



The Safety Beacon is for informational purposes. Simply reading the Beacon does not satisfy your monthly safety education requirements but unit safety officers are encouraged to use the articles in the Beacon as topics for their monthly safety briefings and discussions.

January 2016

## Happy New Year!!!!

As we begin the New Year, I hope all of you had a safe and happy holiday season, enjoying some time with family and friends while being justifiably proud of the part you all played in CAP's successes through the year.

When we started assembling articles for this edition of the Beacon, we noticed there was a theme. Most of this edition is focused on how to properly report and review mishaps. The sole purpose of the CAP mishap management system is mishap prevention. We report every mishap, every safety deviation, every malfunction that might affect safe flight. We do that so we can learn from them, identify hazards, and find ways of preventing mishaps. If we are going to ask members to report every mishap, we need to help them understand why it is important, we need to make that an easy process, and we need to make sure we get all the information we need so we can put their reporting efforts to good use in preventing mishaps.

We're getting ready to roll out some changes to the safety pages in eServices that will hopefully make the pages easier to use. In the meantime, this issue is focused on some guidance for safety officers, and some how-to information on what to report and how to report it. Enjoy, and please let us know what you think, and what we can do to improve.

### What's in This Issue?

- With the New Year comes another year full of CAP activities, including encampments, NCSAs, flight academies, etc, etc. We've got some pointers on what's required of the activity safety officer before, during and after a large CAP activity.
- Col Castle put together a nice primer on how to file an initial report of a mishap. Safety officers should save this on their tablet or computer, or keep it in their continuity binder. A nice step by step guide. He follows up with a short piece explaining where mishap reporting fits into the mishap prevention efforts.
- We made some changes to how encampment and NCSA mishap reporting is done. Check out the easy to follow guidance.
- There are a few short items for the month. Everything from Superbowl Safety, to flat tires, to locked knees.
- As always, we've got a summary of closed mishaps with some lessons learned, and a few hazard reports and suggestions we've received on-line. This is your program so please keep the suggestions coming.

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# Activity Safety Officers

## *What should they be doing?*

George Vogt, CAP/SE

We all know that the Activity Safety Officer is an important part of any CAP activity. But what should they actually be doing as the activity safety officer? What is expected of them? CAPR 62-1 has a short list of things that the activity safety officer needs to accomplish. We're working to clarify the list and help produce some helpful tools, but with encampment season just around the corner it's good to look at the things a safety officer is expected to do.

In all activities, special attention should be given to making the safety officer a dedicated position with no additional duties so they can keep their eyes open and their minds focused on safety.

Here's a quick list of what's expected of Activity Safety Officers, before, during, and after a large scale activity. I'm speaking primarily of cadet activities like NCSAs, Encampments, and Academies, but these duties extend to all large activities.

### **BEFORE:**

CAPR 62-1 outlines some tasks that **must** be completed before each activity. Included are:

- Ensure risk management analyses are completed on all required activities and sub-activities
  - This includes the use of the hazard analysis and risk mitigation worksheets to document the hazards and the mitigation measure decided on
- Ensure risk management safety briefings are presented for each activity and sub-activity
  - This means briefing the hazards and mitigations you have on your risk management worksheets; assistants, to include cadets, can help present these briefings
  - Briefings should include guidance on HOW to avoid the hazards
- Ensure the senior and cadet staff members have completed the basic and intermediate RM courses before the activity begins
- Ensure all attendees receive a review of the basic RM course on the first day of the event

### **DURING:**

Mishap reporting is a big part of the safety officer's duty, but a lot of attention also needs to be given to continuous hazard analysis and risk management; continuously re-assessing.

- Enter all mishaps in the eServices mishap management system. Check-out the next few pages for some guidance on reporting those minor mishaps.
- Monitor all activities to assess hazards and assess effectiveness of mitigation measures.
- Change mitigation measures and activity safety briefings as required.
- Document new or changing hazards and risk mitigation changes.
- Provide updated safety briefing each day of the activity.

### **AFTER:**

"Closing the loop" is one of the most forgotten aspects of Risk Management. Did we properly analyze the hazards? Were our mitigation measures successful? What would we change in the plan? How do we share this with all other activity directors and safety officers?

Stay tuned for the answer to the last question. We will be putting out some guidance soon, but suffice it to say, the new safety regulation will spell out how safety officers at large activities will be expected to turn in an after action report answering these questions.

