



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.

October 2015

It's Safety Survey Time!

Fall is in the air, football season is in full swing, and the fiscal year has turned over. Happy New Year! That means it's time for the annual Safety Survey!

As the clock ticked past midnight on October 1st, the FY16 Safety Survey came on line in eServices. As in years past, units have from October 1 through January 31 to complete their surveys and have them approved. But this year, the survey has changed.

In the past it was just another compliance assessment and it wasn't really a useful tool for improving CAP Safety. The questions were all focused on whether or not units were complying with Safety guidance, rules, and regulations. This year, the survey is focused on improving our CAP Safety Program. With the implementation of a new Safety Management System approach to risk management, we want to know how YOU do safety in YOUR unit. How do you and your commanders run your day-to-day safety programs?

We are asking you to share parts of your safety programs. We want to hear about your best practices. How are cadets involved in safety in your unit? Show us the safety education briefing you're most proud of. Tell us how you do risk management before and during your unit events.

Keep in mind there are no wrong answers and no right answers. The IG won't see your answers (they'll only check to see if it's completed on time). Also keep in mind there is no prize for completing it early. We want you to take your time and we expect safety officers and commanders to discuss the answers. Finishing on the first day means you didn't spend enough time on it.

In summary, this is what we think the survey should be; a chance to learn from you about what works and what doesn't, so we can continue to build a Safety Program that best serves your needs. Remember, if you have any questions as at all, we're just a few keystrokes away at safety@capnhq.gov.

What's New This Month?

- There's a short article on the FAA's new "compliance philosophy." You'll probably see a parallel with CAP's new approach to safety.
- I've got a few short topics to cover. If you ever have anything you'd like to see addressed here, or questions you'd like to have answered, let me know at safety@capnhq.gov and we'll make sure everyone gets the answers.
- After receiving some questions, I've got another article on the new guidance for monthly safety education. Hopefully we can clarify things so everyone is on the same sheet of music.
- One of the most important pieces of the mishap review is the interview. I've got a couple examples of why we need to hear from the person involved in the mishap to know what really happened.
- There's a neat new webpage and app available from the Air Combat Command Safety Office to help you assess risk and plan for safe activities. We'll take a look at it.
- Finally, we have a summary of closed out mishaps this month. LOTS of lessons to learn from some of these mishaps. Take the time to read and discuss in your squadrons.

FAA Announces New “Compliance Philosophy”

George Vogt, CAP Chief of Safety

If you're like me, you looked at this headline with some skepticism...we all know the FAA's compliance philosophy. They expect you to comply. 😊 The change relates to the FAA's philosophy when someone *doesn't* comply, or isn't able to comply.

In FAA National Policy Order 8000.373, FAA Administrator Michael Huerta outlines the new philosophy. This is actually an order from the Administrator to FAA employees, but it is available on line and gives a great feel for his new philosophy. Here's a link to the actual document: [FAA Order 8000.373](#)

As you read the document, I'd like to highlight a few phrases that should sound familiar to you. As you know, the new Civil Air Patrol Safety Program is a Safety Management System based largely on the Safety Management System the FAA has adopted and mandated for airlines, airports, maintenance facilities, and its own FAA offices.

Administrator Huerta makes it clear that everyone operating in the national airspace system has an obligation to comply with regulations. However, in this document he clearly moves away from the “punishment” philosophy, embracing the fact that honest mistakes are made and we need to learn from those mistakes to prevent recurrence of mishaps and “human error.” That philosophy is also embraced by your National Commander and the CAP Safety Program.

The FAA Order goes on to say, “...the FAA believes that its compliance philosophy, supported by an established safety culture, is instrumental in ensuring both compliance with regulations and the identification of hazards and management of risk.” That is a direct parallel to what we are doing in CAP Safety.

He emphasizes the need for data collection and sharing. Likewise, we need to hear about each mishap, error and near-miss in sufficient detail to learn from it and address the hazards and risks it exposed. That is the sole purpose of the CAP Mishap Reporting System.

The FAA, and your CAP leadership, both realize that mistakes can be made by well-intentioned people doing the best they can. Sometimes these honest mistakes are the result of diminished skills and if that's the case then training can address the short-comings. If we determine our own cumbersome or hard to understand rules contributed to a mishap, we can make changes to processes. If we find that training was inadequate, we can address our training programs. CAP believes, just as the FAA does, that “...deviations of this nature can most effectively be corrected through root cause analysis and training, education or other appropriate improvements to procedures or training programs...”

