be submitted or a single bucket should be selected (<$2,000, $2,000-<$5,000, $5,000-<$10,000, and ≥$10,000).

5.5.4 If the four buckets are used to capture vessel or non-vessel property damage estimates, for purposes of reporting out on these damages, the Coast Guard and States should assign a single dollar value to each bucket.

5.5.5 If the four buckets are used to capture vessel or non-vessel property damage estimates, the future reporting system should prompt a user to indicate whether an incident actually met the federal damage threshold of $2,000 if there are two or more buckets of <$2,000 selected in the report.

5.6 PEOPLE ASSOCIATED WITH THE VESSEL(S) INVOLVED IN THE INCIDENT

5.6.1 The Vessel OWNER's Name and Address (basic contact information) should continue to be collected nationally. But as part of this, there should be a field for an officer/investigator to explain if information about/identity of the owner is unknown or cannot be obtained.

5.6.2 The following identity and contact information on the Vessel OPERATOR(s) involved in the incident should be collected nationally: Name, Address, Phone Number; Date of Birth; and Sex (M/F/Unknown). The operator's Age could be automatically calculated based on the Date of Birth and Date of the Incident, but there should be a voluntary field to document an "Approximate Age" in the event a Date of Birth is not available. There should also be a field for an officer/investigator to explain if any of the information about/identity of the operator(s) is unknown or cannot be obtained.

In its discussions, workgroup members considered the necessity of and issues associated with collecting the identity and contact information currently required in regulation. The Coast Guard representatives noted that addresses and phone numbers were necessary for any follow-up with the individual. In addition, part of the address has been used to study "out of State" boating, comparing the operator's State in their address with the State of incident.

Some members expressed difficulty obtaining the operator's date of birth (DOB) and questioned whether it was really needed. Others, however, felt that the DOB was an important piece of information to collect because it was often used to verify an operator's identity. In considering "age," the workgroup concurred that even though the figure may be automatically calculated based on the DOB and date of the incident, there should still be a voluntary field for "approximate age" in the event the DOB could not be obtained. Initial concerns that "approximate age" could not be used by the Coast Guard for regulatory purposes were assuaged. Approximating age is a standard practice by law enforcement. Further, ages are usually reported into brackets, so any estimations likely would not affect placement within a bracket. And, finally, there was a line of thought that "an approximation was better than no information at all."

Regarding the current Coast Guard BAR form request for the operator's gender, based on the practices of other major data collections, including the U.S. Census, workgroup members recommended terming the data element as "sex" (M/F/U) not "gender" to focus on biology vice self-identification for demographic analysis. The workgroup discussed a third option to document an operator whose gender had not been determined, but ultimately recommended retaining the sex as female or male since it was anticipated that these options would be appropriate selections for the vast majority of cases.

Finally, before coming to consensus on the recommendation, the workgroup considered other possible collections of data about the operator, such as documenting colorblindness, whether a

person needed corrective lenses, hearing ability, physical condition, and mobility. Ultimately, the workgroup discarded these as national considerations since they could be subjective. However, this would not preclude the State from collecting additional information; some workgroup members thought such information could be important to collect if a State ever chose to license operators.

5.6.3 The following identity and contact information on Victims of the incident -- the Injured and Deceased/Disappeared -- should be collected nationally: Name, Address, Date of Birth; and Sex (M/F/Unknown). The victim's Age could be automatically calculated based on the Date of Birth and Date of the Incident, but there should be a voluntary field to document an "Approximate Age" in the event a Date of Birth is not available.

5.6.4 Identity/contact information on Property Owners or on Witnesses or Passengers--unless they were victims in the incident--should not be required for national collection.

The workgroup considered whether this information—currently cited in regulation—should continue to be required in a national collection; members ultimately decided that this information should not be necessary to submit to the Coast Guard because the Coast Guard does not use it. If the agency were the investigating authority on an incident, Coast Guard personnel would need to collect it under Chapter 10 of Volume V of the Marine Safety Manual.

In follow up to feedback received in the first comment period, however, the project workgroup would like to clarify here (and eventually in the best practices developed for implementation of the data recommendations) that the exclusion of this information from the national collection would not in any way preclude the States from collecting the information for their own investigative purposes.

5.6.5 Vessel OPERATOR(s) and Victim(s) identifiers beyond those indicated in the previous statements should be left for the States to consider and use or not use (such identifiers might include email, other contact info, race, language, etc.).

The workgroup discussed the merits of adding "language" to the data collection, since the resulting information could be used in developing boating safety educational products. While some members thought it might be helpful, they expressed concerns over the ability to obtain objective, valid information. It could be subjective if an officer were asked to evaluate whether a person understood English. The workgroup also considered adding "race," but again felt it could be subjective.