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# How to File a Mishap

Col Robert Castle, CAP/SEA

Note: We are making some changes to the mishap reporting system, working to make it easier for everyone to report, review and track mishaps, and we'll be putting out some clear and complete guidance as we move forward. In the meantime we thought it would be good to give you another short how-to primer on the basic reporting of mishaps. Keep this handy!

So, you're the designated Safety Officer for a weekend of ground team training. You've surveyed the area where your activity is going to be held, filled out your Risk Assessment form, figured out mitigations for the hazards and determined your level of acceptable risk (you DID do that, didn't you?). You delivered a top-notch safety briefing to all the participants and the activity goes exactly as planned. Until...a ground team member performing a line search steps into an unseen hole and twists an ankle. Now what?

First, take care of the member! I'm not going to go into detail on what to do here, because we're pretty good at providing necessary aid and that's not the point of this article.

Second, make the appropriate notifications. Each Wing is required by CAPR 62-2 *Mishap Reporting and Review*, to develop a specific notification policy or supplement that identifies who gets notified whenever a mishap occurs. Each wing is a little different, so I won't go into specifics, but generally the command chain should be notified. I realize this is the modern age of text, email and social media, however when a mishap occurs *most* commanders would prefer a phone call rather than reading about it in an email. Since almost everyone has a cell phone these days, making a call shouldn't be that difficult. This is especially important in the case of a mishap involving death, serious injury or a major accident involving an aircraft or vehicle. DO NOT delay reporting the mishap up the command chain. Make sure you're familiar with the notification for your Wing.

Third, gather as much information about the mishap as you can. The "who, what, when, where and how" are important. Since your first two priorities are already taken care of, this step can be done at a more leisurely pace. Why, there's even a worksheet available to help: [Safety Management System \(SMS\) Mishap Report Worksheet](#). If you fill in all the pertinent details into this form, then filling out the online portion when you get to a computer will be a breeze! It's a good idea to have a blank worksheet pre-printed so you can have it handy when a mishap occurs.

CAPR 62-2 says, "Unit/activity commanders are responsible for ensuring an online mishap notification is accomplished within 48 hours of a mishap." I would strongly recommend that those unit/activity commanders decide *in advance* who they're going to designate to enter the online notification for any mishaps that occur during that activity. That way, it's clear who's responsible and it's less likely that another member, possibly even the injured member, will enter a duplicate report (that happens fairly often).

Once you have all the necessary information, it's time to sit down at the computer or with your mobile device and enter all the details.

After logging onto eServices, go to the CAP Safety Management System (SMS). At the SMS page, select "File New Mishap (1)" which will take you to the Initial Mishap Notification screen. The reporting system was designed to be a two-step process, but if you have all the information available, you can enter it all at the same time. That will keep you from having to go back in at a later date (within 48 hours by regulation) to complete the required entries.

The Initial Mishap Notification entries are all self-explanatory and based on the type of mishap (bodily injury, aircraft, or vehicle) will prompt you to enter additional information. The “Brief Description of Mishap” block is a required field (any field with an asterisk is required). This block is where we see some of the biggest problems with mishap reporting. We’ve seen entries such as, “Cadet presented with sore big toe” to short autobiographies that included what the pilot had for breakfast before the mishap occurred. As you might imagine, what we’re looking for is something more between the two extremes. As the instructions for the block state, **do not** “enter member name, unit name, aircraft tail number or vehicle number! Do NOT comment on cause, fault, or liability.” The names, tail number or vehicle ID get entered elsewhere in the reporting process. The block accepts only 2000 characters, so imagine you’re Tweeting and keep it short.

Adding descriptive words like, “Account: On 14 December 2015 at approximately 1430 hours local time...” eat up precious space that could be better used describe what happened. A better example might be, “Senior member stepped into a previously unseen hole during practice line search and twisted right ankle.”

When the description of the mishap has been entered, you have two choices, 1.) “Submit and Continue Data Entry” or 2.) “Send Mishap Notification”.

If you select “Submit and Continue Data Entry” on the lower left of the screen, you’ll be taken to the “Mishap Update” screen where you can add information about the type of activity, add persons to the mishap (victims, witnesses, etc.) or aircraft or vehicle information (if the mishap type selected was “aircraft” or “vehicle”). If photographs were taken, you can upload them on the update mishap screen.

There’s a block at the bottom of the screen for a “Follow-Up Narrative”, limited to 500 characters (again, pretend you’re Tweeting). This is primarily for small bits of additional information you might not have had when you filled out the Initial Mishap Notification. If you really can’t say all that needs to be said about either the initial description of the mishap or the follow-up, you can always put the information in a Word document and upload it as a statement.