Finally the FAA makes clear another point that is shared by CAP leadership. Errors will occur and mishaps will happen, and we will investigate them so we can improve and prevent. However, intentional or reckless deviations, or disrespect for the FAA's (or CAP's) regulations, will also be handled with enforcement actions as appropriate. A “just culture” includes fairness and forgiveness, but there must also be accountability.

In coming months I will highlight other organizations, corporations and institutions that have adopted the same Safety Management System approach to safety that the Civil Air Patrol has embraced. You'll see that CAP's new approach to Safety is at the cutting edge of modern safety programs.

SAFETY SHORTS

George Vogt, CAP/SE

Checklists!

As you read through some of the mishap close-outs this month you'll see several mishaps where proper aircraft checklist usage would have prevented the mishap. In a couple cases, the checklist was used but maybe not correctly. I want to emphasize here, in addition to what you see in the mishap close-outs, a few points about checklist usage. The first point is the obvious one: Use them! That means you don't skim over them or do them from memory; you do them item by item and you think about each step. If you get pulled away from a checklist by another task, go back to the checklist and RE-accomplish a couple items to make sure none are missed. Not sure where you left off? Re-accomplish the whole checklist. Having a hard time doing the checklist while you're taxiing? Stop the airplane. Have another crew member with you? Have them back you up, item by item. Slow down.

Everyday Risk Management Examples

Occasionally I write about "everyday risk management." I focus on those everyday activities where we use the risk management principles of hazard identification, risk assessment and mitigation in everyday activities like crossing the street, packing your car for a road-trip, or planning a backyard barbecue. I'd like to shift gears a little and ask for some inputs from you. What do you do in your non-CAP job? What kind of risk management do you use? I had an interesting conversation with a fire-fighter who discussed the way he makes decisions on the move while fighting a fire. He talked about the education and training that resulted in his awareness of specific hazards. He talked about safety equipment and teamwork mitigating risk. He also talked about how decisions about the "acceptable level" of risk can change when there are lives to save in a burning house; different than fighting a fire in an abandoned building.

I want to hear about what you do in your careers, jobs and recreational activities. How do YOU use risk management principles to keep yourself safe? safety@capnhq.gov

My Philosophy of Safety

When it comes to safety, and CAP's new Safety Program, I think it's important for everyone to understand our new philosophy. On the previous page, you saw how our approach to compliance and a just culture parallel the FAA's thoughts on the same subject. As we go forward I'll offer some other insights into how our safety program will work, using quotes or articles written by some of the world's foremost experts on the psychology of safety. Psychology?? Yes, I firmly believe that one of the most important things we can look at in mishap prevention is why people make the decisions they do when confronted with a combination of hazards, problems, rules, groups, and habit patterns, all viewed through the lens of their unique experiences.

Safety won't just be about enforcing rules. It will be about learning how to keep ourselves safe.

Dr. Robert Long is a Social Psychology and Safety professor in Australia and author of several books on risk management. Here are some of his words to ponder:

"Safety shouldn't be about safety, it should be about living and learning. This is why I prefer to talk much more about risk than I do about safety. The moment you tell someone you are into safety they think you are either the fun police or some legal nerd who loves checklists. If safety is some engineering exercise of shifting [rules] to keep some system clean, then we have lost the plot. If safety is about trying to memorize sections of the [regulations] so we can dominate and rule others, then we have lost the plot. If safety is a power trip so that we can bully others to 'keep them safe for their own good', then we have lost the plot. Safety should be about none of these things. When we put learning first, people first, relationships first, respect first and living first, then we might get to the heart of safety."

Are you on board?
safety@capnhq.gov

Monthly Safety Education

George Vogt, CAP/SE

It has been three months since we implemented the change to the monthly safety education requirement in CAPR 62-1. As everyone knows, there is no longer a safety education “currency” required for a member to participate in CAP activities, but there is still a requirement to get safety education once each calendar month. I’ve heard a lot of feedback on the change. I’m happy that most of it is very positive, but I’d also like to take the time to address some concerns and offer some additional clarification. I had the pleasure of sitting down with Major General Vazquez three days ago and we discussed the monthly safety education program in detail; I wanted to be very sure we were on the same page before I updated all of you. We are both in agreement on all issues discussed here.

First of all, this change does not in any way de-emphasize the importance of Safety awareness in the Civil Air Patrol. It places the onus for compliance directly in the hands of commanders so it can get the emphasis we both feel it deserves. Emphasis on safety, risk management, and our new Safety Management System will continue to increase.