In the event States adopt additional identifiers beyond those required nationally, workgroup members expressed a desire to add fields to the new reporting system. The Coast Guard members noted that Phase 2 of this policy project would take up design of additional fields and other related considerations, including funding for it and updating administrative documentation for these additional fields.

5.6.6 Currently, the element OPERATOR(s)' Boating Safety Education focuses on the source of instruction completed. In the future, the element should focus on whether the operator was required to have instruction in the State of operation. If "yes," did the operator meet that requirement? and if "no," did the operator take a course anyway?

This element precipitated lengthy discussions among the workgroup members. In considering the current regulatory requirement to collect information on the operator's boating safety training and the fields currently on the Coast Guard's BAR form, the workgroup considered multiple data collection pieces on education: the source of instruction (agency, organization), means of instruction (classroom, online, on-the-water), whether education was required, and whether education was met.

The workgroup recommended removing questions about the source of education because the validity of the data was in question, as was the currency of the education. Some members noted that the source of education is not documented on their boating safety education cards, so the information is hard to obtain. Some educational sources do not forward their certificate information to States, so States will not be able to account for them. There are some entities (like a maritime academy) that offer boating instruction, but may not issue a certificate. Further, workgroup members noted that there are a limited number of sources presented on the Coast Guard's BAR

form and in BARD-Web. Often, an officer will opt for the “Other” category, which may not produce fruitful information for analysis.

Further, the workgroup considered that the source of education does not necessarily correlate to risk. One member noted that many boaters take online courses through BoatUS; just because boaters involved in an incident have taken a particular course does not correlate to a faulty course.

In considering how to collect the data, workgroup members discussed a series of questions that could be posed, such as: Has the operator taken a boating course? If yes, was it NASBLA-approved? If yes, was it a classroom, online, or combination of both? Was the operator exempted from taking such a course (for instance, if the operator had a Coast Guard license)? Did the course meet the standard? Workgroup members felt that obtaining answers to these questions would be difficult.

The workgroup recommended creation of a centralized database to track operator education so that education information could be validated.

Workgroup members expressed general concern about data collection on education because some States have different education requirements so it might be difficult to document whether an education requirement was met. One member noted that if an out-of-state boater is involved in an accident, it would be helpful to collect information on whether that operator met education requirements in the member’s state, not just whether the operator took a NASBLA-approved course.

The workgroup also discussed the possibility of documenting the means of education. Workgroup members did not feel the means of instruction (whether online, classroom, on water, etc.) was important to collect because there is no requirement that describes how an operator must receive instruction. One member noted that initially, there was concern that people taking online courses were not retaining information because they were not paying attention. However, this concern has since been dispelled, and in the member’s state, upwards of 90 percent of the boaters are taking online courses.

At the time of workgroup’s discussion on this data element, no course providers had yet been approved for on-the-water standards. In the future, the means of education might be more important to document as it could be used to gauge how effective on-the-water is vice other means.

For all these reasons, the workgroup recommended that the national collection involve a simplified series of questions on education: Was the operator required to have instruction in the State of operation? If "yes," did the operator meet that requirement? If "no," did the operator take a course anyway? The workgroup further recommended that any other boating safety education questions be left up to the State to decide for their data collections.

5.6.7 Currently, OPERATOR Experience focuses on the operator’s hours of experience (via range of hours) with the type of vessel involved in the incident. In the future, this element should capture: 1) whether the operator ever operated that <u>type of vessel</u> before (yes/no), with voluntary completion of a follow-up, fill-in estimate of hours of experience; and 2) a voluntary question as to whether the operator had experience <u>boating at that location</u> before (yes/no), with a voluntary follow-up, fill-in estimate of the number of times at that location.

Much like education, the discussion of operator experience also precipitated lengthy discussions among the workgroup members. The group considered the current regulatory requirement to collect information on the operator’s vessel experience as well as the ranges of experience currently on the Coast Guard’s BAR form. The workgroup first considered collecting “total experience,” noting that just because someone is new to standup paddleboarding does not necessarily mean they have not gleamed important skills from operating some other type of vessel (whether it be a kayak, open motorboat, or personal watercraft). Workgroup members noted that “total experience” could be helpful because it could provide a snapshot of the operator’s boating experience, and could aid in identifying contributing factors to an incident. Members also expressed

some interest in documenting experience by vessel type, including mandatory collection of the estimated hours. However, workgroup members were concerned about validating experience.

Ultimately, the workgroup recommended documenting the operator's experience in hours versus years to get a better estimate of experience. A person could report, for example, that they had five years boating experience when they had only been out a few times during that timeframe. As for the value of the information, some workgroup members felt that while a data collection on experience was subjective, some data on it "was better than nothing." Further, what is captured could be used for marketing, legal, or analytical purposes.

