DISPOSITION OF COMMENTS from SECOND EXTERNAL REVIEW AND COMMENT PERIOD

The project workgroup acted on nearly 170 comments and questions affecting 76 of the 125+ recommendations that were presented to the States for review beginning March 27, 2019.

KEY:

RECOMMENDATIONS THAT DID NOT HAVE SPECIFIC COMMENTS OR QUESTIONS DIRECTED AT THEM ARE SHADED IN GREY

RECOMMENDATIONS (specific items or entire sections of recommendations) THAT HAD COMMENTS OR QUESTIONS FOR THE WORKGROUP TO DISCUSS AND RESOLVE ARE HIGHLIGHTED IN BLUE

State or Agency (submitter's name): comment or question

Workgroup's response to comment/question: presented in red.

The project workgroup discussed and made initial responses to the comments during teleconferences conducted Aug. 14, Aug. 20, Aug. 27, Sept. 3, Sept. 20, Sept. 24; additional work to resolve feedback occurred in November and December 2019, and January 2020, and included workgroup sessions on Dec. 16 and 18, and January 8 and 13.

RECOMMENDATIONS THAT RECEIVED NO SPECIFIC FEEDBACK FROM COMMENTERS WERE STILL REVIEWED BY THE WORKGROUP TO DETERMINE IF THEY NEEDED TO BE REVISED IN ACCORD WITH DISCUSSIONS AND DECISIONS MADE ON RELATED ITEMS.

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

GENERAL COMMENTS ON PROPOSED CHANGES TO THE REPORTING STRUCTURE AS DESCRIBED IN SECTION ONE – all general comments below had content that needed to be taken up by the workgroup

California (Johanna Naughton): "California is concerned regarding the recommendations associated with alternations [sic] boating accident collection and submission process. California cannot guarantee compliance with any activities that go beyond current federal statutes and regulations. Federal policies mandating an activity would be considered an underground regulation regardless of whether or not consensus has been reached by the majority of states.

"The state of California also does not have centralized law enforcement. Currently, neither federal nor state law requires other agencies to report accidents to DBW. These issues would make complying with any two-tier system very difficult, if not impossible, depending upon the design or requirements of such a system."

Workgroup response: Understood. Many of these recommendations would impact federal regulation, which in turn, would impact state regulation. Many of the concerns expressed by California may be resolved if federal regulation is successfully updated.

Nevada (Brian Bowles): "…recommend that on waters of concurrent jurisdiction with federal authorities and/or other states that 'best practices guidance' from this workgroup speak to issues of responsibility and jurisdiction for each party."

Workgroup response: Acknowledged. Best Practices (which will be developed in Phase 2 of this project) should better address jurisdictional concerns.

Arizona (Tim Baumgarten): "…I would [also] encourage the collection of the notification date to the State Reporting Authority to prevent the common misconception that the date of the incident is the same as the notification date. This would also provide the CG an accurate date from which to base reporting compliance."

Workgroup response: **The collection of the date that the State Reporting Authority was notified of the incident is incorporated into recommendation 5.2.5.**

Pennsylvania (Corey Britcher): "do we define incident anywhere? Would think you would want to do that in [this section]."

Workgroup response: **The term "Incident" was defined in the introduction to the recommendations' Review Document, as was "state":**

- **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.**
- **"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).**

The definitions for these two terms along with those of any other pertinent terms and abbreviations will be listed in the front of the final recommendations document.

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

California (Johanna Naughton): "California law gives local agencies the authority to investigate boating accidents, but does not compel them to do so. Additionally, as noted [see above general comment], there is no federal or state requirement for law enforcement agencies to forward accident reports to the state authority except in specific cases (e.g. if they receive funding). Therefore, requiring the operator or any other party to report an accident to a law enforcement agency rather than DBW would hinder our ability to collected [sic] accident reports."

Workgroup response: **Understood. Many of these recommendations would impact federal regulation, which in turn, would impact state regulation. Many of the concerns expressed by California may be resolved if federal regulation is successfully updated.**

With regard to the specific concern regarding the reference to law enforcement, it is noteworthy that in its earlier discussions, the workgroup did weigh the notification of "[State] reporting authority" (as currently cited in CFR) versus "law enforcement." The workgroup ultimately settled on "law enforcement" with the intent that a State could use more specific language in its implementing Statute, if it so desired.

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.

Michigan (Tom Wanless): recommend the State be responsible for collecting information

Workgroup response: **Understood. Several recommendations (e.g., 1.9 and 3.1) address this suggestion.**

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

California (Johanna Naughton): "Due to our lack of centralized law enforcement, California cannot comply with the suggested changes regarding the two-tiered system addressed in 1.3, 1.4 and 1.8." [see other comments above]

Workgroup response: Understood. This and many of the other recommendations would impact federal regulation, which in turn, would impact state regulation. Many of the concerns raised by California may be resolved if federal regulation is successfully updated.

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

California (Johanna Naughton): Due to our lack of centralized law enforcement, California cannot comply with the suggested changes regarding the two-tiered system addressed in 1.3, 1.4 and 1.8.

Workgroup response: Understood. This and many of the other recommendations would impact federal regulation, which in turn, would impact state regulation. Many of the concerns expressed by California may be resolved if federal regulation is successfully updated.

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.

1.6. Federal provisions should identify the minimal required information to be collected ~~for the~~upon notification of an incident ~~stage~~. *[The "minimal required information" is~~—~~ the preliminary information about an incident (date, time, location, vessel type(s), and numbers of deceased and injured) ~~— is~~as described in recommendation 1.9.]*

Workgroup overall response to comments submitted on recommendations 1.6 and 1.7: The workgroup revised this recommendation and 1.7 in response to a commenter's suggestion regarding "notification" as a point in time as opposed to a "stage" (a period of time), and, for clarity and ready reference, to actually list the items intended to be collected as part of the "minimal" or "preliminary" information described in recommendation 1.9.

As revised, 1.6 now reads: Federal provisions should identify the minimal required information to be collected upon notification of an incident. *[The "minimal required information" is the preliminary information about an incident (date, time, location, vessel type(s), and numbers of deceased and injured) as described in recommendation 1.9.]*

California (Johanna Naughton): "Regarding 1.6, 1.7, and 1.9, current in-house practice provides for "placeholder" information entered into BARD as soon as possible while waiting for fatal accident reports to be submitted. However, this is a courtesy and may not happen in every case. Therefore, we cannot commit to activities that go beyond what federal statutes and regulations currently require…. "

Workgroup response: Understood. This and many of the other recommendations would impact federal regulation, which in turn, would impact state regulation. Many of the concerns expressed by California may be resolved if federal regulation is successfully updated.

Coast Guard (Verne Gifford): Re: 1.6. and 1.7., the words "notification stage" should be replaced with "notification" so that a point in time is referenced, versus a period of time.

Workgroup response: Agreed. The workgroup modified this recommendation 1.6 along with recommendation 1.7 to reflect "notification" (a point in time) vice "notification stage" (a period of time). Also, for the sake of clarity and ready reference, this recommendation has

been edited to directly name the "minimal required information" that is identified in recommendation 1.9.

1.7. The State should determine how best to obtain the minimal required information--the preliminary information about an incident (date, time, location, vessel type(s), and numbers of deceased and injured) as described in recommendation 1.9--to be collected ~~for the~~upon notification ~~stage~~ (e.g., receipt from the operator; gathered by officer/investigator; etc.).

Workgroup overall response to comments submitted on recommendations 1.6 and 1.7: The workgroup revised this recommendation and 1.6 in response to a commenter's suggestion regarding "notification" as a point in time as opposed to a "stage" (a period of time), and, for clarity and ready reference, to actually list the items intended to be collected as part of the "minimal" or "preliminary" information described in recommendation 1.9.

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California (Johanna Naughton): "Regarding 1.6, 1.7, and 1.9, current in-house practice provides for "placeholder" information entered into BARD as soon as possible while waiting for fatal accident reports to be submitted. However, this is a courtesy and may not happen in every case. Therefore, we cannot commit to activities that go beyond what federal statutes and regulations currently require…."

Workgroup response: Understood. This and many of the other recommendations would impact federal regulation, which in turn, would impact state regulation. Many of the concerns expressed by California may be resolved if federal regulation is successfully updated.

Coast Guard (Verne Gifford)**:** Re: 1.6. and 1.7., the words "notification stage" should be replaced with "notification" so that a point in time is referenced, versus a period of time.

Workgroup response: Agreed. The workgroup modified this recommendation 1.7 along with recommendation 1.6 to reflect "notification" (a point in time) vice "notification stage" (a period of time). Also, for the sake of clarity and ready reference, this recommendation has been edited to directly name the "minimal required information" that is identified in recommendation 1.9.

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

California (Johanna Naughton): "Due to our lack of centralized law enforcement, California cannot comply with the suggested changes regarding the two-tiered system addressed in 1.3, 1.4 and 1.8.

"Further…California also cannot require other agencies to comply with any activities that go beyond what federal statutes and regulations currently require. This type of law or requirement would be considered an unfunded local mandate."

Workgroup response: Understood. This and many of the other recommendations would impact federal regulation, which in turn, would impact state regulation. Many of the concerns expressed by California may be resolved if federal regulation is successfully updated.

Coast Guard (Verne Gifford): Re: 1.8., the recommendation should read, "The State Reporting Authority should complete the form after notification of an incident." An investigation should only be required for fatal incidents; all other incidents should require a less onerous data collection.

Workgroup response: The workgroup favors retaining the recommendation as currently worded. In discussions prior to releasing the recommendations for external review, the group did consider the idea of having different length collections for incidents of different types or severity, ultimately dismissing it in favor of a universal data collection. On an August 2019 call, members reaffirmed the original recommendation, noting that an investigation is used to determine the facts about an incident, and should include a systematic gathering of whatever information and detail is available at the time to identify potential causes or contributors. In considering whether a definition of "investigation" should be developed to accompany the recommendations at this time, members pointed instead to NASBLA's Boating Accident Investigation training materials and suggested referencing them in the Best Practices that will be developed in phase two of this project.

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.*

South Carolina (Donnie Pritcher): disagree with the 15 days; 30 days is OK. '

Additional information from the respondent: At the request of the project workgroup, with the intent of gathering additional insights into South Carolina's concerns over this recommendation, Susan Weber corresponded with Donnie via email on Aug. 19. In response to her question as to why he found the 15 days to be disagreeable, Donnie said, "Our officers are required to get the preliminary report to the INV. office in 10 days leaving five days to get it to the CG. We didn't feel that there was adequate time to make notification to the CG." Susan followed up with a further request as to what is currently collected in their preliminary report (clarifying that the information that would be requested per the recommendation would be minimal (i.e., date, time, location, vessel type(s), and numbers of deceased and injured)) and how long after receipt of the preliminary report from officers does it typically take for the information to get into BARD. Donnie replied that "….it doesn't take long. However, I'm looking to avoid the one that comes in on day 10 and my officer that is entering is out on leave or a big case that would prolong entering the information."

Pennsylvania (Corey Britcher): I think 15 days for notifying the USCG is too short, if we find out after the fact but it takes multiple days to conduct the investigation, the deadline comes quick.

*Additional information from the respondent: Similarly, at the request of the project workgroup, Susan Weber corresponded with Corey via email on Aug. 19. In response to her question as to why he found the 15 days to be disagreeable, Corey said, "There are times that we do not find out about an accident that should be investigated until the self-reporting form comes in or when the owner is trying to get the insurance to pay for fixing the boat. In such cases we might already be at or beyond the 15-day window." Susan clarified that the "…wording of the recommendation doesn't put a State "on the hook" for the preliminary information until *they* are notified of it…" and asked if that made him more comfortable. Corey responded in the affirmative.*

Alabama (Walter Thompson): …I think 15 days is pushing it. Maybe a little longer timeframe should be considered.

Additional information from the respondent: As she did with the respondents from South Carolina and Pennsylvania, Susan corresponded with Walter via email on Aug. 19. In response to her question as to why he found the 15 days to be disagreeable, he said, "… I was in agreement with several other BLAs that commented that the 15 day should be extended. The extra time may not be needed, but in case it was, it just gave us that extra time in case we needed it…." Susan followed by asking if they usually have the date,

time, location, vessel type(s), and numbers of deceased and injured within 15 days of being notified of an incident? Walter said they do.

Workgroup response to commenters from South Carolina, Pennsylvania, and Alabama: After reviewing the original comments submitted by the state respondents from South Carolina, Pennsylvania, and Alabama, the workgroup asked that Susan Weber contact them for more detail on the issues their states would face if the 15-day submission of preliminary information were to be retained as a recommendation. In her request to these states, Susan was asked by the group to include the additional information from the Resource Document (v. March 2019) and remind them that the recommendation as written is prefaced with the condition "if a system can be built" to accommodate it. The group thought it possible that a couple of the commenters might still have been thinking about the current 30-day reporting period – i.e., how things are done now as opposed to how things *could* be done (and improved) in the future. But some workgroup members who had also expressed concerns in earlier deliberations on this recommendation indicated they understood why there might be some hesitation as it took them a while to come around to the prospect of a 15-day submission of preliminary information. Among the concerns expressed: potential burden for states that have a large volume of incidents; possible use for program compliance; various contractual issues associated with some states' third-party reporting systems; and the time required for supervisors to review the preliminary information prior to submission.

Some workgroup members even suggested an alternative timeline whereby if a final report were not available within 30 days of the incident, the State would agree to submit a preliminary report to include the minimal information required by the Coast Guard. The Coast Guard, however, has expressed continuing interest in a 15-day requirement because of their requirement to report casualty performance metrics quarterly to the Department of Homeland Security and monthly for internal purposes.

In turn, the workgroup members requested that the language "of being notified of an incident" be included in the recommendation so that the states wouldn't be "on the hook" for delayed submissions on incidents for which they had received untimely notifications.

With regard to the other issues identified by the workgroup in its development of the recommendation and members' consideration of the concerns expressed by the external reviewers, there was discussion about the need for:

- **A phase-in period to accommodate the submission requirement, and the potential for states' use of their grant money to make changes to independent third-party systems;**
- **The future reporting system to facilitate deleting or deeming as "non-reportable" initial reports that later were found to be false or unnecessary.**
- **A stipulation that only the Coast Guard or a State Reporting Authority would be able to delete the report (an officer in the field shouldn't be able to do so); and**
- **Finally, additional training or resources in order for some State Reporting Authorities to comply with this requirement should it move forward.**

Ultimately, based on prior discussions and then, consideration of the additional information provided by the state respondents who had expressed concerns during the comment period, the workgroup agreed to retain the recommendation, as currently worded, with the noted caveats regarding the future reporting system.

California (Johanna Naughton): Regarding 1.6, 1.7, and 1.9, current in-house practice provides for "placeholder" information entered into BARD as soon as possible while waiting for fatal accident reports to be submitted. However, this is a courtesy and may not happen in every case. Therefore, we cannot commit to activities that go beyond what federal statutes and regulations currently require. Additionally, we

do not support the wording changes from "30 days from the receipt of a report" to the 15-day clock starting at "notification of an incident." Notification from whom? We may not have the authority to collect from the notifying party.

Workgroup response: Regarding the concerns about notification--the notification parties are outlined in recommendation 1.4.—i.e., operator, owner, other entity. Before settling on the term "other entity," the workgroup considered "responsible parties," but ultimately discarded 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," however, would not absolve anyone involved from complying with the investigation of the incident.

With regard to what the federal statutes and regulations currently require—this and many of the other recommendations would impact federal regulation, which in turn, would impact state regulation. Many of the concerns expressed by California may be resolved if federal regulation is successfully updated.

Arkansas (Stephanie Weatherington): I like the idea of an "override" system because many times it's not until an incident is fully investigated that it's determined to be non-reportable. Also agree on preliminary information w/in 15 days of notification NOT 15 days from the incident.

Workgroup response: **Understood. The workgroup thought these were important requirements in revising the system.**

Section 2: DETERMINING WHICH INCIDENTS REQUIRE A REPORT TO THE COAST GUARD (including Recreational Boating Incident Report Decision Matrix for graphic representation)

GENERAL COMMENTS REGARDING THE DECISION MATRIX GRAPHIC -- all had content that needed to be considered by the workgroup

Nevada (Brian Bowles): Love the matrix and like other commenters, worried about the double negative wording. Would recommend retooling the language to avoid the double negative.

Florida (Gary Klein): I find flow charts to be very useful in certain situations and this is one of them. However, I think many people struggle with language such as "Did incident involve an event that is NOT listed in the non-reportable Events section (next page)?". This requires a bit of mental gymnastics and isn't necessary if you just strike "NOT" and then switch the arrows which follow. The way it is written currently is you arrive at "no, it is not a non-reportable event.

Arizona (Tim Baumgarten): Although I like the concept of a flow chart or matrix, I agree with previous comments that the use of "Not" in the context with "non-reportable" does require more attention than necessary. There is a problem that results from an over simplistic Part II, i.e. when applying a common reportable incident as an example and following through the dichotomy...I arrived at an incorrect conclusion--and that concerns me. Of course, that maybe just me...So consider an incident that involves an allision with one boat impacting another that is docked. It is in agreement with Part I as the combined damage of both vessels exceeds $2,000. The matrix then directs to Part II; Did it involve a docked vessel? "YES"; Did it involve one of the following? "NO". The conclusion states "...no further action needed for reporting to the CG" This conclusion is incorrect. Although 2.3 discusses the scenario of a commercial tug impacting a moored recreational vessel as non-reportable (I believe due to the much larger damage threshold?), the same scenario with an offending recreational vessel is not. So I believe my misinterpretation can be avoided by clarifying the criterion as applying to only a single vessel incident.

Workgroup response to comments about double negatives appearing in the matrix: The workgroup agreed with the concerns expressed by the commenters from Nevada,

Florida, and Arizona. The matrix has been redrafted to eliminate the double negative in the sections on anchored vessels and vessels with all other operational statuses.

Workgroup response to comment regarding the matrix and application to single vessel incidents: The workgroup acknowledged the concern expressed by the commenter from Arizona; the matrix has been revised to direct the user to the appropriate action in the event of incidents involving multiple vessels with different operational statuses.

2.1. Incident should meet three initial, qualifying conditions:

2.1.1. Occurred on State or concurrent jurisdictional waters;

2.1.2. Involved at least one of the federal regulatory reporting thresholds:

2.1.2.1. A person dies.

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.

Workgroup response to the comments (overall): The workgroup agreed with suggestions that it would be helpful to describe what "observation without treatment" means in the Best Practices to be developed in phase two of this project – for example, observation by emergency medical personnel without treatment is not considered an injury for purposes of meeting the federal threshold.