There have been a few unit commanders who expressed concern that their safety education participation rates will be scrutinized and they’ll be “dinged” if their rates are too low. We have even heard of a possible case where a higher echelon commander may have been instructing subordinate unit commanders to put 50-year members and other less active members into Patron status to make those “rates” look better. This arbitrary practice amounts to “cooking the books” and has been shown to be a negative factor in retention. It also doesn’t allow us to get a valid look at how many members are keeping up with the safety education requirement so we can refine and improve the process. Speaking for the Commander, this practice needs to stop now! It is 180 out from what we are trying to do.

Let’s talk about those “rates.” The rates reflected on the Commanders’ dashboard, and in the Safety Education Participation Report, simply reflect who has and who has not completed their safety education for the current month. The unit safety officer or commander can use the report to get in touch with those members who haven’t completed their safety education to remind them of the requirement and inquire about why they might not be participating.

Obviously the tally of how many members in a unit got their safety education last month, and how many did not, will result in a percentage “rate” of participation. We have not issued any criteria on what is a “good” rate and what is a “bad” rate. In my mind, a good rate is any rate the commander can explain.

Let me give an example. Let’s say a squadron has 50 members. Forty of them participate regularly. Of the remaining ten, four are 50-year members who only show up for big annual functions like the conference and the Christmas party. Two are in the military and are deployed overseas. One is in college and is just keeping her dues current so she can return as a senior member when she graduates. One is a high school football coach and just doesn’t have time for CAP during football season. One is in Europe on a business trip, and one took the kids to see grandma in Hawaii; they both assured the commander they will begin participating again when they get home. If the commander of that squadron told me his participation rate was “only” 80% but he explained the situation regarding the other 20%, I’d say his participation “rate” was just fine and his involvement with his members and their safety training was exemplary. He has shown commitment to the program while exhibiting the leadership and discretion we’d hope for.

What if a commander has a member who just refuses to take monthly safety education or attend a monthly safety briefing? Despite the best efforts of the safety officer to make training available, and the peer-pressure encouragement of other members, and a reminder from the commander that this training is a regulatory requirement, the member refuses to participate in monthly safety education. NOW, Patron status may be warranted. But...

Placing someone into Patron status based on failure to complete required training must be done in accordance with CAPR 39-2. CAPR 39-2, Para 3-1.b.(3)(a) lays out the process. If a commander has exhausted all other options, they can inform the member that he will be put in Patron status due to his failure to complete required training. If the member objects to the transfer, he will have 90 days to complete the required training. In this case, it gives the member a chance to restart participation in the mandatory monthly safety education. If he complies with the training requirement, he remains an active member. If he does not comply within 90 days the commander will place him in Patron status. Due process is built into the system.

Monthly Safety Education will remain a requirement. If there is anything we have missed or your concerns have not been answered, let me know and we will continue to address those concerns. safety@capnhq.gov

What's the WHOLE Story?

Why Interviews Are So Important in Mishap Reviews

George Vogt, CAP/SE

Occasionally I'll get an e-mail from a safety officer asking me to delete a mishap that was entered into the Mishap Management System. Usually it is because two members entered accounts of the same mishap. That occurred recently and the mishap really highlighted the need to get the full story and talk to all the people involved.

This mishap involved a cadet who fainted and fell to the ground. A senior member filed the mishap as "First Aid Only" and in summary said the cadet fainted while standing in formation, cut his chin, and was released to his parents after recovering. Pretty routine, right?

Well, thinking he needed to file it himself, the cadet also filed a mishap report a couple days later. Here is what the cadet had to say:

"I was doing physical training at the airport. I had just finished the mile, push ups, and sit ups. I was standing at attention, and locked my knees. I started to feel sick and dizzy, and my eyes closed and I fell to the ground. I woke up 1 minute later and I was on the ground and found out that I fainted and needed to get stitches in my chin."

In this case the senior member gets a C- and the cadet gets an A! First of all, the fact that the cadet needed stitches makes this mishap an "incident" rather than a First Aid Only "minor mishap." Secondly, the cadet's account told us the events that led up to the fainting episode. He had done a full CPFT profile then had to stand at attention in formation. Hopefully the squadron (and the rest of our readers here) learned a lesson that maybe standing at attention right after CPFT is not a great example of risk mitigation.

There's another case that stands out in my mind as a good example of why an interview of the victim or witness is so important. This similar case also involves a cadet who felt dizzy and collapsed after a run. The senior member who filed the mishap report gave a very detailed account of how the 5K (3.1 miles) early-evening slow-paced run was organized for the cadets with plenty of supervision, followed by an account of how the cadet collapsed, the treatment given, and how the cadet recovered.