Before closing the discussions on operator experience, some workgroup members felt that a data collection on experience operating at the location of the incident might be useful. However, there were some differences in how "location" would be defined (for example, would it be defined as the "direct vicinity of the accident"?).

Workgroup members also took up the possibility of collecting "boating experience" for all people onboard the vessel(s) involved in the incident. Some members felt that this information would be pertinent because often times the operator may be incapacitated and an occupant may play a role in the incident outcome (such as knowing how to operate the vessel or knowing how to recover an individual in the water). Additionally, the occupant could be a victim or could have caused the boating incident. Ultimately, the workgroup recommended collecting boating experience solely for the operator because, currently, the operator is the one impacted through educational requirements.

5.6.8 Data on the following safety measures should be collected nationally for the Vessel OPERATOR(s): whether an engine cutoff device ~~switch (ECOS)~~ was used or leash was worn at the time of the incident, and whether the proper item was used, properly attached, and in proper condition.

The current Coast Guard BAR form requests a "yes/no" response to whether the operator was wearing an engine cutoff switch. In developing this recommendation, workgroup members decided on the inclusion of a combined question about engine cutoff switches and leashes because these two items are critical to a person's survival if they became separated from the vessel and because it would be obvious which item applied based on the vessel type involved. Moreover, the group recommended that the collection be mandatory in order to provide useful results for analysis.

In the first comment period, as a result of feedback received, the project workgroup revised this recommendation to acknowledge emerging technologies and electronics that do not require a physical "switch."

In its earlier discussions, workgroup members also considered the question "Was self-rescue available?" as a possible data collection element. Ultimately, the workgroup decided that question was too vague to be of use.

5.6.9 For the Vessel Operator and ALL victims -- injured and deceased -- there should be national collection of Alcohol use (yes/no, with BAC optional); BUI arrest information (as applicable); Drug use (legal and illegal, yes/no~~); and Marijuana use (yes/no).~~, with drop-down menu for selecting options from among the following drug categories, which are also used in motor vehicle crash reports: cannabis (marijuana), depressants, stimulants, hallucinogens, inhalants, narcotic analgesics, other drug(s))

Current federal regulations require the "opinion of the person making the report as to the cause of the casualty, including whether or not alcohol or drugs, or both, was a cause or contributed to causing the casualty." Apart from including alcohol and drug use among the contributing factors selections, the workgroup recommended that alcohol use, drug use, whether the person was arrested for Boating Under the Influence (BUI), and marijuana use be collected not just on the operator, but for all victims of the incident.

The workgroup originally recommended a separate data collection on marijuana given the number of States that had legalized recreational (10, to date) and medical cannabis (33, to date). However,

in discussing comments submitted in the first external review comment period, the workgroup also recognized the potential for confusion in selection and possible duplication in counts as a result of having the marijuana option disassociated from the Drug use (legal/illegal) option. As a result, the workgroup considered and ultimately agreed to put forward to the States in the second comment period a modified recommendation that deletes the separate marijuana field and instead allows for a drop-down menu of drug categories comparable to those used in motor vehicle crash reports.

Members of the workgroup from Texas and Wisconsin provided the drug category codes used in their vehicle crash reports and the common categories were pulled for consideration in this recreational boating-related recommendation: Cannabis (Marijuana); Depressants; Stimulants; Hallucinogens; Inhalants; Narcotic Analgesics. An "Other drug(s)" category would also be included. Definitions comparable to the following would need to accompany the coding and be included in best practices to be developed for implementation of these recommendations:

> **Cannabis:** scientific name for marijuana. The active ingredient in cannabis is delta-9 tetrahydrocannabinol, or THC. This category includes cannabinoids and synthetics like Dronabinol.
> **Depressants:** slow down the operations of the brain and the body. Examples include barbiturates, anti-anxiety tranquilizers (e.g., Valium, Librium, Xanax, Prozac, and Thorazine), GHB (gamma hydroxybutyrate), Rohypnol, and many other anti-depressants (e.g., Zoloft, Paxil).
> **Stimulants:** accelerate the heart rate and elevate the blood pressure and "speed-up," or over-stimulate, the body. Examples include cocaine, "crack" cocaine, amphetamines, and methamphetamine ("crank").
> **Hallucinogens:** cause the user to perceive things differently than they actually are. Examples include LSD, peyote, psilocybin and MDMA (Ecstasy).
> **Narcotic Analgesics:** relieve pain, induce euphoria, and create mood changes in the user. Examples include opium, codeine, heroin, Demerol, Darvon, morphine, methadone, Vicodin, and oxycontin.
> **Inhalants: i**nclude a wide variety of breathable substances that produce mind-altering results and effects. Examples include Toluene, plastic cement, paint, gasoline, paint thinners, hair sprays, and various anesthetic gases.
> **Other drug(s):** explain.