Nevada (Brian Bowles): Object to inclusion of phrase "Observation without treatment is not considered an injury." There are some injuries that are significant that do not merit "treatment" such as torso injuries that could amount to severe bruising, cartilage separation, or greenstick fracture ("cracked ribs") that have no meaningful treatment but are still significant to the injured party and should trigger the "injury" threshold. Unless an investigator can determine that the relevant medical professional rendered a diagnosis of "no injury" to an automatically transported victim, then the threshold should be met.

Workgroup response: **The injuries described here would likely meet the federal injury threshold. Even for severe bruising, cartilage injuries, and cracked ribs, pain medication is usually prescribed. If so, then the person would have received treatment by a medical professional at a licensed medical facility.**

Wyoming (Aaron Kerr): WY statute refers to injury as "treatment beyond first aid at the scene." This is generally interpreted to mean treatment at a medical facility and would not include transport to or observation at a medical facility with no additional treatment. Patients here do have the right to refuse medical attention or transportation. Our direction to our officers is that if an injury appears to be serious and may require further treatment after a person initially refuses medical attention, go ahead with a full investigation so we can report it if necessary.

Workgroup response: **Understood. States can always have a lower injury threshold.**

Oregon (MariAnn McKenzie): What about paramedics that treated an injury but not enough to be transported to a medical facility or the person refused to be transported, but has an injury that should be looked at by a medical facility.

Workgroup response: **In this scenario, the injury would not meet the federal threshold.**

California (Johanna Naughton): There are many people who are obviously injured beyond first aid that refuse medical care for one reason or another. People often refuse care if they do not have insurance and cannot afford it or if they are undocumented, therefore we go with the officer's determination if a person is injured.

Workgroup response: **Understood. In its development of the recommendation, the workgroup had discussed language to include an injury for which a "reasonable or prudent person" would seek treatment. However, there were concerns about the subjectivity of the words "reasonable" and "prudent" even though they are commonly used in law. The workgroup further considered the qualifier that "a person received or should have received treatment," but ultimately discarded "should have received" also because of concerns about subjectivity. The workgroup decided that removing that qualifier would not significantly affect the number of injured victims as it was anticipated that the number of injuries missed would be low. In short, if a person did not receive treatment at a licensed medical facility by a medical professional, the person would not be considered as meeting the federal injury threshold. However, states can always have a lower injury threshold.**

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

Alaska (comment from Kelli Toth): suggests insertion of "unintentional" to describe the death or injury. Clarify non-reportable incidents include self-inflicted injuries, examples include self-inflicted wounds, ingestion of controlled substances or poison, gunshot wounds, attempted or completed suicide.

Workgroup response: The workgroup did not concur with this suggestion. Instead, the group thought it best to leave the threshold broad and allow the investigation to reveal whether a death was intentional or unintentional. If found to be intentional, then the incident would be excluded from federal reporting.

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

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).

Workgroup's overall response to comments from South Carolina, Maryland, Arkansas, Iowa, Wyoming, Oregon, Arizona, Montana, Nevada, and Alaska (listed pp. 10-11). *[The workgroup's responses to specific aspects of comments from Nevada and Alaska can be found on p. 11]:* **For this comment period, states were asked to consider both the workgroup's original recommendation to maintain the current threshold of $2,000 and a Coast Guard-proposed increase to $2,800 (a recalculation based on a methodology similar to one recently applied to the commercial side). After consideration of the state responses and further airing of**

opinions among its own members, the workgroup's preference remains with the $2K threshold for federal reporting purposes. Members felt that an increase in the threshold might inadvertently place the dollar amount beyond the 'beginner boat' cost level and, as a result, there would be a loss of important information about this population. That said, the group did acknowledge that there might need to be future adjustments to the federal regulatory reporting threshold to accommodate cost increases. The workgroup does remind, however, that even if that does happen, the states would still have the option of maintaining a lower dollar amount threshold.

As to the suggestion that officers may not have the ability to evaluate and make exact assessments of dollar amounts, the workgroup notes that recommendations 5.5.1 through 5.5.5 establish dollar ranges ("buckets") from which an officer would be able to make selections.

South Carolina (Donnie Pritcher): disagree with the proposed amounts [i.e., possible change to $2,800]. Move to 3,000.

Maryland (Charles Vernon): I am not in favor of raising the damage threshold. There are so many other factors that play into the reporting of all boat accidents that the threshold is only part of the equation. By raising the threshold, as has been stated already, year-to-year data will be skewed for the foreseeable future. Additionally, what about the major insurance vendors? Are they going to require reports for damages under the new threshold? Just like automobile accidents they want an at-fault operator. That may only be determined through investigation.

Arkansas (Stephanie Weatherington): I do not support increasing the threshold to $2,800; however IF the consensus dictates that an increase is necessary, then it needs to be a whole number - period. Either go with $3,000 or higher (again if necessary). Make it a simple even thousand dollar amount or don't change it at all.

Iowa (Susan Stocker): I think the damage threshold needs to stay @ $2000 based our desire to have good data and spending so much effort to get good data. Change the parameters and that data becomes garbage.

Wyoming (Aaron Kerr): … We support the recommendation to exclude personal property from consideration. We experience several instances annually of boats, especially whitewater rafts, capsizing with no damage or injury but loss of cell phones, fishing gear and other equipment.

Oregon (MariAnn McKenzie): I agree with a lot of the comments above regarding the misperception of incidents decreasing if the threshold is higher. The data will be skewed. I recommend to keep the $2K threshold. As for the personal property recommendation, I agree to take it out, some people do not report their amount of loss.

Oregon (Randy Henry): I am supportive of all aspects of section 2 with one exception - I would like to see the threshold increased as CG-BSX proposed. For simpler public outreach hand education, I would suggest $3000 even. A best practice would be helpful in guiding more accurate reporting of what $3k damage looks like. For a $100,000 wakeboard boat, that's a long gelcoat scratch.

Arizona (Tim Baumgarten): I do not agree with increasing the damage threshold to $2,800 as proposed in 2.1.2.4. Officers are not good insurance adjusters and are poor at estimating actual damages, unless they have current independent training or repair experience. I believe we are significantly underestimating damage losses now because each involved boat is unique in repair costs and depends on the location of the damage. Moving the bar higher only increases the numbers of under-reported incidents. In my experience in reviewing damage estimates, when an officer identifies the minimum threshold ($2K), the damage most likely approximates $2,500-$3,800 depending on who does the repairing of the damage. We use guidelines, such as each 12" scratch in

gel coat is $500, but this reference changes from boat to boat due to construction factors, manufacturer and I'm sure doesn't hold true in all parts of the US. We should be more concerned with capturing a competent data set to evaluate and address the underlying contributing factors than placing some arbitrary value on property loss. In other words, increase the data set, reduce the variables we have no control over and scrutinize those we may be able to influence.

Montana (Phil Kilbreath): I see no issue increasing the reporting threshold to account for inflation, increased repair costs etc. I think property damage should be limited to damage resulting from an actual accident. tipping over a canoe and dropping a $2,000-dollar camera overboard does not seem like it should be reported.

Nevada (Brian Bowles): As a new guy to the group, you all may have already had this discussion, but I thought I would throw it out there (again?):

Object to using a dollar amount of damage to determine a reporting threshold. Ultimately, using a dollar amount will always be a moving target with relation to inflation, and invites ambiguity and vagueness and allows for disparity from region to region, and vessel to vessel for the cost to repair or recover, without regard to the type of damage incurred in the incident. We would propose scrapping the dollar amount paradigm altogether, and in place of the dollar amount include threshold language to the effect of "vessel damage that results in clear impairment to the operational functionality of the vessel to include any structural, mechanical, and electronic component (etc etc)" Or something like that.

With regards to the $2000 vice $2800 issue, we would prefer to keep $2000 as the triggering amount, as increasing in this manner would lead to losing 10% of Nevada's reportable incidents, which is a concern for our RBS program. Further, we agree to exclude the cost of incidentally present personal property from the calculation. And we agree with keeping the dollar amount, whatever it may be, to the nearest thousand for simplicity's sake.

Workgroup response to the suggestion from Nevada regarding scrapping the dollar amount paradigm: Understood. In earlier discussions, the workgroup considered using descriptors such as no damage, minor damage, functional damage, and disabling damage instead of using dollar amounts. Ultimately, the group maintained its desire to capture damages in dollar amounts for federal regulatory purposes, and reminds that the states would still have the option of maintaining a lower dollar amount damage threshold.

Alaska (Kelli Toth): Confused to why we are concerned with personal property lost as part of calculation of threshold. Boater should be insured, what is the cost to society for the loss of personal property? How would an intervention be changed based on dollar amount? If one region of a state experiences a higher dollar amount lost due to higher dollar of personal property lost, does this not infer an economic disparity? Would resource allocation for education interventions be based on amount of property damage?

Workgroup response: The workgroup recommends that personal property be excluded from the value of damages due to concerns of consistency in reporting. For example, workgroup members cite the possibility of two incidents involving similar circumstances wherein one involved personal property damage that met the damage threshold but another did not. They question the consistency of collecting information on one incident and not the other.

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 or the owner has chosen not to recover it ~~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.

Louisiana (Clay Marques): … I'm not comfortable with the wording in the partial definition that states " has sunk and its location is known, but is unrecoverable due to availability and cost. Boaters should take all necessary action to remove their vessels from the waterways, which may avoid future incidents of others striking their "total loss".

The term I would use in this specific situation is abandonment.

Workgroup response: While the workgroup did not agree with the use of the term "abandonment" because of concerns that it may conflict with State laws that use the term, the comments from Louisiana did lead members to modify the recommendation for the sake of clarity. See the proposed revisions to this recommendation 2.1.2.5 (markup above, clean version below).

Also noteworthy is that the definition of total loss was sourced from CG-INV, the Coast Guard Office of Investigations and Analysis. It is published in their Marine Safety Manual, https://media.defense.gov/2017/Mar/29/2001723821/-1/-1/0/CIM_16000_10A.PDF.

As revised, 2.1.2.5 now reads: 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 or the owner has chosen not to recover it; and where it is a constructive total loss, i.e. the vessel is so severely damaged that it is not financially worth repairing

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

2.1.3.1. A vessel used for recreational purpose.

Alaska (Kelli Toth): Recreational purpose is this still defined as "any non-commercial activity including subsistence?"

Workgroup response: Yes, subsistence is considered "recreational."

2.1.3.2. A State-numbered uninspected vessel.

Alaska (Kelli Toth): State numbered uninspected vessel. Vessels engaged in commercial fishing could be recreational boats. If people are engaged in commercial fishing and are injured or killed, even if they are on an uninspected vessel, they should not be considered recreational because there is not something the state could do to intervene when the activities in the boat are different from recreational boating. For example, on a commercial fishing (uninspected passenger vessel) such as an open skiff, occupants and operators are pulling over nets, reaching aggressively over the gunwales, have a higher entanglement risk pulling in lines, buoys and several feet long and wide fishing nets, may be pressured to go out and fish during severe weather due to openers (dates and times allowed/restricted fishing periods by Fish and Game). Regardless if the CG- INV has the ability to investigate or inspect commercial fishing vessels, the focus of reporting is related to recreational boating interventions, recreational boaters do not behave as commercial fishermen and therefore the RBS program would not have the means or ability to design interventions specific to this activity.

Recommendation: "The CG-BSX noted that there may have an opening for CG-INV to

investigate state-numbered uninspected commercial vessels." State numbered uninspected vessels should be exempt from reporting if they are engaged in commercial fishing activity for the reasons stated above.

Workgroup response: **Understood. CG-BSX will discuss with CG-INV.**

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

2.2.1. For properly docked or moored vessels, ~~a report to the Coast Guard is required if~~ determination should first be made as to whether 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. Fire~~s~~/explosion~~s~~ that occurred while fueling or starting the vessel or that was attributed to the vessel's equipment or electrical components.

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

The feedback submitted by the state commenters and the Coast Guard prompted the workgroup to consider alternatives to and clarify the criteria associated with this recommendation 2.2.1, and ultimately to revise other criteria covered in the Matrix. See p. 15 for the group's overall response and discussion of revisions to 2.2.1. See below for responses to specific comments about this recommendation.

As revised, 2.2.1 and its sub-recommendations now read:

For properly docked or moored vessels, determination should first be made as to whether the incident involved one or more of the following events:

--Carbon monoxide exposure
--Stray electrical current that was attributed to the vessel
--Fire/explosion that occurred while fueling or starting the vessel or that was attributed to the vessel's equipment or electrical components

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

2.2.1.1. Carbon monoxide exposure

2.2.1.2. Stray electrical current that was attributed to the vessel

Alaska (Kelli Toth): Does this mean electric shock in a harbor causing harm to a swimmer?

Workgroup response: **Such incidents resulting in electrocution due to stray current related to a vessel are currently among the types reported in the Coast Guard's annual statistics. In the Accident Types/Events list accepted by NASBLA membership Sept. 11, 2012, the term was replaced by Electrical Shock and the definition was revised to read: *Death, injury, or property damage resulting from contact with electrical current. This includes system failure and stray current. It does not include lightning (see Natural Phenomena).***

2.2.1.3. Fire~~s~~/explosion~~s~~ that occurred while fueling or starting the vessel or that was attributed to the vessel's equipment or electrical components

As revised, 2.2.1.3 now reads: Fire/explosion that occurred while fueling or starting the vessel or that was attributed to the vessel's equipment or electrical components. See p. 15 for general discussion of revisions to this and other criteria in this section.

Arizona (Tim Baumgarten): agree in concept with the clarification of events and in consideration of my previous comments on the matrix and reporting of incidents. See my general comments regarding incidents involving docked or moored vessels.

Workgroup response: Understood.

California (Johanna Naughton): How is a vessel that is tied to a mooring buoy (docked or moored vessels) different from a vessel that is anchored?

Workgroup response: Because an anchored vessel is in a temporary holding environment, the workgroup felt that some incidents involving anchored vessels warranted reporting to the Coast Guard

Alaska (Kelli Toth): The discussion [in Resource Document] includes boats not properly moored, or not putting in a drain plug, is this with the caveat there was a severe injury or fatality? Even if the boat was a total loss, and nobody was injured or killed, is it still be reportable? I agree with 2.2.1 items to be reportable if serious injury or death was also involved in the incident. When exploring protective factors, CO monitors are not required carriage requirements but can be found in the NASBLA education requirements in states with mandatory education, how to properly install plugs or inspect electrical wiring is not required or included in the NASBLA education standards (is this to address electric shock in marinas?), and running the blower four minutes prior to starting the engine, and conducting the "sniff test" is not required by law, but can be found in the NASBLA education standards. If Stray electrical current is going to be reportable, it should be included in the NASBLA mandatory education standards.

Workgroup response: The workgroup would like to clarify that the example in the Resource Document regarding an operator forgetting to put in a drain plug resulting in the vessel taking on water was discussed but ultimately excluded as a scenario that would qualify for federal reporting purposes.

As to stray currents, electrocutions resulting from stray currents related to vessels are already among the types reported in the Coast Guard's annual statistics (see response to your related comment re recommendation 2.2.1.2); the current recommendation would continue their inclusion for incidents involving docked or moored vessels. Under revisions now proposed by the workgroup, however, the matrix would also stipulate that it applies to "properly" moored or docked vessels, and if the incident involved stray current, CO exposure or fires/explosions, an additional qualifier would ask whether the incident involved any of the non-reportable events listed on the second page of the decision matrix. Of note is that the workgroup has added "lack of / improper maintenance" to that list (recommendation 2.3.12).

The National Education standards do address preventive maintenance (3.4) including regarding the vessel's electrical systems, but it is true that unlike CO (4.7) and propeller intervention (4.8), stray currents resulting in electric shock drownings, etc., are not directly referenced in the content. This is outside the scope of this project, but the commenter may wish to take this up with the Education Standards Panel to consider whether specific reference to ESDs warrants inclusion in the core education standards.

Nevada (Brian Bowles): For docked or moored vessels, we believe that some injury incidents not captured in the three exceptions (CO exposure, stray electrical, fire when fueling) could be reportable based upon the ability to educate proper procedures

concerning safety around docked or moored vessels. We would like to see inclusive language around incidents on docked or moored vessels that occurred immediately adjacent in time to an evolution of getting underway or returning from being underway. In this manner, incidents that can reasonably be articulated to have occurred while the boat operator and/or occupants were immediately engaged in recreational boating activity are captured, and incidents that occur not adjacent in time to recreational boating activity (i.e. a boat slipping its moorage in heavy weather) are not. For the three incident types in 2.2.1.1-.3 we could state that in all cases these are reportable but refer to the above reporting thresholds in 2.1 for all other incidents.

Coast Guard (Verne Gifford)**:** Re: 2.2.1, the language concerning incidents collected on docked and moored vessels should be reconsidered. The workgroup recommends capturing only three scenarios from docked/moored vessels: CO, stray current from the boat, and fires while fueling or starting the vessel. A study of data suggests there are incidents our Program would want to capture that would be excluded in this recommended revision to policy. A few examples: 1) A vessel is moored to a rig while fishing. The vessel takes on water and capsizes and a person drowns. 2) A vessel is not moored correctly. The vessel capsizes and a person drowns. 3) A vessel catches fire and a person dies. The cause and activities leading up to the fire are unknown. This incident wouldn't be captured in the recommended revision to policy since it involved a moored vessel fire that couldn't be attributed to fueling or starting the vessel. 4) An individual causes a fire due to his actions. He had a fuel leak in the bilge and tried to "vacuum" it out. A fire started and he later died from burns. 5) An individual moors his vessel to a mooring buoy and exits to try to get into his dinghy (unclear if it was secured to the vessel). He falls overboard and drowns. These lives could have been affected by education and/or vessel manufacturing regulations. I encourage the workgroup to broaden the scenarios captured from docked and moored vessels.

Workgroup's overall response re comments on docked/moored vessels (2.2.1): The above comments from Nevada and the Coast Guard led the workgroup to not only consider the specific suggestions, but also reopen and broaden the discussion on docked or moored vessels and the merits and implications of amending the conditions that would lead to submitting a federal report. For example, the group did consider expanding the scenarios beyond CO exposure, stray current and fires/explosions to include the vessel's equipment, construction, loading, or machinery; it also considered adding a condition as to whether or not the vessel was occupied at the time of the incident. Ultimately, however, the workgroup thought such revisions would dilute the emphasis on incidents that had been of particular interest to the Coast Guard and the national RBS program; and, with regard to whether the vessel was occupied, of potentially leading to the capture of incidents that the group did not view as warranting a report to the Coast Guard (e.g., person drops a cigarette, which leads to a fire/explosion).