When you’ve completed all the required entries and click “Save/Continue” the system will take you to the next screen in order to add person(s) to the mishap. You can use the built-in search function if you don’t know a member’s CAPID. If it’s a non-CAP or USAF member, you’ll be able to add them by Name, date of birth and phone number.

After all the appropriate persons are entered, you’ll be taken to the Attachments tab just in case you forgot to add pictures. The file uploads must be 1mb or less. If you don’t have any attachments to upload, just click “no.”

The last step is going to the “Submit” tab. There will be checkboxes which are automatically filled when all required information is entered. If a checkbox isn’t checked, you’ll need to go back to that tab and supply whatever information is missing. Once all the checkboxes are checked, click “Submit”. You are done, and e-mails will be automatically generated to all appropriate commanders and safety officers all the way up to NHQ.

Commanders are required to direct a review of any mishap classified as an accident or an incident. Most of the mishaps reported are minor in nature and a review isn’t required, however there can be lessons learned from any mishap which will help keep your fellow members from being hurt and the commander should appoint a review officer if there are questions about what happened or they want to uncover those lessons.

If you had selected the “Send Mishap Notification” option back when you filled out the Initial Mishap Notification screen, the automatic e-mail notifications would have been sent out by the system and you would have been taken back to the SMS home screen without adding persons, attachments, aircraft or vehicles. The mishap will be assigned “Awaiting Step 2 Inputs” status. The Step 2 must be entered within 48 hours after the initial notification is sent. Many members overlook this important step under the assumption that they’re done once they complete the mishap notification. The problem is that without the Step 2 inputs, there’s no record of who or what equipment was involved! That’s why it’s much easier to enter all the information at the time the initial notification is made. That way, you’re taking care of Steps 1 and 2 at the same time.

But, let’s say that not all the information was available within the first 48 hours. The initial notification is made as described above and now we need to add the injured person. Simply select the “Update New Mishap (2)” icon from the main SMS screen and you’ll be able to complete the information as described above.

In the past, there has been a problem with reporting aircraft damage that occurred with no intent to fly (for example, a member goes out the airport after a storm passes and discovers the rudder was hit by flying debris). When reporting the damage, the SMS system required the entry of tons of information regarding the latitude/longitude, distance from the center of the airport, mission number, etc. that really don’t pertain in cases like the example. That’s been fixed and the system no longer requires entry of non-pertinent information if the mishap occurred on the ground. Yay!

In a nutshell, that’s how to enter a mishap. We know the system isn’t all that user friendly, but we’re listening to your comments and working to improve *our* safety management system to make it the best we can. Stay tuned for some big changes in the next couple months.

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## “So, Why Do We Need to Report All This Stuff Anyway??”

Some members wonder why they’re required report every little cut, scrape and well, pretty much everything it seems.

The single, ultimate, one-and-only purpose of mishap reporting is mishap prevention. If we don’t report and look into all the mishaps we have, we won’t know what is going wrong. Mishaps help us identify hazards we didn’t know were there. They help us identify problems in our rules and regulations. They show us where our training needs to be improved.

Part of the Risk Management process is assessing how well our risk mitigation measures worked. If we don’t investigate the problems, we can’t make improvements. One of the pillars of the Safety Management System CAP has started to transition to is, “Safety Assurance” which includes collection of data and validates predicted risks and mitigation strategies. In plain English, that means we can’t fix what we don’t know is broken.

For example, a while back CAP Safety noted a growing number of cadets being hurt while doing the shuttle run – slips and falls resulting in sprained ankles, skinned knees and hands. Safety identified the trend (cadets getting hurt) and, working with Cadet Programs, helped develop a plan (risk mitigation) to eliminate the shuttle run and replace it with a modernized fitness test which is less likely to cause injuries.

CAP/SE is also collecting mishap data for aircraft and vehicles. So, while a low voltage light on an aircraft in flight might seem like a maintenance issue, it is a safety concern as well and we can work with Logistics to identify problem areas and help devise solutions.

Please note that we’re working hard to make it easier to report – changes to CAPR 62-2 and a completely revised Safety Information Reporting System (SIRS) are in the works as we go to press.

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# ENCAMPMENT TIME!

## *What do we need to see in those mishap reports?*

George Vogt, CAP/SE

One of the primary duties of the Activity Safety Officer is to look into, and report, all of the minor mishaps and injuries that occur whenever we have a large activity or encampment. Each time there is a mishap, the safety officer should take a look at what contributed to the mishap, whether or not any new hazards were uncovered, and whether or not the risk mitigation plan adequately addresses those hazards. All that, and they need to make sure the mishaps are properly reported in eServices.