5.6.10 For ALL victims -- injured and deceased -- there should be a mandatory national collection of data on Life Jacket use. If the life jacket was a factor in the incident then the following detail should be mandatory: Type of life jacket; whether inherently buoyant or inflatable; whether serviceable; whether properly used; and whether of proper size.

Current federal regulations require the report of the availability and use of personal flotation devices. The current Coast Guard BAR form requests the number of persons onboard wearing lifejackets, and whether the operator, injured, and deceased persons also were wearing them. In their deliberations, the workgroup considered collecting life jacket information for all people onboard the vessel(s) involved so that efficacy could be determined (if there is information as to whether the person entered the water in the incident) and so that the information could be compared to life jacket wear rate studies. However, this consideration was eventually dropped in the interest of a shorter data collection and an acknowledgment that such an extensive data collection would be difficult if the people involved in the incident had dispersed prior to an investigator's arrival on the scene. Additionally, there was a concern about the validity of data. If an investigator arrived late on scene, a person might answer in the affirmative about wearing a life jacket based on his or her perception of the legal requirement to wear one.

Ultimately, the workgroup recommended the mandatory collection of life jacket use for all victims, with the mandated collection of additional detail if the life jacket was a factor in the incident.

The discussions on life jacket use led the workgroup members to also briefly entertain the possibility of collecting circumstantial information on victims, such as their location on the boat, whether they were ejected, and method of injury. However, workgroup members did not express an interest in documenting such information in a national collection.

5.6.11 The Coast Guard should consult the medical community to develop standardized fields for Cause of Death. This should include seeking the appropriate terminology for describing deaths due to "natural causes" and determining whether and how "hypothermia" should be used.

At least one workgroup member expressed a strong interest in eliminating "hypothermia" as an option because of possible misuse. Other group members noted other possible causes of death that could be used, including: cold water drowning (although the Coast Guard expressed concerns about introducing this term since it can already be isolated by examining the cause of death and water temperature), fire, smoke, blunt force trauma, and additional options for trauma (such as specifying an amputation). Group members also considered having two categories: one for the cause of death, and another for more technical language from a medical examiner.

Ultimately, the workgroup recommended that the Coast Guard consult the medical community for a list of appropriate causes of death.

5.6.12 In reference to Drownings, consideration should be given to using the following standard terminology to report outcomes: 1) instead of the current "Death-by drowning," use "Drowning, fatal"; and 2) in the case of an injury, use "Drowning, non-fatal."

In developing this recommendation, the workgroup consulted the following source and definitions regarding drownings, which would be adapted for general reference and incorporated into best practices guidance for officers/investigators: http://www.surfersmedicalassociation.org/drowning-sea-misinformation-drydrowning-secondary-drowning-andrew-schmidt-d-o-mph/. *The medical definition of drowning is "the process of experiencing respiratory impairment from submersion/immersion in liquid." (Definition of Drowning: A Progress Report. Bierens J, Drowning 2e. Berline: Springer, 2014.) Drowning has only three outcomes: fatal drowning, nonfatal drowning with injury or illness, or nonfatal drowning without injury or illness.*

5.6.13 Regarding Cause of Death, there should be a field that would allow the officer/investigator to write a fatality synopsis.

5.6.14 There should continue to be mandatory collection of the primary injury for persons injured in the incident (those who meet the threshold). The capture of any secondary injuries should be optional.

5.6.15 For injured persons (those who meet the threshold), the references to body parts/areas of injury should be standardized. If the current categories in the national statistics are used, the term "whole body" should replace "body" to distinguish from "trunk."

The workgroup recommended a standardized collection on the area of injury. Using the categories that currently appear in the Coast Guard's annual statistics report (Table 28) as the basis, the workgroup recommended the following injury areas: arm, whole body, foot, hand, head, leg, neck, trunk, unknown, and other. Some workgroup members (and a State reviewer in the first comment period) also suggested documenting whether an injury was "internal" or "external."

5.6.16 For injured persons (those who meet the threshold), the references to the nature of injury should be standardized. If the current categories in the national statistics are used as a basis, the following terms should be removed, retained pending further information, or introduced: remove "scrape/bruise" (in accordance with revised injury definition); retain "hypothermia" pending consultation with the medical community on usage; introduce "drowning, non-fatal."

Using the categories that currently appear in the national statistics report (Table 28) as the basis, the workgroup recommended the following injury types: amputation, broken bone, burn, carbon monoxide, concussion, dislocation, drowning- non-fatal, electric shock, hypothermia, internal organ injury, laceration, shock, spinal cord injury, sprain/strain, other, and unknown.

6. REPORT DATA INPUT FORMATS (preliminary – will be addressed in more detail in Phase 2 of project)

RECOMMENDATIONS (see detail below)

The future reporting system should accommodate both on-site entry of report data through mobile platforms and manual entry of report data into fillable, printable PDF forms that would allow content to be transferred into the system.