That said, the workgroup agreed that there needed to be some revisions to the conditions and criteria associated with docked and moored vessels. They include: 1) that the initial screening for this vessel status should be "properly" docked or moored vessels (see revision to recommendations 2.2.1 and 2.2.3)—i.e., "properly" meaning secured to an object designed for permanent docking or mooring, not to a rig or piling; 2) that incidents involving vessels that have not been properly docked or moored should be taken up under the decision criteria associated with "all other vessel operational statuses" on the matrix; 3) that the fires/explosion condition should be revised to accommodate incidents where the fire/explosion could be attributed to the vessel's equipment or electrical components (not just in the process of fueling/starting); 4) that these modifications warranted the additional step of determining whether the incident involved an event listed among the Non-Reportable Events; 5) that the Embarking/disembarking non-reportable event should be relabeled as Boarding/departing to conform with terminology used in the (Immediate) Activity at Time of Incident terms and definitions list; and 6) that a Non-Reportable Event associated with the Lack of/improper maintenance of the vessel

should be added (see new recommendation 2.3.12 in the Non-Reportable Events list).

2.2.2. For anchored vessels, the list of "Non-Reportable Events" should be consulted (for list, see recommendations under 2.3 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.

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

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. 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:

2.3.1. Non-Reportable Event. ~~Person voluntarily departed vessel~~ Voluntary departure injuries/fatalities: The ~~first and~~ only event involved the injury or death of a person who voluntarily ~~departing~~ entered the water from a vessel, the ~~(or departing~~ shore, or a place of inherent safety. ~~to swim after a vessel).~~

Workgroup response (overall - see comment-specific responses below through p. 19): The workgroup does not dispute that open-water drownings constitute a public safety issue or that collecting data on such events at some level has merit. However, given the overwhelming preferences expressed by state members, both in the open comment period for this project and in past efforts to improve incident reporting, workgroup members maintain that such events should not be reported to and counted by the Coast Guard as recreational boating incidents. In the wake of its discussions on the comments received, the workgroup did make some additional revisions to the original language of the recommendation to further clarify that the exclusion would cover not only a person's voluntary entry into the water from a vessel, no matter its operational status, but also the shore or other places of inherent safety (conditions currently excluded by the Coast Guard from federal reporting). The workgroup does note, however, that if this exclusion is adopted by the Coast Guard—meaning that it would not be a mandatory collection for federal reporting purposes—a state could always choose to collect information on such events.

As revised, 2.3.1 now reads: Non-Reportable Event. Voluntary departure injuries/fatalities: The only event involved the injury or death of a person who voluntarily entered the water from a vessel, the shore, or a place of inherent safety.

Further, in light of some of the questions and comments submitted by the states, the workgroup wants to emphasize that "non-reportable event" does not mean an incident is "not investigated." The expectation is that upon notification of such an incident, a response and some level of investigation and systematic gathering of information would be needed to identify potential causes of or contributors to the incident and to determine whether a report to the Coast Guard would be required.

Louisiana (Clay Marques)**:** Do you know if this has always been this way? if the operator states someone jumped off the tube for unknown reasons and drowned would we not treat this as a boat incident fatality? What if we do investigate and find the operator error was what caused the incident it is obviously reportable at that time? I think the way it is written one could say ok case closed and move on without much more investigation if it could be ruled non-reportable. But if the person drowns I would think it could (maybe should) be reportable.

Workgroup response: From 1962-2000, the Coast Guard excluded swimming incidents from the annual statistics publication, regardless of the vessel's operational status. In 2001, that policy was revised to capture swimming incidents from underway vessels (the policy change did not refer to casualties while swimming from docked, moored or anchored vessels; those continued to be excluded from reporting requirements).

However, since that 2001 policy change, there has been a lot of opposition to the collection of data involving swimmers who voluntarily depart a vessel and subsequently are injured.

In 2006, NASBLA membership unanimously approved a "Recreational Boating Accident and Casualty Reporting Decision Matrix" as the preferred method for determining which boat-involved incidents should be captured by the RBS program. In that matrix were two recommended changes from the reporting criteria associated with departing a vessel: 1) it called for excluding incidents where a person died, was injured, or went missing as a result of jumping, diving, or swimming for pleasure from a vessel; and 2) it recommended adding "another vessel" as a place of inherent safety (along with a shore or pier) to the exclusion involving a person who died, was injured or went missing as a result of swimming to retrieve an object or a vessel that was adrift from its mooring or dock, having departed from that place of inherent safety. In 2007, NASBLA members approved Resolution 2007-2, in support of the Coast Guard initiating changes to CFR to accommodate adoption of these and other criteria in the matrix.

In 2009, a task force of the Coast Guard's National Boating Safety Advisory Council (NBSAC) issued 15 recommendations to revise accident reporting, one of which also was to exclude all swimming incidents from reporting requirements. The NBSAC recommendation suggested that incidents where the vessel was being used as a swimming platform and/or a person voluntarily left the vessel as the first event, whether the vessel was underway or not, should *not* be considered reportable boating accidents; however, the Council still recommended that CO poisoning and in-water electrical shock events should continue to be counted.

In 2011, the Coast Guard issued a Federal Register Notice to request comments on the 2009 NBSAC recommendations. Of the 28 states that responded to the swimming exclusion recommendation, 25 supported it (two were against it and one was on the fence). See the comments for docket USCG–2011–0674 at http://www.regulations.gov/#!documentDetail;D=USCG-2011-0674-0001

Additionally, this workgroup recommends excluding them as boating incidents. If, as the only event, a person voluntarily enters the water from a vessel – no matter the vessel's operational status -- or from the shore or another place of inherent

safety to swim and is injured or dies as a result, the workgroup felt such incidents should be excluded; they viewed the resulting casualty as swimming-related, not boating-related. For the same reasons, for example, an incident involving a person who voluntarily leaves a vessel and enters the water to retrieve a hat or other object that had flown out of the vessel and subsequently drowned would be considered "non-reportable" because members felt that education would not have prevented the incident.

Of note, is that a state could always collect information on such incidents; however, if this exclusion is adopted, then the Coast Guard would not mandate their collection for federal reporting purposes.

Arizona (Tim Baumgarten): I agree swimming from a boat or jumping in to go should have never been reportable, yet a PWC operator jumping in to cool off, after hanging their PFD on the yolk and not being able to re-mount or swim to catch up to a wind blown craft--then drowns, creates that conflict for me. Impairment causing persons to jump from moving vessels, or off the top-deck of a house boat and never resurfacing causes that conflict for me. I believe educational emphasis on PFD wear and sobriety can make a difference in these cases.

Workgroup response: Understood, and concur with the worthiness of emphasizing PFD wear and the hazards associated with alcohol use on the water, no matter the type of vessel. As it stands, however, the workgroup still feels that if the only event involves a person who voluntarily enters the water from a vessel (no matter its operational status), the shore, or another place of inherent safety and is subsequently injured, the incident should be excluded from reporting to the Coast Guard. A state could always collect information on such incidents; however, if this exclusion is adopted, then the Coast Guard would not mandate their collection for federal reporting purposes.

California (Johanna Naughton): [We should look at whether a boating safety class could have prevented an accident in determining if it is reportable or not] We have drownings where people leave a vessel to swim and their vessel drifts away. The drowning could have been prevented if they anchored the vessel first or had someone else on the vessel knew how to operate the vessel. We also recently had an accident where the father jumped in the water without a PFD to rescue his son (who WAS wearing a PFD). Father drowns and son survives. These accidents could have been prevented if they had a boating safety course.

Workgroup response: Understood, and concur with the worthiness of boating safety courses. However, the National Boating Education standards currently do not cover swimming from a vessel. Most workgroup members recommended the exclusion because they viewed the casualty as swimming-related, not boating-related. For this reason, the workgroup recommended excluding them. A state could always collect information on such incidents; however, if this exclusion is adopted, then the Coast Guard would not mandate their collection for federal reporting purposes.

Coast Guard (Verne Gifford)**:** Re: 2.3.1, as we have in the past captured records of fatalities on underway vessels where the victim voluntarily departs the vessel, we reviewed individual case records to better determine the impact of this recommendation. Presently, this workload averages 50 fatalities per year. In reviewing data for 2017 (41 fatalities), it was noted that seven were on rented vessels, nearly 10 involved alcohol, over five involved a passenger who couldn't operate the vessel after the operator voluntarily departed, and nearly 10 were persons who didn't anchor the vessel and watched it drift away from them. These are all possible factors that make us question whether to eliminate the collection of these records. I encourage the workgroup to reconsider the proposed exclusion of these incidents.

Workgroup response: Since 2001, when Coast Guard policy was revised to capture swimming incidents from underway vessels, the states have expressed opposition to the collection of such data as boating incidents.

In 2006, NASBLA membership unanimously approved a "Recreational Boating Accident and Casualty Reporting Decision Matrix" as the preferred method for determining which boat-involved incidents should be captured by the RBS program. In that matrix were two recommended changes from the reporting criteria associated with departing a vessel: 1) it called for excluding incidents where a person died, was injured, or went missing as a result of jumping, diving, or swimming for pleasure from a vessel; and 2) it recommended adding "another vessel" as a place of inherent safety (along with a shore or pier) to the exclusion involving a person who died, was injured or went missing as a result of swimming to retrieve an object or a vessel that was adrift from its mooring or dock, having departed from that place of inherent safety. In 2007, NASBLA members approved Resolution 2007-2, in support of the Coast Guard initiating changes to CFR to accommodate adoption of these and other criteria in the matrix.

In 2009, a task force of the Coast Guard's National Boating Safety Advisory Council (NBSAC) issued 15 recommendations to revise accident reporting, one of which also was to exclude swimming incidents from recreational boating reporting requirements. The NBSAC recommendation suggested that incidents where the vessel was being used as a swimming platform and/or a person voluntarily left the vessel as the first event, whether the vessel was underway or not, should *not* be considered reportable boating accidents; however, the Council still recommended that CO poisoning and in-water electrical shock events should continue to be counted.

In 2011, the Coast Guard issued a Federal Register Notice to request comments on the 2009 NBSAC recommendations. Of the 28 states that responded to the swimming exclusion recommendation, 25 supported it (two were against it and one was on the fence). See the comments for docket USCG–2011–0674 at http://www.regulations.gov/#!documentDetail;D=USCG-2011-0674-0001

Additionally, the feedback from the states during this comment period overwhelmingly indicated support for excluding these voluntary events from federal reporting requirements, and as such, this workgroup stands with the recommendation to exclude them. As described in the overall response from the workgroup, however, as a result of more extensive discussion on the comments received, members did agree to some additional revisions to clarify that such an exclusion would also cover entry from the shore or other places of inherent safety, conditions currently excluded by the Coast Guard from the federal statistics.

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

Workgroup response (overall): The workgroup reviewed all of the comments received from the states and Coast Guard, and appreciated both the favorable and unfavorable reactions to this proposed non-reportable event. Even as the workgroup discussed the arguments for and against the exclusion, there remained some differences in opinion among members themselves as to whether the exclusion should exist at all due to valid concerns about interpreting and applying it appropriately and consistently. However, ultimately, the majority of members maintained their original positions and supported retaining the exclusion because their boating safety and educational programs are not geared toward towed watersports' participants, who may—as a result of their own skill-level or purposeful actions—sustain injuries that were not due to the vessel's operation or its equipment.

That said, the workgroup acknowledges that as with the other criteria in this decision matrix, there will need to be more detailed guidance and examples in the

Best Practices to be developed in phase two of this project; in the case of this exclusion, for example, that might involve checklists to better define contributors to towed watersports incidents and to describe scenarios involving certain types of watersports that would likely NOT be excluded from reporting because they are more fully under the operator's control, such as tubing. The workgroup recognizes that officer training will be critical to the accurate and consistent interpretation of this and the other non-reportable events.

In addition, the workgroup modified recommendation 2.3.3. re Vessel use exemptions to reinforce the reporting exemption for sanctioned activities, which would exclude vessels used in practicing for or competing in towed watersports events, such as shows, competitions, etc.

> **2.3.3. Non-Reportable Event. 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 practicing for and/or competing in an approved or permitted organized or sanctioned race, event or training program ~~approved by a national or international body, or by appropriate permit~~, and where adequate safety precautions are in place).**

> > **As revised, 2.3.3 now reads: 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 practicing for and/or competing in an approved or permitted organized or sanctioned race, event or training program, and where adequate safety precautions are in place).**

Finally, the workgroup emphasizes that if the Coast Guard adopts exclusion 2.3.2 (Towed watersports injury exceptions)—meaning it would not be a mandatory collection for federal reporting—a state could still choose to require the collection of data on all towed watersports incidents for its own purposes.

Louisiana (Clay Marques)**:** It seems that it is still unclear in the way it is described on whether an incident involving a person being towed behind a vessel is "Reportable" or "Non-Reportable". I believe that if injury occurs due solely to the "purposeful actions of the person/persons being towed" alone, then the incident should be deemed "Non-reportable".

> **Workgroup response: The workgroup concurred with this interpretation and some shared the commenter's concerns over the clarity of the non-reportable event. As described in the workgroup's overall response to the comments, members recommend officer training, as well as more detailed guidance and examples in Best Practices for accurate and consistent interpretation.**

Missouri (Matt Walz)**:** I would agree this is still an area that needs some adjustment. Either do away with towed watersport injury accidents altogether or come up with a consistent method to determine what must be reported. A significant problem with the current proposal is the skill level of the person being towed may be a factor in determining whether the boat operation was the cause. This would be extremely subjective.

[Upon further consideration of others' comments]: Agreed that all towed watersport injuries should be reported. There is not likely going to be language which can address every scenario which may occur during this type of activity. Whether a person falls within a boat while underway, or while being towed, and is injured, we should take the report. In either case, it may or may not be due to operation. It's often difficult to determine. If it's likely due to boat operation, that's where the law enforcement aspect kicks in. If it's not reported, we can't make that determination. Do appreciate all the work put into this document by the work group. Many great ideas!

Workgroup response: **As described in the workgroup's overall response to the comments, while there was some difference in opinion among members as to whether the towed watersports exclusion should exist due to concerns over inappropriate and inconsistent application, the majority supported the exclusion and recognized the need for officer training, as well as more detailed guidance and examples in Best Practices for accurate interpretation. As also noted, the workgroup emphasizes that a state could always collect information on such cases; however, if this exclusion is adopted by the Coast Guard, it would not be a mandatory collection for federal reporting purposes.**

Nevada (Brian Bowles): Strongly object to excepting towed watersport participant injuries. There is no way to reasonably conclude that operation of a vessel is not a significant factor in any towed watersports injury: the vessel is required to impart the motive force that allows the towed watersport participant to engage in that activity. The towed participant is not considered another vessel, conversely, a towed participant is included as being associated with the towing vessel for other reporting requirements if a separate reportable incident occurs (see recommendation 5.4.1.) There is no example that I can think of that would reasonably conclude that the responsibility for an event that ended in injury would be vessel operator 0%/towed individual 100% in terms of liability or causality. Towed watersport boat operation is obviously riskier, one must treat their vessel and its parameters differently: you modify your starting and stopping operation to accommodate your towed individual, you must assume your "functional beam width" is that of your beam, plus the scope of the towline at maximum side angle. You must operate with a spotter and use heightened care as you are routinely putting an individual in the water. In my opinion you are halfway to a "restricted in ability to maneuver" status. All of these evolutions and advanced boat operation skills are amenable to an education effort and are regulatable and enforceable within an RBS program.

Workgroup response: **The workgroup concurs that boat operation skills associated with towed watersports do lend themselves to safety education and enforcement within the national and state RBS programs. But, as described in the workgroup's overall response to the comments, the majority of members support retaining the exclusion because their boating safety and educational programs are not geared toward the towed watersports' participants themselves. That said, and as noted in the overall response to these comments, the workgroup recognizes the need for officer training, as well as guidance and examples in Best Practices for accurate interpretation. The workgroup also reminds that a state could always collect information on all incidents involving towed watersports; however, if this exclusion is adopted by the Coast Guard, they would not be a mandatory collection for federal reporting purposes.**

Florida (Gary Klein): I agree with the recommended edits and the remaining original language except that I agree with several others that the distinction is too subtle with respect to 2.3.2 and towed watersports. I think including this language will result in missing data that should be included. A compromise might be to provide an example (waterski pyramid collapse, etc.) for the category not intended to be reportable.

Workgroup response: **The workgroup shared the concerns over the clarity of this non-reportable event. As noted in the overall response to these comments, along with recognizing the importance of officer training and guidance and examples in Best Practices, the group modified recommendation 2.3.3. re Vessel use exemptions. The edits are intended to reinforce the reporting exemption for sanctioned activities and would exclude vessels used in practicing for or competing in towed watersports events.**

Wyoming (Aaron Kerr): I agree with the recommendations in this section except 2.3.2. I lean toward including all towed watersport injuries as reportable.

Workgroup response: As described in the workgroup's overall response to the comments, while there was some difference in opinion among members as to whether the towed watersports exclusion should exist due to concerns over inappropriate and inconsistent application, the majority supported the exclusion, and recognized the need for officer training, as well as more detailed guidance and examples in Best Practices for accurate interpretation. As also noted, the workgroup emphasizes that a state could always collect information on such cases; however, if this exclusion is adopted by the Coast Guard, they would not be a mandatory collection for federal reporting purposes.

Arizona (Tim Baumgarten): I strongly disagree with this proposed exemption. In my experience very few towed watersports injuries are the sole fault of the person being towed. Yes there are a few dislocated knees, torn ligaments and back injuries from wakeboarders attempting flips and 360s, but the majority of injuries are caused by the operator and observers who enjoy seeing bodies fly through the air during high speed turns, only to find cracked skulls, concussions and facial fractures because their little melons banged together. Or when a leg sticks out inadvertently and the femur fractures due the force of the water. In both of these real incidents the investigating officer found operation of the vessel "did not contribute." There is too much subjectively to overlook this continuing issue. In my experience, the vast majority of towed watersport injuries are caused by excessive speed and an operator not perceiving the danger of bodies flailing over the water at speed or in some negligent circumstances, a tow toy that flies into the air at a height of 30' or more then dumps the bodies or crashes with them--these manufacturers need some oversight. Without reporting, there is no data--no oversight. The caveats of "wasn't due to operation or equipment of a vessel" is too subjective and places all the reporting judgment on the officer. If these incidents continue to be reported as they are now, they could all be collectively reviewed by independent investigators and a more comprehensive conclusion can be drawn. Less experienced officers are less apt to place blame, especially if family members were the injured parties.