Here are some guidelines to be used when reporting mishaps. This guidance is intended for the activity safety officer, and most of it applies to minor bodily injuries, but it is a good guide for ALL safety officers. Feel free to print this out and keep it handy.

- Mishap reports will be accomplished by the Activity Safety Officer or designated assistant
  - Part 1 and Part 2 need to be completed within 48 hours, so most safety officers take copious notes during the day and enter the mishap at the end of the day
- Every bodily injury mishap account needs information on what contributed to the mishap
  - To obtain this, the safety officer should interview the victim, or direct the victim to enter a statement in the mishap management system
  - Statements from witnesses who saw *what led up to the mishap* are also valuable
- Each mishap review (or mishap summary in the case of First Aid Only) MUST include a review of factors that contributed to the mishap
  - What was the activity being performed?
  - Did the environment (terrain, heat, rain, etc) have an effect on the mishap?
  - Was the victim hydrated? Rested? Well nourished?
  - Was the victim under stress? Felt hurried? Peer pressure? Can-do attitude? Afraid to speak up?
  - Is there *anything* else that contributed to the mishap?
- What was the final extent of the injury? For example, was it a sprain, or was it a fracture?
- When the mishap is filed, the wing that is entered for the mishap is the *home wing of the person involved in the mishap*
  - The activity safety officer will file the mishap, but this allows the members home wing to see and coordinate the review and closure of the mishap
  - Examples:
    - If a cadet from Wyoming is injured at a Colorado encampment it is entered as a WY Wg mishap
    - If an Ohio member is injured at a National Flight Academy, it is entered as an OH Wg mishap

As everyone knows, the whole purpose of reporting mishaps is so we can learn how to prevent them. We can't learn how to prevent them unless we know what caused them. Merely saying that a cadet had a bruised leg, and how you cared for the bruise, doesn't tell us anything we can learn from. Give us some information on how it happened, or we'll send it back to the wing to finish it up.

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# SAFETY SHORTS

George Vogt, CAP/SE

## **Superbowl!**

Superbowl Sunday is arguably the biggest unofficial holiday of the year! I remember when I was a bit younger I would campaign to get the next day off so I could sleep in!

Unfortunately, Superbowl madness also brings drinking, and drinking can bring accidents. Please, please, please, plan a safe Superbowl Sunday, and if you plan to drink, make plans to get home safely.

The National Highway Traffic Safety Administration (NHTSA) has some great promotional material that can be downloaded to help highlight the need for responsible fan behavior. Click [HERE](#).

They also have a great app available to help you get home if you've had a little too much. Go to your app store on your mobile device and search for NHTSA SaferRide. It'll help you get a cab or phone a friend and even help you figure out where you are.

Please be safe.

## **Aircraft Flat Tires**

We talked about aircraft tire inflation last month. We realize that tires just wear out sometimes and they go flat through no fault of the pilot. At NHQ we will continue to look at all the causes of tire and tube failure so we can ensure we are doing everything we can to prevent those unnecessary flats. One of the main causes of flat tires and failed inner tubes is low tire pressure. As another reminder, the pilot is required to check the pressure of the aircraft tires during the pre-flight inspection. With that in mind, if you file a mishap saying you had a flat tire, and the flat tire wasn't caused by something like an obvious skid or a nail sticking through the tread, we're going to want to know what your tire pressure was when you checked it during your pre-flight. Did you forget to check the pressure? If so, just tell us that when you file the mishap.

## **Go-Around!**

The go-around is one of the most under-emphasized but most important maneuvers a pilot can learn. Every pilot should be confident in going around from final, short final, in the flare, or ANY time they can't safely land out of an approach or their parameters don't look quite right to them. The go-around should be practiced from just about every conceivable phase of final approach and landing so the pilot is confident enough to execute safe go-around rather than trying to salvage a marginal approach.

Here's a fun video, complete with a catchy tune you can show as you get together in your pilot meetings to discuss proper go-around decisions and techniques. [GO AROUND!](#)

## **What was THE cause of that mishap?**

There is a common fallacy in safety that we should investigate and investigate until you find the “root cause” of a mishap. Another variation of that fallacy is that once you’ve found something that went wrong, you can stop investigating because you’ve found “the cause.”