The review officer, who happens to be a Wing Director of Safety, then took the time to interview the cadet. That's where we find out that the cadet had a good lunch, but didn't get to eat any dinner before the meeting. She drank a "normal amount" of water during the day but didn't have time to drink before the run. She had just finished running a mile before the longer squadron run. And finally, "I have never passed out or collapsed like that before; *I have also never run more than a mile at a time.*"

She hadn't eaten since lunch. She didn't hydrate before the run. She ran 3.1 miles with her squadron after a 1-mile run...4.1 total miles and she had never run more than a mile before. I think I'd pass out too. We can learn a lot of lessons from this one, thanks to the interview, and thanks to that young cadet for honestly telling her story.

There is no huge hurry to get a mishap review closed out. The purpose is to learn from these mishaps and the interview is a primary way of gathering facts. "Tell me what happened." "What did you do earlier in the day?" "What did you have to eat and drink?" "Walk me through the sequence and tell me what you were thinking." These types of questions, asked in a supportive and caring way, will get the information we need.

Sharing and learning are two major components of mishap prevention

“Check 3 GPS”

A New Safety App From Air Combat Command

The active duty component of our Total Force has always known that more Airmen are injured in off-duty activities than on-duty. It’s easy to keep an eye on our Airmen while they’re at work, and there are detailed checklists and risk management processes for just about all the tasks an Airmen might face. But how do we give those same Airmen a tool they can use to prevent injuries when they’re off duty? That’s the question the Air Combat Command Safety Office asked, and they’ve come up with a cool new app for your smart phone and a webpage to explain the program.

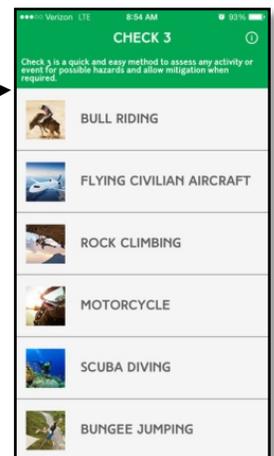


The program is called “Check 3 GPS” and is a sort of shorthand way of performing hazard assessment and risk management before an activity, using the common acronym “GPS.” “G” stands for “Gear;” your equipment, vehicle, water, food, supplies. “P” stands for “Plan;” your timeline, the weather, and back-up plans. “S” stands for “Skills;” time for an honest appraisal of your experience, your skills, your fitness, and how rested you are. Going through those three areas will help you assess hazards you may be facing and help you plan how you can mitigate the risks they present.

Here’s a link to the webpage: ["Check 3 GPS"](#) Take the time to go through the website to see all it has to offer. There are posters, videos, and lots more. It is still new and it’s a work in progress but it’s got great potential to help people plan out high risk activities. Going on a motorcycle trip? Planning a hunting trip? A Rafting adventure? Rock Climbing? This site can guide you through the process.

There is also a free smart-phone app for “Check 3 GPS.”  Go to your app-store and search for “Check 3 GPS” and you’ll find it!

Speaking of high risk activities, wouldn’t it be nice to have something like this in Civil Air Patrol? I’d sure like to make it happen but I need some of our expert members to step forward. Is there anyone out there who has experience developing websites like this? Any experts in building apps like “Check 3 GPS?” Any experience working with SiteViz website developer? Drop me a line at safety@capnhq.gov and I’d be happy to share some ideas and put you to work!



August 2015 Mishap Closeouts

Col Robert Castle, Assistant Chief of Safety

Welcome to the mishaps that closed out in August. Again this month, I've broken the mishaps down into general categories. Keep in mind that some of the mishaps cover a couple of categories. Fainting, trips/slips and PT mishaps frequently result in cuts and bruises although I've not counted them in the "cuts" or "pain" categories. Many of the bodily injury mishaps for this month occurred during encampments, and cadet members continue to be the most frequently injured.

The 2015 air show season is wrapping up, but there are still a few events scheduled for the remainder of the calendar year. If your unit is planning to assist with an aviation event, be sure to have plenty of sunscreen and water available and use a rotation schedule so members have a chance to get away from the flight line/parking areas to rest and get out of the sun.

CAP has had a couple of recent aircraft mishaps reported (see below for one example) where distractions have led to missed checklist items. Fortunately, the damage to equipment was minor and crew members' egos suffered the biggest blow. These events do serve to illustrate the potential consequences of missed steps leading to a major mishap. One technique is to start the checklist section over from the beginning to ensure no steps were missed anytime the crew is interrupted.