Workgroup response: As described in the workgroup's overall response to the comments, while there was some difference in opinion among members as to whether the towed watersports exclusion should exist due to concerns over inappropriate and inconsistent application, the majority supported the exclusion, and recognized the need for officer training, as well as more detailed guidance and examples in Best Practices for accurate interpretation. As also noted, the workgroup emphasizes that a state could always collect information on such cases; however, if this exclusion is adopted by the Coast Guard, they would not be a mandatory collection for federal reporting purposes.

California (Johanna Naughton): All towed watersports should be reportable. It is difficult to determine if operation played a role in an injury. For example, when a person breaks their leg while waterskiing, was it due to being pulled out of the water too fast?

Workgroup response: As described in the workgroup's overall response to the comments, while there was some difference in opinion among members as to whether the towed watersports exclusion should exist due to concerns over inappropriate and inconsistent application, the majority supported the exclusion, and recognized the need for officer training, as well as more detailed guidance and examples in Best Practices for accurate interpretation. As also noted, the workgroup emphasizes that a state could always collect information on such cases; however, if this exclusion is adopted by the Coast Guard, they would not be a mandatory collection for federal reporting purposes.

Oregon (MariAnn McKenzie)**:** agree that towed watersport injuries should not be excluded from the data; bare footing could be added to non-reportable if using a boom, but even injury could be caused by the boat or operation by the operator.

Workgroup response: The workgroup recognizes the need for officer training, as well as more detailed guidance and examples in Best Practices for accurate interpretation of the role of the vessel's operation and equipment.

Alaska (Kelli Toth): Does this mean only people who suffered an injury or does this include death of a participant? This may need to be clarified to include death.

For clarification, is a tow line considered "equipment of a vessel?" For example, the person who is being towed who is on a tube, somehow gets the line wrapped around a body part, is killed or injured, is this considered due to the operation of a vessel, is the line included as equipment of a vessel?
If a person being towed is run over by another operator, is that included in this exemption? Wanted to clarify that "operation of a vessel "includes all vessels, beyond those not directly engaged in towing.
If the purpose of reporting is to gather information designing interventions to reduce serious injuries and fatalities, the examples in items 2 and 3 are related to recreational boating. It would seem the states and interest groups such as the Watersports Foundation and others could use this information to identify trends and design specific outreach interventions.

Further: The issue seems to be whether or not an officer would have enough training and expertise to determine if the incident was reportable or not. With this two -tiered system, if an officer were to report an incident tier one, wouldn't the expertise of an investigator resolve this issue of expertise and determination in tier two of the reporting? If this were the case, I would think we would want towed sports to be reportable, in tier one, and be investigated and potentially dismissed in tier two by a boating investigator subject matter expert.

Workgroup response to questions posed: The intent of the recommendation is to include both non-fatal and fatal injuries. The tow line would be considered part of the vessel. And, regarding the final paragraph: as with all of these "non-reportable" events, "non-reportable" does not mean "not investigated." The expectation is that upon notification of such an incident, a response and some level of investigation would be needed to determine what occurred, and then, whether a report to the Coast Guard would be needed.

Coast Guard (Verne Gifford)**:** Re: 2.3.2., there should not be an exclusion for some towed watersports incidents due to concerns about consistency in reporting. Regardless of the cause of the incident, the participants were still involved in recreation, which is the focus of the National Recreational Boating Safety Program.

Workgroup response: The workgroup reviewed and greatly appreciated all of the comments received—both favorable and unfavorable to the recommendation. As described in the workgroup's overall response to the comments, while there was some difference in opinion among members as to whether the towed watersports exclusion should exist due to concerns over inappropriate and inconsistent application, the majority supported the exclusion. They felt that their boating safety and educational programs are not geared toward towed watersports' participants, who may—as a result of their own skill-level or purposeful actions—sustain injuries that were not due to the vessel's operation or its equipment. The workgroup does recognize the need for officer training, as well as more detailed guidance and examples in Best Practices for accurate interpretation and consistent application.

More detail on this determination is documented in the workgroup's overall response to the comments.

2.3.3. Non-Reportable Event. 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 practicing for and/or competing in an approved or permitted organized or sanctioned race, event or training program ~~approved by a national or international body, or by appropriate permit~~, and where adequate safety precautions are in place).

Workgroup note: As described in the workgroup responses to comments on recommendation 2.3.2 (Towed watersports injury exemptions), this recommendation 2.3.3 was modified to reinforce the reporting exemption for sanctioned activities, which would exclude vessels used in practicing for or competing in towed watersports events, such as shows, competitions, etc.

As revised, 2.3.3 now reads: 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 practicing for and/or competing in an approved or permitted organized or sanctioned race, event or training program, and where adequate safety precautions are in place).

Louisiana (Clay Marques): Vessels used in criminal activity are deemed "Non-Reportable." Does this include vessels engaged in illegal fishing activities? If someone is shrimping during the closed season, or is on a Management Area at night when not allowed, etc. and an incident occurs, it seems that this should still be considered a "Reportable" boating incident, even though the vessel was being used solely for a criminal activity.

Non reportable offenses, vessels involved were used solely in the course of criminal offenses. So scenario two men in a boat night hunting which is a criminal offense. The two strike a tree the passenger is ejected and is now deceased. The vessel was used for the sole purpose of hunting deer at night, which is a criminal offense. With the current vessel use exception an investigator could justifiably stop his investigation at this point. If the investigator were to go further beyond this point he would/ could learn FACTS of the incident, such as operator violated several rules of the road for vessels causing the incident.

By the vessel use exceptions this vessel was being used solely for the illegal taking of deer (criminal offenses), hence would make this boating incident non reportable.

To remedy this problem, I would strike through words as follows Criminal (activity in the course of a criminal offense, with the exception of impairment and boating safety related offenses).

Workgroup response: The workgroup agrees that illegal fishing or illegal taking of deer (both criminal offenses that involve people recreating) would be "reportable." However, with regard to the suggestion that the parenthetical information explaining "criminal" (and presenting the exceptions of "impairment" and "boating safety related offenses"), be deleted, the workgroup did not agree. Members want to retain the current wording to ensure there is no question that the exception does not apply to incidents involving alcohol or drug impairment or other safety-related offenses. However, the Best Practices developed to accompany this matrix should better define "criminal" for the purposes of this exclusion.

Coast Guard (Verne Gifford): Re: 2.3.3., incidents involving some criminal activity (a person stealing a vessel for recreational use) are presently captured and provide an overall awareness of incidents involving recreational activity; moreover, these incidents only amount to about one death per year and these events are presently captured by NHTSA for vehicle crashes. Vessels that are used for criminal activity (such as transporting stolen goods or using a vessel to evade police) are not currently represented in our statistics and should continue to be excluded.

Workgroup response: **The workgroup maintains the exclusion of such joyriding incidents because the affected audience could not be impacted through education or regulation. NHTSA captures such incidents because program dollars are available to capture all activity on the roads (transportation, commerce, etc.). With the RBS program being user based, there is no reasonable or feasible way to affect the behavior of such users or allocate funding to prevent them from the activity. As in the workgroup's response to other comments on this exclusion, however, the Best Practices developed to accompany the matrix should better define (and provide examples for) "criminal" for purposes of the exception.**

Also, Re**:** 2.3.3., sanctioned events should be captured as the vessels were still involved in recreation. This scenario presently represents about two fatalities per year.

Workgroup response: **The workgroup recommends retaining this exclusion. Sanctioned events currently are granted exemptions from recreational boating requirements (e.g. carriage, registration, other safety exclusions, etc.) and are also excluded from CFR manufacturing provisions and related requirements (e.g., level flotation and build standards). When a state approves sanctioned events, those exemptions from recreational boating requirements are part of the permitting process. That said, the state still has the ability to collect and report on such incidents outside of any mandate for national collection. And, if an events organization does something with their watercraft outside of the sanctioned activity, they must meet all requirements for recreational boating at that time; should they be involved in an incident, the incident would be investigated and reported.**

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

Alaska (Kelli Toth): We may wish to include language to include "intentional injury," and clarification of intent of a suicide attempt and include intentional death, suicide. The existing language is not clear, if there is evidence of suicide. Clarification would assist the state in determining an incident as non-reportable. For example, a skiff is found free floating, the boat is a recreational vessel, the operator was known to have been out alone in the boat, there is no evidence of the person being ejected, such as boat motor running, engine cut-off switch still engaged. After further investigation with the family it is noted the operator has verbalized intent of suicide. The missing person lost their job, had overwhelming debt, and family issues, and left a suicide note of intent. This should not be considered a reportable incident, because the RBS program is not a suicide prevention program.

Workgroup response: **The workgroup recommends retaining the current wording and not referencing "intent" as the words "intentional" or "intent" take on a different meaning depending on perspective (law enforcement vs public health). However, the workgroup did change the label for this event—adding "fatalities" to make clear that this exclusion does not apply only to non-fatal, self-inflicted injuries.**

As revised, 2.3.4 now reads: Non-Reportable Event. Self-inflicted injuries/fatalities: 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.

2.3.6. Non-Reportable Event. Medical events: An incident caused by a person who experienced a medical ~~event~~ emergency ~~(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 underway vessel was involved. ~~reporting threshold was met.~~ A medical event does not refer to physical impairments such as poor eyesight, poor hearing, or mobility difficulties.

Arizona (Tim Baumgarten): **I c**ould go either way and acquiesce to consensus. It's hard to say a vessel did not contribute to a fatality when the same medical event, if it had occurred anywhere on land, the person would've survived. Realistically, can we really have any effect on an individual's health? An adult male suffers a heart attack while fishing and falls overboard. No PFD, he drowns. Was his presence on a boat a contributor to his death? Yes, because if he would have fallen anywhere on the ground or been in a motor vehicle, there is a high likelihood he would be resuscitated by responders. Should a PFD be worn, Yes, should this be a reportable incident? No. Older adult male riding a PWC gets grounded on a sandbar, he tries repeatedly to free the craft, his wife goes for help, we respond to find him floating face down dead. ME indicates he suffered a heart attack and drowned, most likely due to the strain of trying to free his craft. Was this a boating incident, yes, should it be reportable, no because we clearly could not have any impact on the heart health of individuals.

Workgroup response: The workgroup spent a good amount of time discussing the role of medical events on vessels as well, and acknowledged that sometimes the role of the vessel cannot be validated. For the sake of reporting, however, the workgroup has retained the exclusion, with revisions to the language to further clarify its application; the group also recommends that additional guidance be provided in the Best Practices that will be developed in phase two of this project.

Coast Guard (Verne Gifford)**:** Re: 2.3.6., two changes are suggested: 1) eliminating the words "no other reporting threshold was met" and 2) adding words "no other party was involved." The scenario would read, "**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 party was involved."** The first change is recommended to better reflect the scope of the program. Even if a person became incapacitated, which resulted in significant damages from a grounding, the program would not have been able to prevent that grounding because it would not have been able to prevent the preceding medical event. The second change is recommended to better reflect the scope of the program. If another party was involved, then the Program would want to capture the data because at least one party (the one unaffected by the medical condition) could possibly take an action to prevent the incident (in this case, a likely crash between two vessels).

Workgroup response: After much consideration, the workgroup has recommended retaining the exclusion, but with revisions to the language to clarify its application, and to eliminate the reference to "no other reporting threshold" being met. The group also recommends that additional guidance be provided in the Best Practices that will be developed in phase two of this project.

As revised, 2.3.8. now reads: Non-Reportable Event. Medical event: An incident caused by a person who experienced a medical emergency when the vessel did not contribute and no other underway vessel was involved. A medical event does not refer to physical impairments such as poor eyesight, poor hearing, or mobility difficulties.

2.3.7. Non-Reportable Event. 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~~ tote, floating dock, unmodified log, snowmobile, and/or seaplane).

***** Per 1 U.S. Code § 3 (Vessel as including all means of transportation), "[T]he word "vessel" includes every description of watercraft or other artificial contrivance used, or capable of being used, as a means of transportation on the water. **Per recommendation 4.1.1, for purposes of** vessel determinations within **the** context 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."

Alaska (Kelli Toth): The examples of what is not a vessel include fish box, if this was a comment from Alaska, a fish box could be interpreted as a box used to mail/ship fish, when the incident that was a fatality was a person who used a fish tote, a large open box used to transfer fish with a crane from a boat to a processor. Rather than specifically naming a fish box, what about clarification language, "any floating object designed for the intent to floating" should not be considered a vessel. Something designed with the intent of transporting a person on the water would be considered a vessel. The fish tote was designed with the intent to transport fish, not people, therefore shouldn't be considered a vessel. If we focus on design intent of use, maybe this would be more inclusive or make interpretation of a vessel clear. The design intent of a fishing float tube or pool toy is to float, the design intent of a canoe, kayak, SUP is to transport someone on the water, thus defined as a vessel. Perhaps recommendation 4.1.1 resolves this issue, however the list specifically mentioned paddle, motor, sail etc. Recommend, adding oars to this list.

Workgroup response: The Best Practices that will be developed to accompany this matrix should better define what craft are vessels. However, in response to this particular comment, the workgroup agreed that "fish tote" should replace "fish box" in the recommendation's examples. Note also that in response to a comment on recommendation 4.1.1, the workgroup has added the statutory definition of "vessel" asterisked in this recommendation 2.3.7,

As revised, 2.3.7 now reads: Non-Reportable Event. 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 tote, floating dock, unmodified log, snowmobile, and/or seaplane).

*** Per 1 U.S. Code § 3 (Vessel as including all means of transportation), "[T]he word "vessel" includes every description of watercraft or other artificial contrivance used, or capable of being used, as a means of transportation on the water.**

***Per recommendation 4.1.1, for purposes of vessel determinations within the context 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."**

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

2.3.9. Non-Reportable Event. 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 federal regulatory reporting threshold was met.

Workgroup note: The only adjustment to this recommendation was to edit the description to clarify that the threshold referenced is the federal regulatory threshold for reporting.

Montana (Phil Kilbreath): I would like more clarification on this. We have frequent weather related accidents.

Workgroup response: This particular entry is not intended to exclude weather-related natural phenomena like lightning or hail. This exclusion is intended primarily to address non-weather natural phenomena such as interaction with marine life or interaction with nature. The Best Practices that will accompany this matrix should provide further guidance for the selection of the event.

However, just a bit of background as there have been lengthy discussions about whether incidents involving natural phenomena could be prevented. The Coast Guard historically has tracked some incidents involving natural phenomena to match the practices of other federal agencies. For instance, the highways program administered by NHTSA would collect information on incidents involving cars hit by tumbling cliff rocks, and attempts to prevent these incidents by posting warning signs of "falling rocks." Likewise, the Coast Guard has witnessed incidents where tumbling rocks impact a vessel. However, for this project, workgroup members had some differing perspectives on the utility of such warning signs. For example, one expressed concern about how people would change their behavior based on a sign; as a driver, the workgroup member said they wouldn't change behavior because doing so (driving faster or slower) could cause an accident. On the other hand, another group member noted that warning signs of "hazardous waters ahead" sometimes prevent boaters from approaching a waterway, thus averting danger. The group discussed the predictability of events as well. While signs can warn boaters of known dangers ahead, other events such as lightning and hail may come with little to no warning.

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).

Nevada (Brian Bowles): Strongly object to exclusion of launching/recovery incidents. Launching and recovery is an integral part of recreational boating activity. Launching and recovery is a distinct module in federal boat operator training at the most basic level (DOI's MOCC course). These evolutions are absolutely amenable to an educational effort within an RBS program, and could easily be regulated and enforced with a "due care" type law. Not capturing these statistics then puts USCG in the dark regarding a potential need to highlight the "beginning and ending" evolutions of recreational boat operations from an educational standpoint.

Workgroup response: The workgroup does not concur with this suggestion. However, members want to emphasize that a state could always collect information on such cases; if this exclusion is adopted by the Coast Guard, however, it would not be a mandatory collection at the national level.

Arizona (Tim Baumgarten: I strongly disagree with exempting these incidents as reportable events. Launching and trailering a vessel are critical portions of most recreational voyages and are important training components of safe boating. The criterion of "not on the water" or "free from the apparatus" are very ambiguous and subjective. At what points, when a vessel is in motion, are these criterion to be judged. A case that comes to mind is one that occurred during a fast approaching summer storm. The trailer was backed in and the operator was attempting to negotiate centering the vessel on the trailer. He miscalculated, the boat overshot the port side of the trailer and the bow landed on his partner that was attempting assist with loading, pinning him to the launch ramp injuring him severely. Given the dynamics of this type of action, how would an officer evaluate the point when the boat left the water and not in use or if it was a grounding due to wind and wave action. Too subjective, due to the importance of this common activity associated with boating and our ability to educate persons to act safely, I do not agree that this type of incident should be "non-reportable"

Workgroup response: The workgroup reviewed the example provided in this comment and believes that the incident as described would in fact have been captured and not excluded. But the group wants to emphasize that a state could always collect information on cases involving launching and loading; if this exclusion is adopted by the Coast Guard, however, it would not be a mandatory collection at the national level.

Oregon (MariAnn McKenzie): do not agree having launching or recovery as non-reportable. Agree with Brian and Tim's comments.

8/27/19 workgroup response: The workgroup does not concur with the suggestions for including launching and recovery as described. But the group wants to emphasize that a state could always collect information on such cases; if this exclusion is adopted by the Coast Guard, however, it would not be a mandatory collection at the national level.

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

Workgroup note: During its review and resolution of comments, the project workgroup revised the labeling of this event as "Boarding/departing" to conform to terminology used in the proposed Activity: Use of the Vessel/Immediate Activity at the Time of the Incident list in Appendix F, and in the description (as in recommendation 2.3.9), clarified that the threshold referenced is the federal regulatory threshold for reporting.

As revised, 2.3.11 now reads: Non-Reportable Event. Boarding/departing injuries/fatalities: A person suffers an injury while boarding or departing a docked, moored, or anchored vessel, when no other event occurred and when no other federal regulatory reporting threshold was met.

California (Johanna Naughton): We have had numerous accidents when people are embarking/disembarking a vessel and this is probably under-reported. Many of these accidents could have been prevented with a boating safety course.

Workgroup response: The workgroup does not concur with this suggestion; boarding/departing events are not attributed to the vessel and as such, the group maintains that they should be excluded from reporting requirements. A state could always collect information on such cases; however, if this exclusion is adopted by the Coast Guard, it would not be a mandatory collection at the national level.

2.3.12. Non-Reportable Event. Lack of / improper maintenance. The unoccupied, properly-docked or -moored vessel(s) encountered damages or loss as a result of lack of or improper vessel maintenance.

Workgroup note: See the responses to comments under recommendation 2.2.1 (pp. 13-15) for information on this addition to the Non-Reportable Events list.