There is almost *never* just *one* “cause” in a mishap. Just like there is *never* just *one* risk associated with an activity. When we prepare for a flight or an activity, we look at ALL the possible hazards and put measures in place to lessen the risk.

Likewise, when we review a mishap, we need to look at ALL the things that could have contributed to the mishap. In the case of an aircraft mishap, it might have been a pilot error in reading a gauge, poor CRM, failure to update a weather briefing, poor training on crosswind landings, not enough recent flying time, fatigue, confusing air traffic control instructions, and get-home-itis that ALL contributed to a certain mishap. When you’re reviewing a mishap, don’t be satisfied until you know ALL the things that might have contributed to that mishap.

Come to think of it, let’s stop using the term “cause.” From now on, our mishap reviews aren’t looking for the single “cause.” We are looking for all the “contributing factors.”

## **“He locked his knees!”**

Remember waaay back to the short article right above this one? We talked about looking for all the “contributing factors” in a mishap? Well I am seeing a lot of minor mishap reports involving cadets fainting, and the summary says the cadet fainted because they “locked their knees.”

Locking knees while standing at attention does not cause fainting. What??? It *can* be a contributing factor. What else might have contributed to this cadet’s fainting spell? Did he eat well that day? Is she well hydrated? Well rested? Just getting over the flu?

Are there things that we as senior members are doing that contributed to the fainting? Did we make them stand in formation too long in the sun? Do we make them stand at attention or parade rest while they wait to give their times after they “leave it all on the field” during their mile run? Are we making them stand in line for lunch in the sun, in black t-shirts, at a summer encampment?

You get the idea. Let’s look at ALL the contributing factors.

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# November 2015 Mishap Closeouts

Col Robert Castle, CAP/SEA

Bodily Injury – 9, Aircraft – 8, Vehicle - 2

## **Bodily Injury**

Five of the bodily injury mishaps were related to physical fitness training/testing. Of those five, two were a result of a previous condition and one mishap involved feeling dizzy and nauseous after the activity.

One cadet suffered a cut index finger while trying to use a knife to open a Meal Ready to Eat (MRE) pouch not realizing that the package was a pull-to-open type.

I'd like to make a couple of observations about these mishaps; things we see repeated over and over.

Our cadet members are highly motivated individuals with a strong desire to excel in all cadet program activities. They are able to accomplish most challenges presented to them with little guidance. As a result, it's easy to forget the fact that they are still young adults with much to learn about the world.

The cadet using the knife to open the MRE was cutting towards himself. When was the last time your unit conducted a knife safety class covering the importance of proper care and usage of this important tool?

We should remember that a lot of our routine activities (opening an MRE, setting up an L-per) can be perplexing for someone who's never experienced them before. Take the time to make sure our members are shown the right way to perform a task the first time! Don't take anything for granted.

Another topic unit safety officers may want to consider covering is proper rest and nutrition. That includes hydration – the topic receives considerable emphasis especially during summer activities. Yet we continue to see reports of cadets feeling dizzy and nauseous during or after PT only to discover that they've had little or no food or fluids all day prior to arriving for the CAP meeting. We can't demand peak performance from our equipment (or our bodies) without proper care and maintenance! Are cadet leaders actively asking cadets about their diet and nutrition before the event? A pre-activity safety briefing IS required.

## **Aircraft**

- C-182Q flying a practice search sortie. Flaps were at 20° and would not retract following the search. Crew elected to divert and landed safely at a closer runway.

-- Flap switched replaced and aircraft returned to service.

- The aircraft (C-172N) was at 1,200' on a traffic survey mission when the pilot and observer smelled melting wire insulation followed by several yellow sparks and smoke coming from the back of radio panel for approximately 5 seconds.
  - The crew immediately diverted to a nearby airport and a precautionary landing was made without incident. Maintenance discovered a burned capacitor in the #2 NAV/COM radio. The radio was replaced and the aircraft returned to service.
  
- Nose wheel tire (C-182T) failed on landing.
  - Maintenance investigated the failure and the tube showed a failure on the seam on the outside radius of the tire. Replaced tire and tube and returned aircraft service.
  
- During return flight from SAREX, aircraft (C-172P) developed intermittent miss / loss of power.
  - Crew declared emergency with air traffic control and diverted to nearest airport where they landed safely with no injuries or damage. Maintenance personnel were unable to reproduce the problem and suspect that the problem was a bit of carburetor ice. Engine ran strong on ground at full power and good magneto operational check. Good compression reported on all cylinders determined by rotating engine by hand. Aircraft returned to service.
  