In the future, revisions to the reporting system should accommodate the least burdensome method for documenting basic injury or damage information that does not meet the injury or damage threshold but is associated with an otherwise reportable incident. *(For example, a field that would allow recording of the number of persons who had injuries below the federal threshold; an officer/investigator would not be expected to fill out an injury record for a person whose injury did not meet the injury threshold. "Best practices" documentation and training should provide guidance on an injury that does not meet the injury or damage threshold, but is associated with an otherwise reportable incident).*

BACKGROUND

The second phase of this policy project will focus on recommendations for a revised reporting system. However, throughout its discussions in this first phase, the workgroup identified areas where the current system is deficient and also noted aspects of the proposed, revised incident report structure that will need to be accommodated. The workgroup also considered whether the future reporting system should be designed to accommodate both incident reporting requirements (for statistical purposes) **and** requirements for a State's criminal investigation. The workgroup suggested that the future reporting system should focus solely on incident reporting requirements because it would be difficult to design a criminal investigation system that could satisfy every State's needs; moreover, some States (for example, Kansas) require that a separate system be used for criminal investigations. Workgroup members also expressed concerns about the sensitivity of information in a criminal investigative record, and the Coast Guard questioned whether the agency would even have the statutory authority to create a data collection system for criminal investigations.

In its discussions on feedback received during the first comment period, the workgroup also emphasized the need for training not only personnel doing the field investigations, but also persons administering the reporting system.

The following recommendations are associated with general data entry and methods for documenting injury and damage information outside of the report thresholds.

6.1 The future reporting system should accommodate both on-site entry of report data through mobile platforms and manual entry of report data into fillable, printable PDF forms that would allow content to be transferred into the system.

Workgroup members felt they would need a variety of mediums to record data. Some members who already have a separate, State-maintained system for reporting their boating incidents planned to continue to use an independent platform. They would continue to need support to transfer data from their State-maintained system into the Coast Guard's future reporting system.

Other workgroup members envisioned a mobile platform to submit data. This platform could be used by all of their officers and by agencies that respond to boating incidents. These members desired a versatile platform that could support a variety of operating systems and devices.

Other members desired a fillable, printable PDF form that could transfer data into the Coast Guard's new reporting system. Having such capability would eliminate the need to be connected to the internet at the scene of the incident (which is not always possible in some remote areas).

Still other members expected that the original documentation of an incident would be done via paper, taken back to an office, and entered into a system.

6.2 **In the future, revisions to the reporting system should accommodate the least burdensome method for documenting basic injury or damage information that does not meet the injury or damage threshold but is associated with an otherwise reportable incident.** *(For example, a field that would allow recording of the number of persons who had injuries below the federal threshold; an officer/investigator would not be expected*

to fill out an injury record for a person whose injury did not meet the injury threshold. "Best practices" documentation and training should provide guidance on an injury that does not meet the injury or damage threshold, but is associated with an otherwise reportable incident).

This recommendation 6.2 is regarding the documentation of injured victims who did not meet the federal injury threshold but were involved in an incident that met some reporting threshold (such as an incident that also involved a death, damages, or total loss). For the purposes of a reporting system, the workgroup recommended documenting the *number* of people who were injured in an incident who did not meet the injury threshold, an action that would ensure all injured victims described in the narrative (whether they met the injury threshold or not) were accounted for in some fashion. For all other victims who met the injury threshold, an investigator would need to document all of the information on the injury.

Some workgroup members expressed concern about overinflating injuries if the number of people who were injured below the injury threshold were documented. However, the Coast Guard currently documents all injured victims in "reportable" boating incidents. Further, the agency has conducted several studies that suggest that injuries, in general, are severely *underreported.*

For the purposes of a report to the public, the workgroup recommended that the Coast Guard distinguish injury severities in the Coast Guard's annual national statistics publication.

7. ROLES AND RELATIONSHIPS

RECOMMENDATIONS (see detail below)

If a State becomes aware that the Coast Guard has assumed the lead investigation of an incident, the State should notify CG-BSX, and CG-BSX in turn should acknowledge the State's notification that the Coast Guard has assumed the lead. (Coast Guard response in the form of a Search and Rescue does not constitute a Coast Guard investigation.)

If the Coast Guard assumed the lead in investigating an incident, the State should be relieved of the duty to investigate and not be required to submit data to CG-BSX about the incident. Further, in the event the State has already gathered some information and shared that information with Coast Guard investigators per the terms of its MOU, the State should not be required to investigate further or submit data to CG-BSX about the incident. CG-BSX would be responsible for gathering and entering information about the case.

Incidents that occur on tribal waters should be excluded from reporting requirements as neither the States nor Federal Government have jurisdiction over them.