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

Section 3: GATHERING DATA, REVIEWING, AND SUBMITTING FINAL REPORTS

3.1 Within 60 days of notification of an incident, the State Reporting Authority should submit ~~all available information~~ all information on that incident to the Coast Guard. "All information" means the information collected on the required data elements described in the recommendations under Section 5. "Notification" means the date on which the State Reporting Authority is notified of / is made aware of an incident.

Workgroup response (overall): The workgroup believes that, for the most part, the concerns that were expressed by the state commenters below should be readily resolved as the group's intent in referring to "all available information" was never for submission of the incident case file, but rather for the submission of data elements described in the recommendations under Section 5 of this project list. As such, the group revised the recommendation by deleting the phrase "all

available information," replacing it with "all information" per the recommended data elements in Section 5, and to repeat what "notification" means for purposes of these recommendations. Related revisions also have been made to recommendation 3.2.

> **As revised, 3.1 now reads: Within 60 days of notification of an incident, the State Reporting Authority should submit all information on that incident to the Coast Guard. "All information" means the information collected on the required data elements described in the recommendations under Section 5. "Notification" means the date on which the State Reporting Authority is notified of / is made aware of an incident**

Nevada (Brian Bowles): Agree, however, it should be clarified what the USCG is using the data to determine. If the Coast Guard is wholly satisfied with a "finding of cause" for the incident, then the timelines are appropriate. Our state investigators, on the other hand, deem "all available information" to include the totality of a potential criminal investigation and all the follow-on circumstances and reportage that arise from that process. States need clarification if USCG is expecting all that information to be included in an update, and USCG should be aware that if they are expecting that information to be complete and included within 60 days then it is an unreasonable expectation. We like the proposal of a two tiered system, and the ability to update reports after "final submission" at the 60 day mark.

> **Workgroup response: The workgroup's intention was not for the submission of the entire case file, but rather for the State Reporting Authority to submit the data elements described in the recommendations under Section 5. This recommendation 3.1 has been revised to clarify that.**

Arizona (Tim Baumgarten): I strongly disagree with the requirement to "...submit all available information on that incident to the Coast Guard." A fatality or serious bodily injury investigation case file may be comprised of 20-60 pages of investigatory notes, diagrams, witness statements, search warrants, chain of custody forms, release forms and not to mention dozens of photographs. There is no conceivable reason why the entire case file of "information" would need to be submitted to the Coast Guard along with the currently required report for the purposes of statistical review for the prevention of casualties.

> **Workgroup response: The workgroup's intention was not for the submission of the entire case file, but rather for the State Reporting Authority to submit the data elements described in the recommendations under Section 5. This recommendation 3.1 has been revised to clarify that.**

California (Johanna Naughton): we have the same concerns with this 60-day requirement that we had with Section 1.9 as noted in that section.

> **Workgroup response: Understood**.

Montana (Phil Kilbreath): I wholeheartedly agree with extending the reporting timeline to 60 days. It should be clear that "notification" means when the state is notified or becomes award of an accident.

> **Workgroup response: Yes, that is the meaning of "notification" in this recommendation. Please note that in response to comments received, the workgroup has revised this recommendation 3.1 to clarify what information would be submitted, and what "notification" means.**

Kentucky (Shane Carrier): I agree and also support comments by Tim regarding "all available information."

> **Workgroup response: Understood. The workgroup's intention was not for the submission of the entire case file, but rather for the State Reporting Authority to submit the data elements described in the recommendations under Section 5. This recommendation 3.1 has been revised to clarify that.**

Wyoming (Aaron Kerr): …I agree with the BLAs from Nevada and Arizona that "all available information" be clarified to mean the reporting of required data elements and not an investigator's entire case file.

8/27/19 workgroup response: Understood. The workgroup's intention was not for the submission of the entire case file, but rather for the State Reporting Authority to submit the data elements described in the recommendations under Section 5. This recommendation 3.1 has been revised to clarify that.

Coast Guard (Verne Gifford)**:** Re: 3.1., all information should be required in CFR. In Best Practices, softer language such as "all available information" can be used.

Workgroup response: In developing these recommendations, the workgroup agreed not to present them in the form of regulatory language or formal policy provisions. Instead, the recommendations are just that—expressions of the preferred policy directions, courses of action, and options for consideration that—upon achieving consensus among stakeholders and formal acceptance by the NASBLA membership—will be passed to the Coast Guard to inform the direction it takes in drafting actual federal regulatory and policy provisions.

In the case of this recommendation 3.1, the workgroup did agree that there was some confusion over the phrase "all available information." To clarify the intent of the states and to ensure that the recommendation is appropriately interpreted by the Coast Guard, the workgroup revised the language to clarify that "all information" means the information that would be collected on the required data elements described in the recommendations under Section 5. The group understands that if this recommendation is accepted and evolves into regulatory language, the Coast Guard would not require the submission of information beyond what would be stipulated in CFR.

3.2 There should be a requirement for the State Reporting Authority to review the final incident report (containing all ~~available~~ information collected on the required data elements described in the recommendations under Section 5). 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 on the required data elements described in the recommendations under Section 5, 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~~ of the incident report information was reviewed and expected as final or whether information was reviewed but was not yet final due to outstanding information.

Arizona (Tim Baumgarten): Although the body of comments addresses the termination date of the proposed 60-day notification period, I believe the initiating notification date to the State Reporting Authority has been a more significant point of contention. I recommend the start of the 60-day notification and

review period be defined as, "When the State Reporting Authority receives a preliminary or completed report of an incident or is provided the required data elements to complete a preliminary or submit a complete incident report." Additionally, in my state, extending the required reporting period from 30 days to 60 days will not ensure a more complete report. In most cases, receiving a coroner's report or blood analysis from the state crime lab will almost always extend beyond 60 days and for our latest fatalities, these reports took 7 months.

Workgroup response: Workgroup members recommended adding the words "of notification" (and per recommendation 5.2.5., an element and field to record the date the State Reporting Authority was notified of the incident) so that states would not be "on the hook" for submitting information on incidents for which they received "late" notification. The language regarding "all available information" (since revised to "all information") is regarding the Reporting Authority's submission of the required data elements outlined under the Section 5 recommendations. This was added because all of the workgroup members acknowledged that certain information such as laboratory results or medical examiner's determinations take time to process.

California (Johanna Naughton): without any federal requirements mandating agencies to actually submit reports to the state authority, it is difficult at this point to assess the suggested changes.

Workgroup response: Understood. As noted in our responses to other concerns expressed, many of these recommendations would impact federal regulation, which in turn, would impact state regulation. Many of your state's concerns may be resolved if federal regulation is successfully updated.

Louisiana (Clay Marques): second bullet point stating " if more information were to become available on an incident, the record could be updated, and should be updated before data is pulled for the annual, national statistics publication.

I agree with this statement, but I believe their [sic] should be a cut off point in which they pull data utilizing a date two months prior to publication. This would ensure that all information submitted would be completed.

Scenario: A boating incident occurs two weeks prior to national statistics publication information is entered into B.A.R.D., and used for national statistics publication although the autopsy is still pending.

I would suggest setting a date two months prior to the national statistics publication which would be a cut off. I would only utilize only these boating incidents. I would give these boating incidents two months till the national statistics publication to ensure that all proper documentation was contained within these reports.

Workgroup response: The Coast Guard does have a cut-off that changes every year, but it is typically 2.5 months after the close of the calendar year. The Coast Guard has incorporated some updates to cases after the cut-off, especially those in which fatalities occurred.

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.

Section 4: VESSEL DETERMINATIONS

4.1. DETERMINING WHICH WATERCRAFT ARE "VESSELS"

4.1.1. **Per 1 U.S. Code § 3 (Vessel as including all means of transportation), "[T]he word "vessel" includes every description of watercraft or other artificial contrivance used, or capable of being used, as a means of transportation on the water.**

***For purposes of vessel determinations within the context 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.**

Coast Guard (Verne Gifford): Re: 4.1.1., the definition of vessel in 1 USC 3 should be used instead of creating a definition as proposed in this section. A fine-tuned definition, as well as a list of vessel determinations (what is and is not a vessel), should be in Best Practices.

Workgroup response: The workgroup's intent was not to replace the statutory definition of vessel, but rather to develop a set of parameters for the practical, programmatic determination of vessels. As such, these parameters will be incorporated into Best Practices. However, for immediate purposes of this project, the recommendation is revised to 1) begin with the statutory definition of vessel that appears in 1 U.S.C. § 3, and 2) follow with the proposed parameters outlined in the original recommendation 4.1.1. This is in line with suggestions from commenters in the first review period that citations for term definitions or the definitions themselves—whether they appear in other recommendations or in U.S. Code or CFR—should be inserted as needed for easy reference throughout the package of recommendations.

As revised, 4.1.1 now reads: Per 1 U.S. Code § 3 (Vessel as including all means of transportation), "[T]he word "vessel" includes every description of watercraft or other artificial contrivance used, or capable of being used, as a means of transportation on the water.

***For purposes of vessel determinations within the context 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.**

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~~ tote, floating dock, unmodified log, snowmobile, and/or seaplane.

Workgroup note: In accord with a change made to recommendation 2.3.7, the workgroup also replaced "fish box" with "fish tote" in recommendation 4.1.3.

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. When the Coast Guard undertakes its internal review of the entire vessel determination process (per the mention in recommendation 4.1.5.1) and makes any revisions to the process, it should also describe how a state would request a vessel determination under such process.

California (Johanna Naughton): We support clarifying the definition of what is and what is not a vessel through the federal regulatory process. This is needed and would promote consistency in accident reporting. The current broad definitions, "used for transportation on the water," would not preclude, for instance, an inner tube being used to travel on a river to be classified as a vessel in some circumstances.

Workgroup response: Vessel determination is actually the result of a Supreme Court ruling, and is not in the regulatory realm. As such, this recommendation (along with others in this section) does not propose that vessel determinations be made through the regulatory process; this would be a policy change associated with the Coast Guard's inherent authority to make such classifications nationally. That said, a state can always determine what a vessel is within its own jurisdiction and for its own regulatory purposes; it just cannot declassify a vessel that has been determined to be a vessel nationally by the Coast Guard.

Oregon (MariAnn McKenzie): The future is here and many manufacturers are building unique boats or adding items (kayaks with peddle/battery powered and small jets) Does a sit-on top kayak with a battery jet motor become a PWC due to the definition of PWC and have to abide by PWC rules? What about the jet "boards" how are they classified?

Workgroup response: A motorized kayak would be classified as an open motorboat not a PWC. Additionally, SUPs or other surfboard-type craft that are powered by machinery would be classified as open motorboats.

Coast Guard (Verne Gifford): Re: 4.1.4., because a standing group already exists (NBSAC) and vessel determinations are infrequently made, a new standing group for vessel determinations is unnecessary.

Workgroup response: The workgroup considered this suggestion and noted that it was also suggested by a BLA (who is also a NBSAC member) during the first comment period. However, the workgroup thought it best to retain the recommendation regarding the creation of a standing group, with the expectation that the Coast Guard will undertake an internal review of the entire vessel determination process in the future. As part of any revision to the process, the workgroup also recommends that the Coast Guard describe exactly how a state would request a vessel determination under a revised process.

As such, as revised, 4.1.4 now reads: 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. When the Coast Guard undertakes its internal review of the entire vessel determination process (per the mention in recommendation 4.1.5.1) and makes any revisions to the process, it should also describe how a state would request a vessel determination under such process.

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.

California (Johanna Naughton): As a note, the State of California has a specific law defining bathers from boaters which applies to "waters of the state." Therefore, in absence of specific federal regulations, USCG policy decisions such as the ones outlined in 4.1.5.1. would not supersede specific state laws.

Workgroup response: Understood.

Coast Guard (Verne Gifford)**:** Re: 4.1.5.1., the reporting of incidents on all Paddleboards and Kiteboards, regardless of location, should be recommended in Best Practices.

Workgroup response: Workgroup concurred. The Best Practices that will be developed in Phase 2 of this project should encourage reporting of kiteboard and paddleboard incidents regardless of location.

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.

Alaska (Kelli Toth): While the Coast Guard determines a gold dredge as a vessel, for RBS purposes, as part of the determination to be reportable, the incident involving a vessel would have to be used for recreational (non-commercial) purposes. Some gold dredges are commercial operations, therefore would not be considered reportable. For example, if an operator were ejected and severely injured while moving their gold dredge from shore to a mining site for commercial purposes, the incident would not be considered reportable. As mentioned earlier in the example of a commercial fisherman using a state numbered uninspected vessel, reporting would only be applicable if operators were engaged in noncommercial activity.

Workgroup response: For a gold dredge involved in commercial activity, a report would be required under federal regulation, but the information would be tagged as "non-reportable" for statistical purposes. This is in light of the fact that CG-BSX is currently unable to shift the responsibility of reporting commercial-only incidents to the Coast Guard Office of Investigations and Analysis (CG-INV) as CG-INV does not have purview of state-numbered uninspected commercial vessels in their regulation (see related narrative associated with recommendation 2.1.3.2 on page 13 of the March 2019 version of the Resource Document).

Oregon (Randy Henry): I agree with all of 4.1.5. To be clear, if the gold dredge has a propulsion motor on it, it should be a vessel and should be registered.

Workgroup response Yes, it would be considered a vessel and should be registered.

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").

Section 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, G)

Workgroup note regarding the collection of data elements at the national and state levels: In this comment period, some of the states expressed agreement with information in the Resource Document (March 2019) that was based on comments workgroup members had made in the first review. Those comments were about the states' collection of information even if there is no federal mandate for it. Specifically, their agreement was with the sentiment that "Exclusion from the national collection does not preclude the States from collecting the information for their own investigative purposes," and the comment "Witness and passenger information should be collected at the state level, but need not be transmitted to BARD. So, the platform for collecting initial information should retain these fields with a "filter" for BARD. Otherwise an investigator may not collect the info."

As such, the workgroup wants to remind that a state has discretion to collect additional information within its own jurisdiction for its own program purposes; and that features such as described above should be taken into account in designing the future reporting system.

GENERAL COMMENTS REGARDING THE PROPOSED CHANGES TO THE DATA ELEMENTS

Arizona (Tim Baumgarten) for consideration in recording incidents: "..The current theory of any vessel collision is to capture the human factors from the perspective of both vessels, independently. This theory works in part because the factors are unique to each operator and vessel. Where it doesn't work is when one of the vessels is moored, anchored or docked and the incident becomes an allision. Clearly when the incident type is an allision, there are human factors and causes that are associated with the striking vessel. From the perspective of the allided vessel, with no operator and no passengers, there's no activity, no human or contributing factors, yet from that vessel's perspective the incident is typed as a vessel to vessel collision--this makes no sense and I recommend that in cases where the vessel becomes a fixed object, that it has no perspective from which to incorrectly contribute to the BARD data. Lastly, I recommend that all reporting agencies become more consistent with motor vehicle crash investigations and emphasize during training that when it can be determined, the offending vessel be labeled "VI" throughout the report, data collection and narrative."

Workgroup response: As part of this project, the workgroup reviewed the definitions for accident types that were accepted by NASBLA membership in the Terms & Definitions Project of 2012-2013. During this review, the group solidified that the term "Collision with Fixed Object / Allision" would cover instances where a vessel struck a docked vessel. The definition is, "The striking of any fixed object, above or below the surface of the water, except the bottom of the body of water. A Collision with Fixed Object/Allision includes a vessel striking a vessel moored to a dock, pier, or similar structure; and a vessel striking timber or stumps." Further, in the contributing factors/causes list produced and accepted as part of that same project, a new term "Did Not Contribute" was added: "The operator, occupant(s), or vessel did not contribute to the accident." Regarding the consistency of labeling vessels, a 2016 ERAC product "Good Practices: Writing Recreational Boating Accident Report Narratives," which provides guidance on the elements and format for writing a good, clear narrative for BARD submission, will be referenced in the Best Practices to be developed in phase two of this project.

California (Johanna Naughton): We attempt to work cooperatively with the Coast Guard on data collection in the interest of consistency in accident reporting across categories. When we can, in the absence of a federal regulatory change, we try to add clarifications to categories as needed, but cannot commit to changes or additions outside of the current federal requirements. We do not currently use BARD-Web but have our own database that feeds data into that system. Without changes in federal regulation requiring changes, we are cannot commit to making additional changes to our database collection, but may be able to do so.

Workgroup response: **Understood**.

Alaska (Kelli Toth): Some of the items determined to be optional are important data points that should be reconsidered as mandatory as mentioned in the resource document "supporting the goals and strategies of the RBS program, and is then presented by the Coast Guard in its annual recreational boating statistics under the authority of 46 U.S.C. 6102."

Some of the comments in the resource guide suggest only collecting safety gear at the scene of a paddling incident due to the lengthy list of equipment on a power boat. If this type of information were collected during the investigation, by a subject matter expert in tier two reporting, the in-depth research would be worthwhile to design informed interventions. It would be a disservice to powerboat and sail operators to only collect this information for paddlers, if we are collecting this information for paddling incidents, so to should this information be collected on all vessel type incidents. For example, anecdotal evidence supports the faster more efficient and effective rescues are, the higher likelihood of a positive outcome, however there is no means to track how a rescue was initiated. I tried researching number of SAR cases initiated by devices, and the information was unavailable. Are boaters not carrying any devices on board, are they packed away and not accessible, were they the wrong device for the area? (e.g. cell phone without service) This information is extremely helpful when designing interventions.

Workgroup response: **The workgroup previously did consider a mandatory collection of safety equipment/gear for all vessels involved in an incident.**

Initially, there was a desire on the part of some members to document available equipment/ gear for all vessels involved in an incident. One idea was to launch a fairly lengthy data collection that would focus on vessel safety check items such as visual distress signals, sound producing devices, fire extinguishers, navigation lights, and marine radios. Other fields under consideration included dewatering devices, anchor lines, first aid kit, charts, boarding ladder, wet suit, whistle, compass, GPS, flashlight, and water bottles.

Workgroup members ultimately conceded that data collection for all incidents would be too involved, and further had concerns about documenting gear for incidents where items might have been lost due to capsizings, sinkings, or similar events.

However, the workgroup revisited the list to focus on paddlecraft. While members first discussed making the collection of data on equipment/gear mandatory solely in cases where the equipment or lack thereof might have been a factor in the incident, the workgroup ultimately recommended collecting the information for all paddlecraft incidents so that there would be a "universe of cases." Some members expected the data collection to be fairly easy to achieve due to the low number of paddling incidents in their states. But no matter the number of incidents, the future reporting system should be designed to facilitate recording the information, with the fields presented only if pertinent to the vessel type.