- During post-flight inspection, (C-182R) a large crack discovered in plastic cap located on right aircraft elevator.
  - The aircraft and plastic elevator cap was inspected by maintenance and no unusual events occurred that would have caused the crack. The plastic part was old, maybe one of the original parts on the aircraft (manufacture date 1982). The part had numerous cracks that had been "stopped drilled" by maintenance. The likely cause of the crack was due to weather, aerodynamic forces and/or time which caused the plastic part to crack. Part replaced and aircraft returned to service.



- During taxi to parking after landing (C-182Q), right main tire started deflating and went flat.
  - The crew stated they conducted a thorough pre-flight that included making sure the tires were properly inflated. The landing was reported as normal and smooth. As the airplane taxied down the runway the pilot noticed a pulling to one side and made inputs to compensate and was able to pull off the runway and come to a stop. There was no damage to a/c or injury to crew. Maintenance stated that the Schrader valve had sheared causing the flat. The tire and tube were replaced and the a/c was returned to service.

- Upon landing, tower instructions were to hold short of parallel runway. The crew acknowledged the hold short instructions but taxied past the hold line.
  - Patches of snow and ice on taxiways may have reduced visibility, but incursion was primarily due to the pilot's unfamiliarity with the taxiway, the hold short line position, and not ensuring he knew the position of the hold short line before turning onto taxiway.
  
- Low voltage annunciator (C-182T) illuminated after landing.
  - Upon investigation, maintenance found the case bolts on the alternator were loose causing the intermittent problem. The technician said it was not uncommon to find loose case bolts on alternators and inspection of the case bolts were included in the 100 hour inspection. The alternator was replaced and the aircraft returned to service.

**Vehicle**

- CAP member noticed traffic was slowing ahead and began slowing down at which time he was struck in the rear by another vehicle.
  - Incident occurred on a busy highway during dusk/dark in cloudy conditions. No injuries and minor damage to COV.

- While snow plowing (CAP pickup equipped with a plow) driver lost control on ice and the rear end of the truck struck a chain-link fence.

- Member began plowing the aircraft parking ramp at 0230L and was the only member present. Around 0500L, he was attempting to dislodge the truck from a pile of snow when the truck began to slide on the ice and came in contact with the fence. The vehicle was in four wheel drive but it was determined the front hubs were not locked, so four wheel drive was not fully engaged and the truck did not have studded tires. The squadron snow plow plan has been revised to require plowing only during daylight hours and recommends that multiple personnel be present to assist. Damage to the vehicle was limited to minor paint scrapes and two small dents in the left rear quarter panel. There was no damage to the fence.



- Passenger side mirror on van was found damaged during inspection.
  - Van was parked in secured lot. How the mirror was broken could not be determined.

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## **Open Hazard Notices/Safety Improvements**

Here are just a few of the recent Safety Hazard Reports and Safety Suggestions that have been filed in the Safety portion of eServices. If you see a hazard or have a suggestion that will make our operations safer, go to the safety page in eServices and click on "File Hazard Report."

We share these so every member in every unit can be reminded of things they should be checking in their own facilities and at their own activities. The first hazard report is a perfect example.

- During the October 27, 2015 Mission Training at the Grand Prairie Airport hangar, I noted that all the fire extinguishers were well past their annual maintenance and inspection dates and one extinguisher had been discharged and not refilled. I suggest that this item be added to the maintenance schedule for the squadron and visually inspected monthly by one of the safety officers or other qualified personnel.

-- Reported by SM Michael L Bradshaw, SWR-TX-076

- Field operations: I would like to suggest the authorization of wear for Booney covers with the BDU uniform while in the field. The Booney provides much better protection from the sun as well as better protection from facial or eye injury when operating in thick cover.

-- Suggested by Maj William L Reynolds, SER-GA-014

- Squadrons should have a report to show how they plan to eliminate hazards at their meeting locations. As an example of this, there are instances where the owner or other user of the space stores items where they block exits. Those issues remain unchanged since the squadron does not have control of the space 100% of the time. However, things like that always present themselves as a problem and could cause a mishap. Commanders would become aware if a "survey" of the property is regularly conducted, and they could be brought up to and solved by the custodian of the space.

-- Maj Jaime Lichi, SER-FL-249

Thanks to all our members who have made suggestions or highlighted hazards they have seen. Local safety officers and commanders are responsible for following up to make sure these hazards are addressed and suggestions are reviewed. Members should also get feedback on their suggestions.

If you see something that you think needs our immediate attention, don't hesitate to let us know.

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