The Coast Guard should be responsible for collecting and entering information on incidents that occur under the sole jurisdiction of another federal entity, such as the National Park Service, U.S. Forest Service, or U.S. Army Corps of Engineers, or when such federal agency assumes the investigative lead on any such incident.

The State Reporting Authorities should determine how best to maintain and nurture relationships with local entities involved in the accident reporting system.

In the future, if a State official determines that an incident described in a news media report does NOT meet the requirements for a report to the Coast Guard, the Coast Guard should accept the State's determination.

7.1 If a State becomes aware that the Coast Guard has assumed the lead investigation of an incident, the State should notify CG-BSX, and CG-BSX in turn should acknowledge the State's notification that the Coast Guard has assumed the lead. (Coast Guard response in the form of a Search and Rescue does not constitute a Coast Guard investigation.)

This recommendation stems from the Office of Auxiliary and Boating Safety's (CG-BSX) request for notification from a State of any incident in which another Coast Guard asset assumed the lead in an investigation. CG-BSX noted that often times the Office is unaware of Coast Guard involvement in a recreational boating accident. In the past, CG-BSX received automatic notification from the Coast Guard's Marine Information for Safety and Law Enforcement system (MISLE) if there was an incident that may have involved a recreational vessel. Since MISLE's update, the automatic notification no longer exists. CG-BSX has tried to fill in the gap by joining a distribution list maintained by the Office of Investigations and Analysis about their investigations and by searching news media stories of Coast Guard involvement.

Still, CG-BSX has been hampered in its ability to track accidents. Coast Guard representatives to the workgroup relayed information about one fatal case several years ago that CG-BSX missed. Though it occurred in Texas, the State did not report it because the Coast Guard assumed the lead in the investigation, the MISLE notification was not working, and the incident never popped up in the news media. As a result, CG-BSX never knew about it and did not include it in its dataset, an omission that caused embarrassment when a member of the public pointed it out on a website.

Workgroup members admitted that sometimes they are not aware the Coast Guard assumed the lead in an investigation due to a lack of communication from the Coast Guard asset that responded. Members cited difficulty building relationships due to the frequency of Coast Guard member rotation. In discussions leading to the development of this recommendation, workgroup members cited a willingness to inform CG-BSX *if* they became aware that the Coast Guard has assumed the lead investigation in an incident, and they, in turn, would request CG-BSX acknowledgement of the notification. However, in the first comment period, some State members still expressed concerns over the wording of this recommendation, citing that the burden should not be on the State to notify, but that the responsibility to notify should come from the Coast Guard sector or unit doing the investigation, with notification to both CG-BSX and the State.

In an attempt to build relationships between the States and Coast Guard, CG-BSX reminded group members to seek assistance from their District Recreational Boating Safety Specialist. If all else fails, they can request assistance directly from CG-BSX. CG-BSX noted attempts to reinforce communication requirements by participating in sector commander conferences and trainings.

7.2 If the Coast Guard assumed the lead in investigating an incident, the State should be relieved of the duty to investigate and not be required to submit data to CG-BSX about the incident. Further, in the event the State has already gathered some information and shared that information with Coast Guard investigators per the terms of its MOU, the State should not be required to investigate further or submit data to CG-BSX about the incident. CG-BSX would be responsible for gathering and entering information about the case.

In the workgroup's discussions on the Coast Guard's and States' respective investigative responsibilities, the Coast Guard members of the workgroup noted that if a State requires information on an incident that the Coast Guard responded to (but did not assume the lead on), the State should attempt to obtain the information from the responding Coast Guard unit. If the unit is non-responsive, the State should attempt to gain information from the Coast Guard District Recreational Boating Safety Specialist. If all else fails, the State should contact CG-BSX directly for assistance.

Further, the Coast Guard members noted that even though States would be relieved of the duty to investigate if the Coast Guard assumed the lead in investigating an incident, the State could still elect to investigate, but would not be required to submit report data to the Coast Guard.

7.3 Incidents that occur on tribal waters should be excluded from reporting requirements as neither the States nor Federal Government have jurisdiction over them.

As a result of preliminary discussion at the Spring 2019 BLA Workshop, and feedback from the first comment period, the workgroup will be seeking additional comments from the States—and additional research—before making any modifications to this recommendation.

7.4 The Coast Guard should be responsible for collecting and entering information on incidents that occur under the sole jurisdiction of another federal entity, such as the National Park Service, U.S. Forest Service, or U.S. Army Corps of Engineers, or when such federal agency assumes the investigative lead on any such incident.

7.5 The State Reporting Authorities should determine how best to maintain and nurture relationships with local entities involved in the accident reporting system.

Some workgroup members noted that training the local entities would establish a relationship and would remind them of their responsibilities.