Notable is that the workgroup spent a fair amount of discussion on documenting the information associated with paddles. Although group members admitted they have not seen many incidents due to a paddle (lack of paddle, inappropriateness of a paddle, etc.), they could see how the data collection might be relevant, particularly in whitewater situations. Nevertheless, there were concerns about an investigator's ability to determine the "appropriateness" of a paddle for the vessel. This prompted the workgroup's recommendation to have additional guidance in the Best Practices that will be developed in phase two of this project.

There were still concerns, however, about the usefulness of such a data collection. Workgroup members acknowledged that accidents often do not involve static scenes. Particularly with paddlecraft that are involved in capsizing, collection of information on available gear could be problematic if evidence is lost in the water. However, there was support for retaining the list because of the rise of paddlesports incidents that involve participants who are ill-equipped.

In developing the initial recommendation, the workgroup did not discuss the possibility of search and rescue documentation. Members considered the merits of documenting the incident's distance from shore, but ultimately their discussion did not yield a recommendation in the first round. In reviewing and discussing these comments from the second review, however, the workgroup took up the question of whether it would be worthwhile and feasible to document rescue information such as time of notification, means of notification, time of response, and so on. Ultimately, they did not concur with a mandatory collection of this data nationally. Some members said they track rescue information, but only use it for internal purposes. Others reminded that the issues surrounding SAR data had been explored in a past ERAC charge (with no favorable outcome) and cited the difficulty of obtaining and documenting information if another agency is assisting in the response. Moreover, while they appreciated the desire to document the data, members did not feel that as a matter of course it would be practical for their officers/investigators to capture such detail on the device(s) used in the initiation of a rescue operation.

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~~ Foggy/Hazy, Raining, Snowing, Other. Consideration should be given to providing guidance for the selections in a Best Practices document.

Arkansas (Stephanie Weatherington): I'm good with all except using both terms: foggy and hazy. They are too similar and confusing; recommend dropping one of them. However, if the consensus dictates that both terms must be kept, then there definitely needs to be clear guidance given.

Alaska (Kelli Toth): Foggy and hazy seem similar or confusing, suggest using the language "restricted visibility" e.g. smoke, fog.

Workgroup response to both comments: In developing the original recommendation, some workgroup members also had expressed that "foggy" and "hazy" could be similar and would need additional guidance in the Best Practices that will be developed in phase two of this project. In considering the feedback from this comment period, however, the group did not concur with dropping either of the terms as members thought there would be value in retaining both and that use of one or the other term might be based, in part, on regional preference. Ultimately, then, the group recommended that the options be revised to a combination "foggy/hazy." The group did not concur with the suggestion to use "restricted visibility" as an option since two terms associated with "Restricted Visibility"—one regarding environmental conditions (including weather-related) and the other, vessel-related—already appear as factors in the Contributing Factors/Causes list of terms.

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.

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).

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").

Alaska (Kelli Toth) Light conditions are a factor in Alaska boat incidents, such as the sun on the horizon restricting visibility, and in the fall light changes causing people to boat during hunting season in low light without lights.

Workgroup response: Understood.

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.

Oregon (Randy Henry) I wonder if ocean swell should be included at all. Short period swell with high wind waves tell a slightly different story than just wind waves.

Workgroup response: The workgroup had not previously discussed ocean swell as an option, but considered it in response to this comment. Overall, the group did not think that it warranted capture as a separate data field; however, if the interest in capturing ocean swell is more toward the frequency rather than height of the wave and there is an indication that the condition contributed to the incident, then it could be documented in the narrative.

Alaska (Kelli Toth): "Other" would also be a place to describe a river's unusually "high water or swift water" during Spring snow melt or heavy rains. Wave height would not be applicable but high, swift water has been a major factor on river fatalities also contributes to more floating objects and increasing log jams.

Workgroup response: Strong current could be used as well.

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).

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.

Wyoming (Aaron Kerr): As for the location, our officers often collect coordinates, so I don't object to providing them. However, they should only be required to be reported if known. In some cases, the coordinates where an incident is investigated are not the same as where the incident occurred (example - a raft overturns on a river and the occupants and vessel are recovered miles

downstream). In that case, the coordinates reported would be of the recovery locations and wouldn't identify the potentially hazardous location of the incident itself.

Workgroup response: Understood. However, the workgroup still recommends mandatory collection as a matter of general location of the incident. In this regard, the workgroup suggests documenting the source of information (e.g., handheld GPS, report system, etc.), as well as the level of confidence with the coordinates (e.g., within X miles).

Oregon (MariAnn McKenzie): With regards to 5.2.1, Google Earth allows the officer to pin point the location and the coordinates automatically are reported. This tool may be helpful to collect coordinates more accurately. Officers can take a screen shot and send the pic to the person entering the BARD data.

Workgroup response: Acknowledged. The workgroup suggests that information on how to use different tools like Google Earth or Google Maps to find coordinates should be included in the Best Practices that will be developed in phase two of this project.

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. Location on Water should be retained, but no attempt should be made to try to standardize entries

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

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~~ Time of the incident should be recorded in the 24-hour time format, ~~and the~~ and the reporting system should afford the ability to mark a time as "unknown."

Arkansas (Stephanie Weatherington): Absolutely agree with using 24-hour time format as that is what law enforcement uses and it allows for the accurate recording of midnight. Also, there definitely needs to be an unknown option - I know statisticians hate "unknown" but when you have a boat that was discovered floating in the middle of the lake and the only person onboard is deceased/drowned/ unrecovered and no witnesses then determining the time of accident is next to impossible.

Workgroup response: Understood. The workgroup gave further consideration to this recommendation and revised it to require use of the 24-hour time format and ability to mark a time of incident as "unknown."

As revised, 5.2.4 now reads: The Date and Time of the Incident should continue to be collected. Time of the incident should be recorded in the 24-hour time format, and the reporting system should afford the ability to mark a time as "unknown."

Wyoming (Aaron Kerr): Agree with using 24-hour time and the ability to mark as "unknown." As for the location, our officers often collect coordinates, so I don't object to providing them. However, they should only be required to be reported if known. In some cases, the coordinates where an incident is investigated are not the same as where the incident occurred (example - a raft overturns on a river and the occupants and vessel are recovered miles downstream). In that case, the coordinates reported would be of the recovery locations and wouldn't identify the potentially hazardous location of the incident itself.

Workgroup response: Understood. The workgroup gave this further consideration and agreed to revise the recommendation (as shown) to require use of the 24-hour time format and ability to mark a time of incident 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.

5.3 VESSEL CHARACTERISTICS

GENERAL COMMENT RE VESSELS from Coast Guard (Verne Gifford)**:** Re: 5.3., two fields should be added to the data collection to identify those vessels applicable to our regulations. One field should document whether a vessel was subject to inspection, and another should document whether a vessel was required to be numbered. These two fields would allow us to define vessels applicable to our regulations.

Workgroup response: The workgroup considered the feasibility of collecting this additional data. As members agreed that it is unlikely a state would be able to readily document whether or not a vessel was subject to Coast Guard inspection, the group is declining this suggestion.

One other field for consideration is the presence of a Vessel Safety Check and the year of issue.

Workgroup response: In developing the initial recommendations for data elements associated with vessel characteristics, the workgroup had considered whether it would be useful to collect information on the presence of a Vessel Safety Check sticker. At that time, the group decided that the collection would not produce valuable information because the sticker only reflects compliance with carriage equipment on the day that it was given. In considering this current comment, the workgroup again took up the feasibility and utility of collecting VSC data as part of a boating incident investigation, the variations in depth of inspection depending on the source, and whether or not the data would be useful for evaluating the VSC program. While there was general agreement that it might be good to have – and that a state could so document the information even if it wasn't a federal mandate – ultimately, the group suggested that capture as part of citation issuance (rather than boating incidents) would probably be the better route.

Notably, in the 2012-2013 committee cycles, ERAC monitored a VSC data collection pilot program that was sponsored by the United Safe Boating Institute (USBI) in part under a Coast Guard non-profit grant. This was in follow-up to prior committee efforts to secure and analyze data associated with operator non-compliance with safety equipment carriage requirements per what was then Objective 8 of the 2007-2011 National RBS Strategic Plan. The 2012-2013 charges were to provide counsel to activities associated with the USBI and affiliated organizations' efforts to capture VSC data that would be used for analyzing the reasons why vessels fail a VSC (with intent to provide meaningful trend data toward the examinations of operator non-compliance). A 2013 report offered observations about the examiner organizations and failure patterns. See especially, the 2013 ERAC C3 Vessel Safety Check data status report in the NASBLA Connect public library.

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

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.

Oregon (Randy Henry): For 5.3.3, about half of Oregon boats are in multiple ownership (husband / wife) and about 10% are in a trust (corporate / family). Does that matter? We have a growing number of people who are technically an "owner" but that means they just have access to the boat in which they have a share.

Workgroup response: Overall, the workgroup members thought that it would not be necessary or especially useful to document the ownership type as part of an incident report. That said, the question was useful in that it

highlighted the need for guidance in Best Practices to cover what would be considered "owned" v. "rented" for reporting purposes and how to handle, for example, cases involving marina boat clubs and "Airbnb-style" boating arrangements.

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.

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.

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.

Arkansas (Stephanie Weatherington): Need to be able to accurately record a 9.9 horsepower engine (not 99 as is now). Allowing cc's and thrust would be great additions.

Workgroup response: Agreed on the ability to accurately record hp and other measurements of power.

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.

Oregon (Randy Henry): 5.3.9 Overpowering. The most common overpowered craft in Oregon is either an old boat with a missing capacity plate or an inflatable that's exempt. If the text field can capture this nuance, then fine. My guess is it will only show up checked in egregious situations.

Workgroup response: Concur. Some workgroup members noted that a lot of overpowering cases involve modified older boats or race boats.

Alaska (Kelli Toth): 5.3.9 As with reference to the capacity plate and overpowering, if not noted further in the recommendations, other capacity plate information should be noted such as number of persons, cumulative weight (overloading).

Workgroup response: The workgroup considered, but ultimately declined to recommend additional capacity plate information. Members expressed caution as the cumulative weight could be hard to document, especially if some equipment, other items, or fuel are lost in an incident. Moreover, the calculation could be flawed because a combination of adults and children could skew the number and the number of persons is not broken down by adults v. children.

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.

Alaska (Kelli Toth) 5.3.10 Mixing water in gas will cause engine failure, fuel filters mounted properly in a vessel with double clamps ensures less of a chance of water contamination. consider adding a note if a fuel filter is present.

Workgroup response: The workgroup considered this suggestion, but declined to recommend it for national collection (a state could still opt to collect this additional information). Members thought that if engine failure was discovered as a cause of the incident, the presence/absence of a fuel filter could be documented in the report narrative.

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~~The primary hull material should be ~~made~~ identified for each vessel so that data will match VIS/SNS. The State should be able to document secondary and tertiary hull material types if the vessel is made of more than one material. 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.

Louisiana (Clay Marques): **5.3.11 - Hull Material Type** – I understand the Coast Guard's want to keep this section in line with current registration guidelines and not offer a selection for poly-construction, however there are many vessels in our state in which I believe this is a necessity. The biggest example is a vessel which is constructed completely of wood, **including the outer hull**, and then coated in a thin layer of fiberglass. From outward appearances, and even on their registrations, they are listed as being fiberglass vessels. However, in most cases, the fiberglass is doing nothing more than attempting to protect the wood from future rot. When these vessels are operated and are involved in collisions, their damage and the way they interact with other vessels is more representative of a wooden vessel than a fiberglass one, even though it may be registered or listed as a "fiberglass" vessel. There should be a method for documenting this type of poly-construction.

Workgroup response: Agreed. In considering this comment, however, the workgroup also recommended that the next version of the reporting system (to be taken up in phase two of this project) be designed to allow for the optional ranking of hull materials similar to the primary, secondary, and tertiary rankings of contributing factors/causes. In this way, the VIS and SNS matches would be accommodated and the state could still document poly-construction.

The group further recommended that the Best Practices to be developed in phase two of this project address the selection of a primary hull type when the involved vessel(s) was/were constructed with more than one hull material.

As revised, 5.3.11 now reads: 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. The primary hull material should be identified for each vessel so that data will match VIS/SNS. The State should be able to document secondary and tertiary hull material types if the vessel is made of more than one material. 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.

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)

Louisiana (Clay Marques): **5.3.12 – Vessel Subtype** –There is currently no category within the listed sub-types for an open motorboat that an inboard mudboat falls into. I have learned through

my travels with NASBLA across the country that this type of vessel is very specific to a certain portion of Louisiana and is not utilized in any other parts of the country. Because of its small vessel construction with a large inboard engine and high center of gravity, it may be beneficial to have it added to the vessel subtype. Or at a minimum have an "other" section that allows manual entry of this type of vessel.

Workgroup response: The workgroup discussed whether a "mudboat" really represents a specific Vessel Type or an Engine Type. The group recommends documenting a mudboat as an open motorboat (unspecified) with further documentation using the "other" option associated with Engine Type.

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]

Oregon (MariAnn McKenzie): Just to clarify, 5.3.14, you can check SUP or kayak, but also check a box "of Inflatable Construction"? If you don't check the Inflatable Construction, then it would be considered a hard shell?

Workgroup response: Yes. If the inflatable construction is not checked, it would mean that the vessel was not identified as inflatable.

Alaska (Kelli Toth): 5.3.14 Recommend Inflatable boat be considered a vessel type with subtypes to include with a transom for mounting an engine, a drifting raft (inflatable on all sides), Packraft (a small individual kayak) Inflatable canoe, inflatable SUP, and perhaps there are other inflatable/rigid hull combinations and others.

Workgroup response:The workgroup declines the suggestion as members believe it would create more inconsistencies in reporting vessel types.

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.

Oregon (Randy Henry) 5.3.16 collects data that contributes to understanding of a boat's capacity. It's probably very seldom gathered but seems like it might be useful in certain circumstances. I guess this can be handled in crash investigation.

Workgroup response: The workgroup noted that a state could always elect to collect the information, but still did not think it should be mandatory from a national standpoint.

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:

- **Standup paddleboard: Wet suit; Drysuit; Paddle (whether it was appropriate for vessel, and whether it was intact); Leash; Helmet; Communications Device (with text field to describe).**
- **Canoe: Wet suit; Drysuit; Paddle (whether it was appropriate for vessel, and whether it was intact); Helmet; Communications Device (with text field to describe).**
- **Kayak: 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).**

Oregon (Randy Henry) 5.3.17 - I agree with all of this, but with new life jacket labeling arriving, and the fact that white water operators often use or need more specialized gear, should life jacket appropriate for use be included? Or maybe that's assumed for all incidents.

> **Workgroup response: Recommendation 5.6.10 covers documentation on life jackets for victims. The workgroup recommended having a mandatory national collection of data on life jacket use if the life jacket was a factor in the incident. The following aspects were recommended: Type of life jacket; whether inherently buoyant or inflatable; whether serviceable; whether properly used; and whether of proper size. At the time, the workgroup did not discuss adding a field to document the "appropriateness" of the life jacket. In considering this comment, however, the workgroup took up the issue again, and ultimately did not concur with adding it as a separate data field. However, members did suggest that appropriateness of the life jacket – based on more in-depth evaluation of the jacket labeling and the person's use/activity at the time of the incident -- could be documented in the narrative.**

Arkansas (Stephanie Weatherington) I have concerns on 5.3.17 regarding mandatory collection of safety equipment. I can support IF ONLY for Paddlecraft (and therein we need good guidance/determinations of what is a paddlecraft/vessel). A best practices guide would most definitely be required.

> **Workgroup response: Understood. The recommended mandatory collection is only for paddlecraft, with the expectation that the Best Practices to be developed in phase two of this project will provide additional guidance.**

Maryland (Chuck Vernon): I agree with 11,12,13,14,15, and 16 however I will refrain endorsement on 17 and trust the committee had justification for this recommendation.

> **Workgroup response: Understood**.

Alaska (Kelli Toth) 5.3.17 Add distress signaling device to the list because initiating a rescue using a cell phone, VHF radio, Personal Locator Beacon is different than using a distress signaling device such as a mirror, white light, or whistle to alert others nearby and would also aid in pinpointing location.

Under Stand Up Paddleboard, the leash should be noted as appropriate for the body of water type. e.g. straight, coil leash, quick release. Members of ACA could provide guidance on this section.

Recommend adding this language to the other vessel types and consider a drop down for choosing what was available. An officer may not be aware of checking a life jacket for items beyond what was in a gear bag or available in the vessel. A communication drop down list would include a VHF radio, two-way radio, cell-phone, satellite phone, satellite tracker, personal locator beacon. Drop down for distress signals would include: whistle, mirror, pencil flares, smoke, white light, dye marker, signal flag, streamers, glow stick on a string.

> **Workgroup response: Among state members on the workgroup, none currently collects or uses distress signal information from incidents, and none thought there would be sufficient benefit from a potentially burdensome collection on equipment**

that was not required. But the group did note that such information, if pertinent to the incident, could be documented in the narrative.

On the comments regarding the documentation of the leash type and appropriate-ness for the body of water, members generally were not aware of differences in leashes, though they understood that perhaps in the future there might be a need to document that degree of detail. However, they also expressed concern about the level of training that would be required for officers/investigators to determine a leash type and whether it was appropriate. [The workgroup does note that recommendation 5.6.8 (safety measures) addresses the collection of basic information on operators' use of engine cutoff devices or leashes at the time of the incident (including whether the proper item was used, properly attached, and in proper condition.)]

Coast Guard (Verne Gifford)**:** Re: 5.3.17., the data collection on safety gear/equipment should be voluntary.

Workgroup response: The workgroup recommends that this item be retained in current form, as a mandatory collection, for the following reasons: 1) the members recommend a collection on all paddlecraft incidents (not just those in which gear/equipment was a factor in the incident) so that there will be a universe of cases to evaluate; 2) the intent is to design the future reporting system to facilitate the collection of this information, with options presented only if they are pertinent to the paddlecraft type; 3) this project has erred on the side of mandatory collections as members generally believe that voluntary collections result in significant data gaps.

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 and January 2020 following the first and second external review and comment periods, respectively--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)

Note: To align with language adopted by the project workgroup in its modification of the description of the "Non-Reportable Event: Voluntary departure injuries/fatalities" (see recommendation 2.3.1), a technical edit is proposed for the definition of the related entry in this list—"Person Departs Vessel Voluntarily."

Louisiana (Clay Marques): Definitions for Accident types it talks about collision with fixed or collision with floating objects whether above or below the surface of the water. I have experienced a lot of incidents where the object struck is unknown meaning we couldn't locate object whether it was floating and drifted off or fixed and never just located. So maybe having a definition type for Collision with unknown object above or below the water line.

