



The Safety Beacon is for informational purposes. Unit safety officers are encouraged to use the articles in the Beacon as topics for their monthly safety briefings and discussions. Members may also go to LMS, read the Beacon, and take a quiz to receive credit for monthly safety education.

March 2020

## *A few quick updates...*

The Beacon is a little bit shorter than usual this month as we return from a great Winter Command Council and continue to work on some important projects.

If you have any questions on safety policy, the new safety regs, or anything else about the new safety program, drop us a line at [safety@capnhq.gov](mailto:safety@capnhq.gov) and we'll try to use the Beacon to help spread the word and clear up any questions that may be out there.

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## Selecting a Mishap Review Officer

This note is primarily for wing commanders and wing directors safety who are selecting a review officer for a mishap that might have occurred in their wing. The guidance is spelled out in paragraph 6.2. of [CAPR 160-2](#).

In short, and most important, the review officer should be the most qualified member available. That includes a balance of mishap review experience and experience in the type of mission or activity where the mishap took place. Whenever possible a safety officer should be involved in the mishap review, and the safety officer can recruit help as needed. In all cases, if the review officer is going to do a thorough review using the guidance in the regulation and on the [Mishap Review webpage](#), they **need to have taken the Mishap Review course available in AXIS!** That [Mishap Review page](#) is where review officers can find the links to training, the links to mishap review checklists, and the mishap review template. Note that we want to make sure the training is serving its purpose, so we are monitoring who is using the new products (and who isn't) as we go through mishaps.

Here is one **very important** sentence in the mishap review officer guidance (CAPR 160-2, 6.2.5.2.):  
***“Review officers may be appointed from the unit where the mishap occurred, but commanders should strongly consider appointing a review officer from another unit to offer a fresh look at local procedures, practices and circumstances surrounding the mishap.”*** Please remember that the mishap review doesn't just look at the isolated mishap event ... it takes a total look at the planning, the supervision, the risk assessment, and everything else that might have possibly contributed to the mishap. In other words, we are taking a healthy arms-length look at how the event was run. With that in mind, the person running the event is a great source of information, but shouldn't be the review officer.

## NSOC Update... Save the dates

We're starting to get a better picture on when you can expect the next National Safety Officer College (NSOC). More information will be coming soon, but for now our target is to have the first session in conjunction with the CAP National Conference in Louisville, KY, August 13-15, 2020. For those who can't make it to the Conference, the session will be recorded.

**Blended Learning:** Most of NSOC will be online, with readings, webinars, projects, and discussion groups.

**Schedule:** The schedule is still coming into focus, but you can expect to have some read-ahead material followed by a webinar style "meeting" every week or two with some "homework," and hands-on projects to complete. We anticipate the course **beginning in mid-August** at the National Conference and **ending in early November** before the holidays begin. The course won't be easy, but it will be paced in a way that will allow all participants to complete the work even if they can't "attend" every online meeting.

**Who is it for?** As directed in CAPR 160-1, *ALL* region and wing directors of safety are required to take this new course. Even if you attended one of the earlier in-residence NSOC courses, you will still be expected to complete this NSOC in order to be fully up to speed on the new safety program. The course will also be open to members pursuing the safety specialty track, open to CAP leadership, and open to members from mission areas who want to fully integrate risk management into their areas of expertise.

**More to come:** We continue to develop the content and curriculum and will provide updates as we get closer to course sign-up!

## What led up to it? ... another mishap review tip

We're still seeing some mishap reviews that look solely at the mishap event, and not what led up to it. It is easy to focus on the injury that occurred when the member fell, or the dent when the van hit a fence post, or the flat tire, or the ...

But remember, the real mishap prevention lessons are found when you take the time to figure out what led up to the situation where the mishap occurred.

-- What was it that caused the member to fall? Reviewing the activity, the terrain, the weather, and even what the member had to eat and drink that day will reveal things that can be improved upon.

-- WHY did the van hit the post? Distractions? Lack of familiarity with the van? No spotter? Poor weather? Rushing to get to the destination? Those are all things we can improve upon.

So, whatever the mishap may be, take the time to figure out how the member found themselves in that situation and you just may find a lesson that will help others avoid a similar situation.

For more on how to ask "why" a mishap occurred, check out [The Five M's for Mishap Reviews](#) found on the [mishap review webpage](#), where you'll also find some worksheets to help you as you ask "why" about various types of mishaps.

## Do not push down on the tail!!!!

You've might have seen someone do it, and maybe you've been tempted to do it yourself. Some pilots, in an effort to sharply turn their airplane while they are pushing it into a parking spot or maneuvering it in a hangar, will push down on the tail to lift the nose gear off the ground and pivot the aircraft on its main wheels. **DO NOT DO THIS!**



Pushing down on a horizontal stabilizer can cause internal damage that you won't be able to detect; the empennage is simply not built to withstand that kind of pressure. The pictures you see here show some bending and cracking of a stabilizer spar discovered during an inspection. It's impossible to tell exactly what event caused this, but it is the type of damage that can occur when downward pressure is applied to the horizontal stabilizers. Don't do it.



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## “First Aid Only” Mishaps?

The “First Aid Only” option is still available to close those small and relatively simple bodily injury mishaps without spending the time to do a long review process.

You know the type of mishaps I mean ... those cases where a cadet might fall and scrape a knee, or a senior member may scrape their arm while working in the hangar. Wing and region directors of safety can still go into SIRS, review all the information that has been entered about the mishap, and (if appropriate) update the initial mishap entry by checking the “First Aid Only” button. When that is done, we can close it here at NHQ without region or wing commanders needing to spend time looking at them.

“If appropriate?” It is important to remember that the purpose of entering a mishap in SIRS is to determine what led up to a mishap so we can prevent similar situations. If the only information we have on a mishap is that “member cut himself on thumb” or “member fell and scraped knee” then we don't have any information to help us prevent those types of injury.

Here is what CAPR 160-2 (paragraph 6.7.2) says about the “First Aid Only” selection: *“This may be done **only when the information entered in SIRS is enough to determine why the mishap occurred and adequately lists the factors which contributed to the mishap.**”*

So, we encourage the use of the “First Aid” option to speed mishap resolution, but we still need you to look at and list the factors leading up to the mishap. Thanks!

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