7.6 In the future, if a State official determines that an incident described in a news media report does NOT meet the requirements for a report to the Coast Guard, the Coast Guard should accept the State's determination.

Some workgroup members expressed frustration with the Coast Guard's use of news media reports. In particular, they noted frustration with inaccurate information reported in some media reports and the Coast Guard's request for an explanation about a media report. For such reasons, the workgroup recommended that the Coast Guard accept a State's determination regarding an event reported by a news outlet.

In the first comment period, one of the Coast Guard personnel providing feedback noted that CG-BSX has been making an "honest effort" in response to congressional oversight to capture as much data as reasonable and not with intent to overburden the States.

8. VESSEL SAFETY ISSUES, DEFECTS, RECALLS, AND BRIDGE ALLISIONS

RECOMMENDATIONS (see detail below)

The State Reporting Authority should notify the Coast Guard when it reasonably believes a potential safety issue is present on a vessel manufactured for recreational use and the State has been made or became aware of it. Notification should take place as soon as reasonably possible.

The future reporting system should link to the Recalls Database. That way, a HIN or manufacturer/ model/year that matches between the incident and recalls would flag the incident for the State ~~officer/investigator.~~

The State should notify the Coast Guard if a vessel allides with a bridge over waters of concurrent jurisdiction.

The future reporting system should have a means to easily notify a Coast Guard Sector of a bridge allision. The Sector would be coded based on the geographical data in the record.

The Coast Guard should introduce a streamlined reporting process (via the CG-BSX website or in the future reporting system) whereby the State Reporting Authority could report a suspected safety defect.

A State Reporting Authority should be able to report a suspected safety issue apart from the officer/investigator**.**

BACKGROUND

The Coast Guard regulates certain aspects of recreational vessel manufacturing and is responsible for developing and enforcing federal safety standards set out in 33 CFR 181 and 183. The Coast Guard has the ability to investigate suspected defects. Based on the nature of the defect, the Coast Guard will send staff to investigate the issue, direct manufacturers to provide defect notifications to consumers, and/or announce an alert on a defective product.

The Coast Guard, through its Office of Bridge Programs, permits, regulates, and monitors approximately 20,000 bridges that cross navigable waters of the U.S. (through implementing regulations in 33 CFR Parts 114-118) and requests notifications from States in the event a recreational vessel allides with a bridge.

The recommendations in this series relate to notifications, reporting, and other communications between the Coast Guard and the States regarding various safety issues, defects, recalls, and bridge allisions. They are intended not only to reinforce existing regulatory requirements, but also facilitate notifications and reporting.

8.1 The State Reporting Authority should notify the Coast Guard when it reasonably believes a potential safety issue is present on a vessel manufactured for recreational use and the State has been made or became aware of it. Notification should take place as soon as reasonably possible.

In developing this recommendation, some workgroup members expressed concern about the State's authority and liability of such a requirement. For this reason, the qualifier "has been made or became aware of it" were included in the statement.

Workgroup members also recommended that the MOUs between the States and the Coast Guard be updated as well to reflect the intent of this recommendation.

8.2 The future reporting system should link to the Recalls Database. That way, a HIN or manufacturer/ model/year that matches between the incident and recalls would flag the incident for the State. ~~officer/investigator.~~

The Coast Guard's Office of Auxiliary and Boating Safety (CG-BSX) maintains the "Recalls Database" referred to in this recommendation. Currently, it is available to the public on a webpage (http://uscgboating.org/content/recalls.php**)**. Information can be searched by MIC, manufacturer, model, and model year. Usually, cases have a snapshot and status of the issue. The entire Recall List, which includes the MIC, Company Name, Model Name, Problem, and Comments, as applicable, can be viewed online or downloaded as a Microsoft Excel worksheet.

As a result of feedback received in the first comment period, and to acknowledge that not all officers/ Investigators currently or in the future will direct enter into the reporting system, the workgroup modified the wording of the recommendation to indicate that the incident would be flagged for "the State" (i.e., general language in lieu of referencing "the reviewer of the incident report" or "the person entering the data").

8.3 The State should notify the Coast Guard if a vessel allides with a bridge over waters of concurrent jurisdiction.

The Coast Guard's Office of Bridge Programs (CG-BRG) has oversight on permitting, monitoring of construction, and alterations of bridges (under authority of U.S. Code and implementing regulations in 33 CFR Parts 114-118). CG-BRG has requested notification from a State if a recreational vessel allides with a bridge so that the Program can contact the bridge owner for proper inspection of the infrastructure.

In its discussions, workgroup members expressed concerns about the ease of making that notification and the general lack of knowledge of points of contact within the Coast Guard. Coast Guard members of the workgroup reassured that the future reporting system should be designed to make the process as easy as possible. Based on the coordinates or geographical information in the boating incident report, ideally, a State should be able to click a button and the appropriate Sector would receive email notification from the system.