Workgroup response: **The workgroup did not concur with adding another term and definition in the series on Collisions. However, for scenarios like what you have described, the workgroup suggests that "Other" be selected, paired with a description of the scenario where the location of the object was uncertain**

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)

Arizona (Tim Baumgarten) 5.4.3 Neutral...although interesting, I do not believe the collection of this information is germane to a statistical reporting of the incident with the exception of "making way"

Workgroup response: **Understood**

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 and again in January 2020 following the second external review and comment period -- should be adopted for national data collection. (See APPENDIX F for original approved list with markups and notes reflecting workgroup's recommendations)

Nevada (Brian Bowles) 5.4.4 Object to deletion of "Towing a Watersports Participant" see comments for recommendations in 2.3.2

Workgroup response: **Upon further discussion of the issues associated with Towed Watersports, both in consideration of the Non-Reportable Events list and this Activity list, the workgroup concurred with the restoration of the "Towing a Watersports Participant" entry and its definition:**

"Towing a Watersports Participant": Towing person(s) engaged in towed watersports or acting as an observer. Specify the type of watersport _____

The workgroup also reminds, however, that there are several other related terms that should be considered, not only in this Activity list ("Towed Watersports Participant") but also in the Accident (Incident) Types/Events list ("Towed Watersport Mishap") and Contributing Factors list ("Improper Lookout/ Inattention" and distraction codes; "Operator Inexperience,"; "Occupant Behavior"; and "Towed Watersport Participant Behavior").

Coast Guard (Verne Gifford)**:** Re: 5.4.4., the word "commercial" vice "profit-making" should be used for consistency with regulation.

Workgroup response: **While the workgroup appreciates the interest in making terms consistent across systems or in this case consistent with regulation, the group does not concur with reverting to the term "commercial" for purposes of identifying the Activity/Use of the Vessel. At this time, there are significant variations in the meaning and application of "commercial" at the federal and state levels (a primary reason for the proposed term revision), and until such time as there is alignment in the definitions, the workgroup prefers the term "profit-making activity" (and the revised definition a "state-numbered vessel was being used for legal or illegal commercial purpose…." with inclusion of examples) to facilitate accurate identification of the use of the vessel at the time of the incident.**

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 and again in January 2020 following the second external review and comment period -- should be adopted for national data collection. (See APPENDIX G for original approved list with markups and notes reflecting workgroup's recommendations)

Arizona (Tim Baumgarten) 5.4.5 Contributing factors: I agree with recommended amendments except for "Off throttle Loss of Steering". The presence of this definition allows avoidance of establishing true contributing factors and introduces bias against certain types of watercraft and in some cases certain manufacturers. This definition is analogous to a MV collision reconstructionist establishing "icy roads" as the cause of an MV incident, even though the true factors were excessive speed for conditions, following too closely, and driver inexperience with braking and controlling a skid. Yes, icy roads are an environmental factor but in reality we address human factors in this category. In many PWC collisions where the operator has taken their hand off the throttle, it was due to panic and inexperience with a water jet propulsion system. It still is a recognized problem but I have seen many "hired experts" use this description to civilly hold certain manufacturers responsible for their product, when 100% of the liability most likely should be attributed to the operator and their lack of experience.

> **Workgroup response: This term was a subject of much discussion – and some disagreement about its relevance – even when the contributing factors/causes list was undergoing revision as part of the Terms & Definitions Project in 2012. The 2012 Terms project team also questioned whether the entry, which had been deleted from the Coast Guard's BAR form in 2006, should be reinstated if it was largely the result of the operator's inexperience or if it was even relevant in light of engineering advances. However, the decision at that time was to restore it to the terms list as a legitimate phenomenon to be captured if it contributed to the incident—though perhaps as a secondary or tertiary contributing factor under "Operator Inexperience." The current project workgroup still feels that the term should be retained; however, in further consideration of the 2012 team's rationale and your comments regarding operator inexperience, the workgroup revised the definition to guide the officer/investigator toward the selection "Operator Inexperience" if the incident occurred primarily as a result of that inexperience, and to potentially select "Off Throttle Loss of Steering" as a secondary or tertiary factor.**
>
> > **As revised, then, the definition for the entry "Off Throttle Loss of Steering": The operator released or reduced throttle, or there was loss of engine power, which resulted in little or no steering capability. This is usually associated with water jet propulsion units or airboats. *[NOTE: If this incident occurred primarily as a result of the operator's inexperience, select "Operator Inexperience" with "Off Throttle Loss of Steering" as a secondary or tertiary contributor.]***

Louisiana (Clay Marques) 5.4.5 – Contributing Factors – Hazardous Waters and Weathe**r** – I agree with the changing of the definition of Hazardous Waters to include more than just swift moving water, however it should be made more clear with its relation to weather. In the Resource Document, it cites "wave height" as an example of the "weather-related hazardous water" subcategory. In the Appendix for definitions of contributing factors, Hazardous waters only describes "currents, rapids, or rapid tidal flows, or unseen underwater hazards". High wave height is usually caused by high winds as related to weather. Although, high winds could also be a factor separate from the height of waves alone (i.e. – windy conditions in shallow water that do not cause waves). In the definition of "Weather", it says that "if water conditions were caused by the weather, then use Hazardous Waters". I believe that this could be misinterpreted as **any** water conditions due to weather, when I think that they are meaning specifically wave height or moving water. In the example of the wind pushing a vessel into another item, causing damage, "Hazardous Waters" should not be used over "Weather". The term "high waves" should be added to the definition of

Hazardous Waters, and the specifics of this condition should be added to the definition of Weather when it describes the use of the "Hazardous Waters" factor.

Workgroup response: The workgroup appreciated the attention to the detail presented in this comment, but still concurred that the definitions for both "Hazardous Waters" and "Weather" should be maintained as proposed for revision. However, the Best Practices that will be developed in phase 2 of this project should elaborate on the relationships between these two terms and the data element Overall Water Conditions for wave height, and provide additional guidance for selection—either of the main term or the appropriate subcategory under Hazardous Waters.

5.4.6 Regarding vessel design or hull characteristics that might have contributed to an incident, 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.

Wyoming (Aaron Kerr) 5.4.6 - Not sure I like the mandatory response to this question. Many officers are not experts in the engineering of boat hulls and may not feel qualified to make such an assessment. I can see that it would be easy to confuse some actions taken by an operator with design characteristics that may have contributed to an incident. However, I might be overthinking this and including this question does get the investigator considering a boat's design as a possible contributing factor.

Workgroup response: In developing this recommendation, some workgroup members also were concerned that such a question might not be used due to officer inexperience, and could unnerve manufacturers. However, in further discussion, the workgroup thought that the benefits of capturing potential issues outweighed the risks, and as you noted, the question in itself would get the officer/investigator to at least consider the boat's design as a potential factor.

In the original version considered by the workgroup, the response to the question was a "yes/no." However, workgroup members recommended removing "no" as a response selection because they were concerned about culpability. That is, if an officer specifically selected "no" when the answer should have been "yes," the officer's training might be questioned. Apart from removing the "yes/no" format, the workgroup considered other possibilities such as adding introductory language 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 reflected a degree of uncertainty by the wording "is there a possibility." An officer would not be held accountable for his or her response.

Alaska (Kelli Toth): 5.4.6 "Vessel design or hull characteristics that might have contributed to an incident." Could some of these more detailed questions be reflected in the second tier of investigations, thereby not setting up an officer to make assumptions about an incident they may not be a subject matter expert. Perhaps this section could be left to the expert, not the officers completing the first general incident form?

Workgroup response: This question would not be part of the preliminary information collected upon notification of the incident. The field would be available for response in the second tier of reporting as part of the officer/investigator's more thorough evaluation of the contributors to the incident.

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

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.

Alaska (Kelli Toth) 5.5.1 Don't insurance companies have data on boat damage estimates? Why is the value of damage important to the RBS community? Do we need to burden officers with researching vessel value? Isn't the threshold more important than the actual amount of damage?

Workgroup response: The workgroup generally felt that the collection of damage amounts should be retained for supporting and evaluating regulations and legislation. However, the members also were concerned about the burden to the officer/investigator, and thought having the dollar amount "buckets" option would facilitate collection.

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.

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.

General comment from Arizona on these recommendations (Tim Baumgarten) 5.6 Subject Identification; I agree that this information should continue to be collected for investigative purposes BUT much of this information is Criminal Justice Information System (CJIS) protected personal information and can only be disseminated to individuals who have completed CJIS training and certification. Many times officers access CJIS based systems to obtain personal identifier information on operators, passengers and victims. Even viewing CJIS information is prohibited by unauthorized individuals. I recommend that all personal identifier information, OLN, dates of birth, SS#, phone numbers, addresses, HIN numbers and bow numbering should be protected from dissemination and redacted from statistical references.

Workgroup response: Personally-identifiable information is needed in the national data collection to ensure there is no duplication in the dataset. However, the Coast Guard does not disseminate personally-identifiable information unless permitted under law. Moreover, the states themselves vary on this matter. Some workgroup members noted that in their respective states, such identifiers are not protected and all of the information is publicly accessible.

Alaska (Kelli Toth): 5.6.2 and 5.6.3 Race and primary language spoken, are two fields that should be added to the operator information, these should be collected as part of the mandatory reporting nationally. If the RBS strategic plan includes reaching the underserved populations as a priority, we should be gathering this information, and understanding if translating education and outreach materials in other languages makes sense. Traffic officers, hospital input data, and EMS professionals all use race as a data field, they may provide guidance to overcome the comments in the resource document of it being subjective, perhaps a dropdown list would be helpful. Safe Sates Alliance has epidemiologists who may be able to assist with best practices in reporting race. Language would be important for designing interventions, but may be more difficult to capture.

Workgroup response: The workgroup appreciated these comments but does not think "race" and "primary language" should be added to the national collection. In prior discussions, the workgroup did consider adding "language" to the data collection, since such information could be helpful in devising boating safety educational products. However, some members were concerned about the quality of the collection and the ability to obtain the information, as well as subjectivity on the part of an officer asked to evaluate whether a person understood English. The workgroup also considered adding "race," but again felt it could be subjective, even with guidance. However, the workgroup would like to stress that not having either of these items for mandatory collection at the national level does not preclude a state from collecting the information for its own purposes.

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.

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.).

Alaska (Kelli Toth): 5.6.5 Race and language of the operator should be mandatory, see recommendation 5.6.2 and 5.6.3.

Workgroup response: The workgroup appreciated these comments but does not think "race" and "primary language" should be added to the national collection. In prior discussions, the workgroup did consider adding "language" to the data collection, since such information could be helpful in devising boating safety educational products. However, some members were concerned about the

quality of the collection and the ability to obtain the information, as well as subjectivity on the part of an officer asked to evaluate whether a person understood English. The workgroup also considered adding "race," but again felt it could be subjective, even with guidance. However, the workgroup would like to stress that not having either of these items for mandatory collection at the national level does not preclude a state from collecting the information for its own purposes.

Coast Guard (Verne Gifford)**:** Re: 5.6.5., a field should be added to document the operator's primary language so that CG-BSX can better design outreach materials.

Workgroup response: The workgroup understands the interest in improved design of outreach materials, but does not think the addition of "primary language" to the national incident reporting collection would be the best way to get to the needed information. In prior discussions, the workgroup *did* consider adding "language" to the data collection. However, some members were concerned about the quality of the collection and the ability to obtain the information, as well as subjectivity on the part of an officer asked to evaluate whether a person understood English.

The workgroup did consider the possibility of gathering "primary language" in the incident reporting process on a voluntary basis and recording it "if known." However, the group wondered whether this information might be gathered via other means including the National Recreational Boating Safety Survey (which this round is being administered via mail and web, not telephone). A follow-up review of the exposure and participation survey instruments revealed that while there were no questions associated with language, there were two associated with race and Hispanic/Latino/Spanish origin.

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?

Michigan (Tom Wanless): Re: 5.6.6, would recommend collecting the type (online, in-person, etc.) and source (State, USCG Auxiliary, etc.) of training.

Workgroup response: In prior discussions, the workgroup did consider the possibility of documenting the means by which operators received their safety education (online, classroom, on water, etc.). However, the workgroup did not feel the means of instruction is important to collect because there is no requirement that describes how an operator must receive instruction. For example, one workgroup member noted that initially there was a concern that people taking online courses were not retaining information because they were not paying attention. However, this concern has since been dispelled. In the member's state, upwards of 90 percent of operators are taking online courses.

The workgroup also discussed the possibility of documenting the source of education, but some workgroup members noted that the source of education can be hard to obtain as it is not documented on their boating safety education cards. Further, some educational sources do not forward their certificate information to states, so states cannot account for them. Then, too, there are some entities (like a maritime academy) that offer boating instruction, but may not issue a certificate. The workgroup also noted that the source of education does not necessarily correlate to risk. One workgroup member noted that a lot of boaters take online courses through BoatUS, for example. However, just because boaters who have taken a particular course are involved in an accident, does not mean that a line can be drawn connecting the "cause" to a faulty online course.

Finally, workgroup members noted that there are many sources of education and the current rundown of sources on the Coast Guard's BAR form and in BARD-Web are limited. That means a lot of times an officer will simply use the "Other" category, which does not lend itself to fruitful information for analysis.

Coast Guard (Verne Gifford)**:** Re: 5.6.6., the operator be required to show proof of education via their boating safety card.

Workgroup response: The workgroup noted that proof of education is something that would be set and required by state law.

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 type of vessel 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 boating at that location before (yes/no), with a voluntary follow-up, fill-in estimate of the number of times at that location.

Alaska (Kelli Toth): 5.6.7 The officer getting number of hours of experience operating a vessel from a deceased operator will be difficult and hard for survivors to estimate.

Workgroup response: Understood. The workgroup recognizes the limitations of collecting information on deceased operators. In fact, in prior discussions, the workgroup expressed additional concerns about the ability to validate experience no matter the operator's status. However, members generally feel that some data on experience is better than no data at all for supplementing marketing, legal, or analytical work.

In determining how the collection could be improved, workgroup members recommended seeking experience in hours instead of years to get a better (relatively speaking) estimate of experience. For example, if the collection were recorded in years, a person could report that they had five years boating experience when they had only been out a few times over that period.

5.6.8 Data on the following safety measures should be collected nationally for the Vessel OPERATOR(s): whether an engine cutoff device 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.

Alaska (Kelli Toth) 5.6.8 Safety measures recommend: Add life jackets to leashes and engine cut-off devices to the mandatory list of reporting:

Clarify properly used:
Was it the right size for the victim?
Was it worn properly e.g. zippers zipped, buckles fastened?
Was it in serviceable condition? e.g. were there holes in the fabric, flotation material missing, seams ripped, air cartridge missing in inflatable?
Was it worn for its intended use? e.g. was an offshore life jacket worn on a PWC, or an inflatable worn while tubing?
Was it worn in accordance with the label? e.g. was a child under age 16 wearing an inflatable life jacket even though the label indicates "person wearing life jacket must be age 16 or over.'

One interesting note, when researching blunt force trauma, passengers who survived an allision were wearing a life jacket, those that were not wearing life jackets sustained fatal blunt force trauma. Tracking life jacket wear in terms of a protective device from not only drowning, but protection of blunt trauma to vital organs of the operator and passengers.

Workgroup response: The workgroup does not recommend collecting data on life jacket use for the operator unless the operator was also a victim (See recommendation 5.6.10). This is due to concerns about the ability to obtain and validate this important data.

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, 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))

Workgroup message regarding the format recommended for collecting this data: Feedback from the first review and comment period for this project suggested there was potential for confusion and duplication in counts that could have resulted from maintaining a format that had a marijuana option separate from Drugs. In response, the project workgroup modified the original recommendation by deleting the separate marijuana field and proposing instead a drop-down menu of drug categories adapted from those used in motor vehicle crash reports.

The workgroup believes that some of the feedback offered during this second comment period—suggesting certain qualifiers that actually *were* integrated into the revised recommendations as a result of the earlier feedback—might have been the result of commenters reacting to those "older" posts in the Connect community (i.e., from the first comment period).

Maine (Adam Gormely) I Agree with all the drug questions and comments and believe we should ask for Alcohol and Drug use, yes or no, and like Eric's thoughts, follow-up qualifiers for drugs such as Type / Prescription, etc.

Workgroup response: The workgroup believes that these have been adequately addressed in the revised recommendation.

Oregon (Randy Henry): I support these. I hope we can select multiple boxes in 5.6.9 in the drop-down menus. We see a lot of poly-drug use in Oregon, especially alcohol and marijuana, and randomly selecting what is thought to be the impairing substance skews the data.

Workgroup response: Understood. Yes, the intent is for multiple selections and the recommendation to allow for it will be taken up in Phase 2 of this project, which focuses on system design.

Arizona (Tim Baumgarten) I do not agree with collecting data just to collect data. Once the determination is made that alcohol was a factor in an incident, either by operator consumption or generally from activity on the vessel, what do we need to do with information that indicates "all victims" had consumed alcohol vs one, two or none except the operator? In my experience, these scenes are very dynamic and most of the time passengers have disappeared or have be transported by EMS. We can only obtain medical blood draws if the individual is under arrest for impaired operation...no just a victim. I believe we are currently under reporting the incidence of alcohol as a contributing factor, because many officers are hesitant to say alcohol was a factor unless the operator was arrested for BUI--this is a training issue. If alcohol was onboard the vessel, there is a significant reality that alcohol was contributing even if a designated driver was operating given the human factors of distraction. If we require the collection of this information from all victims, we will only achieve under reporting of alcohol use with victims too. I recommend clarifying some guiding criteria when alcohol should be considered a factor in an incident and forget trying to get every detail from every victim. There is a point at which our field data collection forms will not have room for any more data collection boxes.

Workgroup response: The workgroup acknowledges the issues regarding collection of this data. However, 46 USC 6102(a) requires capturing data on the "number of casualties in which the use of alcohol contributed to the casualty," and the proposed collection would provide granularity on the role of alcohol because it expands the capture of alcohol use for the operator and the victims. Further, regarding the reluctance of officers in reporting alcohol involvement and the inconsistencies in reporting use, the workgroup would like to reference (and include as part of the Best Practices to be developed in phase 2 of this project) a 2016 ERAC product that addresses this issue. See GUIDANCE: Documenting Alcohol or Drug Involvement as a Contributor in Recreational Boating Accidents

Delaware (Drew Aydelotte): I back up the points made by Cody Jones and Dan Hesket regarding generalization of "drug" option. Most officers are not trained to a level of pinpointing exactly what type of drug influence (unless they are certified drug recognition experts) a person is under unless the person advises, which could still not be accurate.