The Coast Guard further recommended that a State should notify the Coast Guard Sector whether or not the incident met a federal reporting threshold; even if damages were not readily apparent, there could be underlying safety issues with the bridge as a result of the boating incident.

Workgroup members recommended contacting CG-BRG even if a State had already contacted the Department of Transportation about a bridge allision.

In feedback submitted during the first comment period, State commenters expressed some continuing concerns about the notification process, cited the need for more guidance as to "whom" or "where" in the Coast Guard the State should report the incident, and reinforced the desire for the least burdensome method of making the notification. The project workgroup will be seeking additional feedback from the States in the second comment period, however, before making any modifications to the current wording of the recommendation.

8.4 The future reporting system should have a means to easily notify a Coast Guard Sector of a bridge allision. The Sector would be coded based on the geographical data in the record.

8.5 The Coast Guard should introduce a streamlined reporting process (via the CG-BSX website or in the future reporting system) whereby the State Reporting Authority could report a suspected safety defect.

Currently, the Coast Guard's Office of Auxiliary and Boating Safety (CG-BSX) website has a consumer safety defect report form (http://uscgboating.org/php-contact-form/consumer-safety-defect-report.php) where the public can report a suspected defect on a boat or related equipment less than 10 years old.

The form requires the following information: owner contact information (name, phone number, address, email); boat information (manufacturer, model year, model name, model type, HIN, length, date purchased, purchase type (new, used), dealer name and address, use of boat (recreational, commercial, other)); engine information (engine manufacturer, model year, model name, propulsion type); accident

information (if applicable; number casualties, accident date, location, description); and description of possible defect.

The Coast Guard has the authority to send staff to investigate the issue, direct manufacturers to provide defect notifications to consumers, and announce an alert on a product.

For the Coast Guard to take action on the information provided by the State (or by a boat owner) in a Consumer Safety Defect Report, the reported problem must relate to a boat or associated equipment less than 10 years old, it must be a violation of federal safety regulations, or it must be "a defect that creates a substantial risk of personal injury to the public."

The determinations of a defect that creates a substantial risk of personal injury to the public (safety defect) are based on three distinct criteria: 1) The hazard must occur virtually without warning—an obvious risk or normal wear and tear do not normally create the basis for a defect; 2) The defect must occur with some frequency—one isolated occurrence usually does not constitute the basis for a finding of defect; and 3) The defect must clearly present the risk of death or serious injury.

Regulated areas of concern include:

Hull Identification Numbers – 33 CFR Part 181
Capacity Marking – 33 CFR Part 183 Subpart B
Vessel Flotation – 33 CFR Part 183 Subparts F-H
Electrical Systems – 33 CFR Part 183 Subpart I
Fuel Systems – 33 CFR Part 183 Subpart J
Ventilation – 33 CFR Part 183 Subpart K
Start in Gear Protection – 33 CFR Part 183 Subpart L
Navigation Lights – 33 CFR Part 183 Subpart M
Life Jackets (recreational) – 46 CFR Part 160.064, 160.076, 160.077
EPIRB – 46 CFR Part 161.011
Fire Extinguishers – 46 CFR Part 162.028
Distress Signals – 46 CFR Parts 160.021 – 160.024, 160.028, 160.037, 160.066, 160.072

The following are a couple of examples of actions taken as a result of alerts: 1) Several accidents involving a flat, open motorboat that, after turning quickly, capsized. Upon request from the State, the Coast Guard initiated an investigation of the vessel design by running the boats in a remote-controlled experiment to gauge their performance; and 2) A vessel manufacturer did not install all-around white lights on specific models associated with towed watersports activities. In 2010, the Coast Guard issued a corrective action notice to the manufacturer.

In discussing this activity, some workgroup members expressed frustration with the current defect reporting set-up. Of principal concern was the required source of reporting: the vessel owner vice a State investigator. One workgroup member recalled a concern about ancillary equipment (a range) that had been installed on a vessel and caused a vessel fire, and found the reporting process cumbersome in terms of timeliness and organization. Instead of being able to work with the Coast Guard about the issue, the member had to prompt the vessel owner to submit a possible safety defect. Because the vessel owner was not willing to submit the safety defect, the member typed up an email and sent it to the Coast Guard Product Assurance Branch, and did not receive an expected reaction to the issue. The workgroup member understood that the suspected issue might have been outside the regulatory purview of the Coast Guard, but because of this experience, thought there could be a more streamlined reporting process. The member suggested a form on a portal or attachment in the future reporting system in which the State could report a suspected issue to the Coast Guard, as opposed to the State pressing the vessel owner to submit a form.

8.6 **A State Reporting Authority should be able to report a suspected safety issue apart from the officer/investigator.**