Workgroup response: The workgroup believes Cody and Dan's original concerns have been addressed in the revision that was put forward for this comment period. It also acknowledges that pinpointing a specific drug is more than likely to be out of reach for most officers, but that having the standardized drug categories available for selection could add another level of understanding on the effects of these substances on boat operators.

Alaska (Kelli Toth) 5.6.9 The ability to record more than one drug, often times alcohol, marijuana and other drugs are used in combination.

Workgroup response: Understood. Yes, the intent is for multiple selections and the recommendation to allow for it will be taken up in Phase 2 of this project, which focuses on system design.

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.

Oregon (Randy Henry)**:** In 5.6.10, I assume "properly used" means a life jacket used in a way that is consistent with the label. It should.

Workgroup response: Yes, "properly used" does mean a life jacket used in a way consistent with the label. The Best Practices that will be developed in phase 2 of this project should provide more guidance on its meaning and application.

Alaska (Kelli Toth) For the sake of simplicity, combine life jackets with safety measures section 5.6.8.

Workgroup response: These recommendations do not necessarily correspond to how information will be organized in a new reporting system or on a data collection form. Life jackets are separated here because they apply to a different set of people. The data collection on leashes and engine cut-off devices—the "safety measures section"—is only required for the operator, while the life jacket data collection will only be required for victim(s) who may or may not have been the operator.

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.

Alaska: (Kelli Toth) 5.6.11 Epidemiologists and public health officials can assist with a standardized list of cause of death that would streamline these data fields. Consider consulting with Safe States Alliance Roundtable project. Using the same list of cause of death and injuries will aid in the process of linking trauma registry with BARD reports. Washington state conducted a study linking the two data sets, setting the example for the nation on data reporting. The Passenger safety project is working with the Safe States Alliance to generate the ICD-10 codes for all states to use.

Workgroup response: Understood. The workgroup agrees that there will be benefit to determining the appropriate terms through consultation with the expert communities.

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." *

*Source and definitions regarding drownings used in developing this recommendation: 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."*

Workgroup response (overall): As the three state commenters (from Missouri, Maryland, and Oregon) have raised similar concerns regarding the terminology, they will be taken up in a common response.

The workgroup acknowledges that an adjustment period likely will be necessary to disassociate "drowning" from just one of its possible outcomes, death. As the recommendations in this section encourage the Coast Guard to consult with the medical community for appropriate, standardized terminology, the workgroup aligned with the source and definitions cited with the recommendation. The medical definition of drowning is "the process of experiencing respiratory impairment from submersion/immersion in liquid." As such, there can be fatal and non-fatal drownings. Originally, the workgroup also considered the use of the term "near drowning," but discarded it upon learning that the Drowning Prevention Alliance discourages use of that terminology.

Missouri (Matt Walz): If by non-fatal drowning, we are talking about a "near drowning," it should likely be called that. The definition of drowning is death by submersion in water, so I don't think non-fatal drowning would be the best language if we are talking about a near drowning. I don't think it would be possible to have a non-fatal drowning victim.

Maryland (Chuck Vernon) I agree with the needed training component [i.e., need for sufficient training on these elements] and am also perplexed as to what is a non fatal drowning. I'm sure we can come up with another category to capture that info.

Oregon (MariAnn McKenzie) concurred with Missouri.

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."

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."

Alaska (Kelli Toth) 5.6.15 and 5.6.16 Recommend following public health reporting used by trauma registries, medical examiners and or hospital data entries. Safe States Alliance members can assist through the passenger safety roundtable work of NASBLA and Safe States Alliance.

Workgroup response: Understood. The workgroup agrees there will be benefit to determining the appropriate terms through consultation with expert communities.

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

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.

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).*

Arizona (Tim Baumgarten) Agree to 6.1 and 6.2; the current BARD reporting database is cumbersome and difficult to enter data elements. A web-based platform would better suit modern browsers and software applications. Suggest a data entry format that follows chronologically with a field investigative form. Wouldn't it be nice if all agencies had the same or similar formats for field collection of incident data, then could go directly online and enter the data in a similar format?

6.2 There should be the opportunity for officers to document minor injuries when an incident only met the damage threshold, without reviewers requiring a complete injury supplement for each person as is required now. (Currently, if an incident meets a damage threshold and injuries are mentioned in the synopsis, then BARD requires a complete injury accounting of passengers.)

Workgroup response: Understood. These and other issues will be taken up in phase two of this project, which will address system design.

California (Johanna Naughton): As noted in 5.1, we do not currently use BARD-Web but have our own database that feeds data into that system. Without changes in federal regulation requiring changes, we are cannot commit to making additional changes to our database collection, but may be able to do so.

Workgroup response: Understood.

Alaska (Kelli Toth): 6.2 This is confusing. If there were passengers involved in an incident when someone dies, there is an incident report involving the deceased, whether there was one additional passenger or 10,

there was one person affected. If nobody else was injured why would the officer be expected to include the 10 other participants in the incident who were not injured and how is that relevant or helpful to a state designed intervention? The underreporting is primarily due to people whose injuries are treated and released from a hospital but are not reported to the state as a boating incident. The issue is EMS providers and trauma hospital staff not coding for boating incidents. For example, a person is ejected from a boat and experiences blunt force trauma and has a head injury. The victim is transported to the hospital where their injury is coded as a traumatic bran injury- TBI, and there is no mention of a boat. The same example relates to falls. In Alaska, falls is the number one unintentional injury. We collected a data sample from the trauma registry. There were several instances where the fall occurred on a recreational boat, but these cases are not coded or reported to the state. I am not certain of the magnitude of the problem, but I do know there are some data gaps and an opportunity for improvement.

Workgroup response: The recommendation only pertains to people who suffered an injury that did not meet the injury threshold. Instead of collecting detailed information on each person with minor injuries, the recommendation is to document a count of the number of people with minor injuries. In that way, the number of people injured is captured in a less burdensome way.

Section 7: ROLES AND RELATIONSHIPS

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. If CG-BSX becomes aware that a Coast Guard asset has assumed the lead investigation, then CG-BSX should notify the State. (Coast Guard response in the form of a Search and Rescue does not constitute a Coast Guard investigation.)

Oregon (MariAnn McKenzie): We only know if Coast Guard is involved in the incident through newspaper articles. We sometimes receive the SITREP, but it's only regarding the SAR and not the investigation of the incident. Some information can be gleamed off of the SITREP, but we always follow up with Marine Patrol to see if they were involved or knew about the incident. Sometimes they did not know and either did the RBS Specialist. It has been difficult for them to track the investigative report or even the SITREP down. Communications need to be corrected in all areas. I agree with if USCG takes the lead, then have them report to CG-BSX and the State. Have CG-BSX follow-up for more information instead of putting the burden on the states.

Workgroup response: Understood. If USCG assumes the lead, then CG-BSX will be responsible for collecting information.

New York State: (Chris Fallon): Generally, agree with recommendations, however, relative to 7.1, agree with several other comments that this seems unnecessary; if the Coast Guard has assumed the lead on an investigation, the Coast Guard should assume responsibility for any interagency notifications.

Workgroup response: CG-BSX is requesting notification from the State for any incident in which another Coast Guard asset assumed the lead in an investigation because often times the Office is unaware of Coast Guard involvement in a recreational boating accident. CG-BSX used to receive an automatic notification from the Coast Guard's Marine Information for Safety and Law Enforcement (MISLE) system if there was an incident that may have involved a recreational vessel. However, since MISLE's update, the notification no longer exists. CG-BSX has tried to fill that 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. There was one fatal case several years ago that CG-BSX missed. Though it occurred in Texas, Texas authorities didn't report it because the Coast Guard assumed the lead in the investigation, the MISLE

notification wasn't 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 the annual statistics publication, which caused embarrassment when a member of the public pointed out the omission on a website.

Workgroup members advised that sometimes they are not aware that the Coast Guard assumed the lead in an investigation due to a lack of communication from the Coast Guard asset that responded. Members cited the difficulty in building relationships with the Coast Guard due to the frequency of Coast Guard member rotation. However, workgroup members did indicate a willingness to inform CG-BSX if they became aware that the Coast Guard has assumed the lead investigation in an incident. In turn, they requested that CG-BSX acknowledge such notifications.

In an attempt to build relationships, CG-BSX advised State workgroup members and is advising any State to seek assistance from their District Recreational Boating Safety Specialist. If all else fails, request assistance from CG-BSX. Of note, the Office also tried to reinforce Coast Guard communication requirements through efforts to make Coast Guard assets aware of their obligation to notify and share information with the States. Some CG-BSX staff have been doing this by participating in sector commander conferences and trainings.

Louisiana (Clay Marques): This statement acknowledges that all states should notify CG-BSX to assume the lead on an investigation when appropriate. I'd like to see a comment addressing the opposite as well – USCG should notify states to assume the lead when appropriate.

Workgroup response: So noted. The workgroup modified the recommendation to add that CG-BSX should notify the State when it becomes aware of a Coast Guard-led investigation in concurrent jurisdiction.

As revised, 7.1 now reads: 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. If CG-BSX becomes aware that a Coast Guard asset has assumed the lead investigation, then CG-BSX should notify the State. (Coast Guard response in the form of a Search and Rescue does not constitute a Coast Guard investigation.)

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.

California (Johanna Naughton): it is not clear if this includes the Coast Guard following up on their own SITREPS and MISLE reports that are taken on recreational incidents that they do not plan to fully "investigate" and no local jurisdiction responded. We support the USCG entering those reports and all missing details into the BARD system as it is problematic for states to collect these details from the local USCG districts.

Workgroup response: This recommendation does not relate to cases where the Coast Guard responded to but did not investigate an incident.

If a State needs information on an incident that the Coast Guard responded to (but did not assume the lead), the State should first try to obtain the information from the responding Coast Guard unit. If the unit is non-responsive, the State should try to gain information from the Coast Guard District Recreational Boating Safety Specialist. If all else fails, the State should contact CG-BSX for assistance.

Alaska (Kelli Toth): 7.1 and 7.2 Point of clarification, if the Coast Guard assumes the lead in a search and rescue or investigation does this mean the state relinquishes the reporting authority? Isn't it the state's responsibility to be the reporting authority? I thought it was up to the state BLA to determine an incident to be reportable, this seems to shift the responsibility and authority to the Coast Guard. When the Coast Guard is involved in an investigation or search and rescue, the RBS specialist should work with the BLA to relay information, so the state can determine report-ability and be responsible for reporting to BSX. This will strengthen relations between the RBS specialist and the BLA and ultimately the state and federal relationship. In the example noted about Texas, had the Search and Rescue team notified their RBS specialist, they could have contacted the BLA for further investigation, and reporting. It surprised me when the Coast Guard rescued my neighbor involved in a boating incident, he was treated and released from the hospital. Had he not have been my neighbor, and unless there was not a news article written, we would have not heard of the incident. How ironic for a state employee to request a boat accident form from a survivor, when the Coast Guard picked him up, so that I could report it back to the Coast Guard.

Workgroup response: This recommendation does not relate to cases where the Coast Guard responded to but did not investigate an incident.

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

Arizona (Tim Baumgarten): I Strongly disagree with this statement because it is factually incorrect. I recommend amending this statement to only exclude "sole tribal waters" so as to clearly not exclude joint jurisdictional waters. The US Supreme Court concluded in *Nevada v. Hicks* (2001) and in applying *Montana v. U.S.*, 450 U.S. 544 (1981), that Tribal Courts are not courts of general jurisdiction, lack criminal jurisdiction over nonmembers and state sovereignty/jurisdiction does not end at the reservation boundary. Additionally, the Court held that states have sole authority over nonmembers when investigating criminal acts. In most states, violations such as reckless operation, impaired operation and many navigational rule violations are criminal acts. In the case of BUI when more serious offenses are involved such as negligent homicide or involuntary manslaughter, clearly the state would have criminal investigative jurisdiction on the case. Although unsure of the legal reference, from past experience, the FBI maintains federal jurisdiction over all homicides on tribal lands that involve members and nonmembers. The joint jurisdictional issue is usually addressed with state certified tribal peace officers. On the Colorado River, a federally navigable waterway, there are several reaches where the river is recognized as tribal waters with joint jurisdictional authority. The State of Arizona will continue to maintain its sovereignty over these waters.

Workgroup response: The workgroup reviewed the information provided and has changed the recommendation to apply to "sole tribal waters."

As revised, 7.3 now reads: Incidents that occur on sole tribal waters should be excluded from reporting requirements as neither the States nor Federal Government have jurisdiction over them.

Alaska (Kelli Toth): Although some tribes are recognized as sovereign nations, there should be further research in land use and jurisdiction issues.

Workgroup response: Understood.

Montana (Phil Kilbreath): I don't think boat accidents on tribal waters are always this simple, flathead lake is half on and half off a reservation and our agency legal opinion is the state has jurisdiction of RBS activities on the water. Perhaps incidents that occur on tribal waters where neither the state or federal government have jurisdiction are excluded from reporting.

Workgroup response: The workgroup reviewed the information provided and has revised the recommendation so that it applies to "sole tribal waters."

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.**

Arizona (Tim Baumgarten): disagree with federal entities reporting incidents on sole federal waters--I would challenge that there may not be such a beast as sole federal waters because a state would likely not relinquish sovereignty within state borders. For the same reasons, explained below, I believe a "non-reporting" exclusion would not relieve the owner or operator from the legal responsibility to report the incident to the State Authority. I am VEHEMENTLY opposed to reporting of incidents directly to the USCG-BSX by federal agencies patrolling joint jurisdictional waters that may arise if they assume investigative lead on incidents that may occur on joint waters. This is an untenable proposal because the differences between the state and federal reportable threshold for property loss are significant and would result in the under reporting of state incidents, rendering historical data incomparable. This situation would also expose owners or operators to legal jeopardy when they believe they had met the reporting requirements of an incident to federal agency and that agency does not report it to the State Authority because they believe it did not meet the federal reporting threshold. In Arizona, within the Lake Mead National Recreation Area, Glen Canyon NRA and Grand Canyon National Park (NPS), there are approximately 6-12% reportable incidents that occur in these waters. Remember that these are joint jurisdictional waters and the investigative lead is determined by what agency arrives on scene first (With the exception of Grand Canyon Natl. Park.) Depending on NRA staffing levels, the response and subsequently the number of investigations may be more or less in certain years.

> **Workgroup response: This recommendation is limited to incidents that occur under the sole jurisdiction of another federal entity. An example is Aberdeen Proving Grounds in Maryland. Maryland authorities do not have jurisdiction to investigate on waters on this Army compound. While there is a difference of opinion between commenters regarding this recommendation, the workgroup is sensitive to the concern expressed here and has removed the examples to avoid any additional confusion.**
>
> > **As revised, 7.4 now reads: The Coast Guard should be responsible for collecting and entering information on incidents that occur under the sole jurisdiction of another federal entity, or when such federal agency assumes the investigative lead on any such incident.**

Wyoming (Aaron Kerr): Agree with this recommendation. Wyoming has been held accountable for late reporting on accidents that occurred on the Snake River in Grand Teton National Park and weren't reported to the State. Although a joint-jurisdictional water, Park Service staff are generally unaware of state reporting requirements. Depending on who is in charge, they are not always easy to work with when trying to obtain required data for reporting. Currently, the working relationship between our state game wardens and federal park rangers is good. However, it's been my experience that some federal employees don't like being told by state agency people that they are required to share information with us. It makes sense to me that the Coast Guard work directly with the Park Service to get the necessary information. Once the Coast Guard has collected the required data elements, the details of an incident should be shared with the State reporting authority in case there are differences in property damage thresholds and the state wishes to include those incidents in its statistics.

> **Workgroup response: Understood. The workgroup does want to advise that the recommendation is limited to incidents occurring under the sole jurisdiction of another federal entity (such as Aberdeen Proving Grounds in Maryland), and has removed the examples from the recommendation to avoid further confusion.**

Oregon (MariAnn McKenzie): Do they even know they need to report incidents to USCG? Some counties have excellent partnerships with other federal agencies and they will be called and assist in the investigation, most of the time taking the lead.

> **Workgroup response: Understood**.

Montana (Phil Kilbreath): this probably will not happen much in Montana, although it did happen last year. Coast guard may want to consider asking the state to notify them (when they are aware) when this occurs to ensure an accident gets reported.

Workgroup response: The workgroup considered whether this comment should result in an additional recommendation, but thought that it should instead be included in Best Practices.

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

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.

California (Johanna Naughton): We want to reiterate that federal regulations do not require that states follow up on news clippings regardless of whether or not the USCG or the State finds them to be reportable. Regulations only require reports submitted by the operator/owner/other involved parties are required to be submitted to the Coast Guard. While we make every effort to follow up on news clippings, we want to stress that this activity is not outlined in regulation. If the Coast Guard wants any action taken on news clippings, they should make sure that any regulatory changes clearly define what that activity entails. Therefore, we have concerns with present and future activities regarding them.

Workgroup response: Understood.

Section 8: VESSEL SAFETY ISSUES, DEFECTS, RECALLS, AND BRIDGE ALLISIONS

General comment on this section from Arkansas (Stephanie Weatherington): … more guidance needed on the "how and who" to report to...like others have responded our Hwy Dept. would be the agency that responds to a bridge allision and determines safety. Also like some other states, I don't envision our officers ever direct entering into BARD (or the new system) so don't know how the "flagging" system will work with recalls.

Workgroup response: Understood.

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.

Maryland (Chuck Vernon): I have a suggestion for the wording of 8.1. I think it would read better if the sentence stopped at " manufactured for recreational use." The additional verbiage seems redundant because the State Reporting Authority could not report if they were not aware of it. Just a thought.

Workgroup response: The workgroup acknowledges the redundancy, but recommends retaining the current wording as it was developed with input from the legal staff of one of the state members of the project workgroup.

Oregon (Randy Henry): For 8.1, and perhaps for others, I'd appreciate a system to report such concerns that alerts a duty station and not an individual. Something like vessel.rec.report@uscg.mil, that would go to all individuals charged with responding, and a feedback message with additional information.

Workgroup response: Understood. This request will be taken up under Phase 2 of this project, which addresses system design.

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.

8.3 If the State becomes aware of a vessel allision with a bridge over waters of concurrent jurisdiction, ~~T~~the State should notify the Coast Guard~~ if a vessel allides with a bridge over waters of concurrent jurisdiction.~~

New York (Chris Fallon): generally, agree with recommendations although with regard to 8.3, the state boating agency is often not aware or not notified of these types of incident.

Workgroup response: **Understood. The workgroup has revised the recommendation to more clearly reflect this intent.**

As revised, 8.3 now reads: If the State becomes aware of a vessel allision with a bridge over waters of concurrent jurisdiction, the State should notify the Coast Guard.

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.

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