I'd like to offer an observation about maintenance and this applies to both aircraft and vehicles – if something doesn't seem right, it probably isn't. Write it up and make sure the person responsible for maintenance gets it looked at and repaired as necessary. Occasionally, we tend to defer items until the next scheduled maintenance, and we get used to things being "not quite right" when the prudent thing is to stop and have it looked at. This doesn't apply to all the things that can break on an airplane or vehicle, but whenever the control systems or powerplant are affected – get it looked at and don't be satisfied until you KNOW what is wrong.

Bodily Injury

Bodily injury types were all over the map this month. There were 12 mishaps related to Physical Training (testing, team sports, obstacle courses and leadership training). Four cases of fainting. Three insect stings. Five members became dehydrated during CAP activities. 19 reports of general pain (ankles, knees, migraines, etc). One puncture (member stepped on a nail). Four members reported nausea. Two members had worsening of their pre-existing conditions. Three reports of blisters. One member with an eye irritation. Five members fell or tripped resulting in scrapes and bruises. One member with a nose bleed. One cadet had trouble sleeping. One case of asthma. Four cuts. One case of general illness. One case of low blood sugar. One case of sunburn (see my comments about working aviation events). One member broke a tooth while eating a sandwich. Whew. And what did we learn to prevent all of these? Not nearly enough because we continue to see mishap accounts and reviews that tell us what happened *after* the mishap and not what led up to it. This will be a continued emphasis item.

Aircraft

- After adding oil to engine (C-182T), pilot did not replace dipstick. It was left on the step in front of left strut and lost during taxi or run-up.
 - Pilot became distracted during pre-flight and did not return the oil dipstick / cap after adding oil. Aircraft took off without the oil cap installed, and oil began to siphon out during flight. Returned for full stop landing. *When you're distracted or interrupted, return to the checklist. Repeat if necessary!*

- After nine landings (C-182T), the left main tire deflated.
 - The crew checked tire pressures on the preflight and added air to the recommended pressures. The mishap report *did not include photos of the deflated tire* and there was *no review conducted* to determine what caused the tire to deflate. *Note: If you're planning on flying a proficiency sortie with a lot of landings, make sure you're tires look good before you press.*
- Main tire (L23) lost air pressure on landing.
 - Inner tube failed on glider main gear wheel, resulting in flat tire. Something to be aware of: Because of the normal low tire pressure in a glider main tire, landing on pavement versus grass increases the wear on the inner tube (due to increased friction on landing) resulting in lower mean time between tube failures when compared with grass landings.
- While performing a short field takeoff from runway 24, the aircraft (C-172R) performed normally to approximately 600 feet AGL, when the engine began to vibrate and run rough with loss of power. Vibration worsened, and the crew executed a return to runway 6, for an emergency landing.
 - Post-flight inspection found that the #4 exhaust valve was stuck in the open position. The push rod and shroud were both bent.
- During the flight (C-182R), the low voltage light came on. The pilot cycled the alternator switch and it reset. The low voltage light illuminated again, so a precautionary landing was made.
 - Maintenance inspected and replaced a faulty voltage regulator.
- During takeoff roll (C-182T), the aircrew experienced a power reduction from the engine and aborted takeoff.
 - After troubleshooting, maintenance discovered the #5 fuel injector blocked, causing the other five cylinders to run very rich, pushing oil off cylinder walls overboard onto the belly. Replaced all spark plugs, cleaned injector, reset timing on mags.
- Aircraft landed with flat tire (C-182T).
 - Right landing gear tire sustained damage during take-off roll from an unknown cause. PIC elected to continue to airport with Crash/Fire/Rescue services. Aircraft landed safely with damaged right tire and sustained no further damage.
- Pilot made precautionary landing after aircraft (U206G) failed to develop normal full power after takeoff.
 - The aircraft was inspected the following day and the malfunction could not be duplicated. The aircraft contains an electronic engine monitoring system. It is believed that on the previous flight the aircraft was incorrectly shutdown causing a surge in the unit. The manufacturer of the system recommended rebooting the unit to clear any incorrect memory. The unit was rebooted and the aircraft has been flown 10 hours since without incident. The pilots of this aircraft have been briefed on proper shutdown procedure of the aircraft. *Note: If you are flying several different aircraft types or models, with different components, you should really study the subtle differences before you fly.*
- While investigating the cause of the chronic problem of additional rudder trim needed during level flight (C-182R), the aircraft mechanic discovered the cause to be a preexisting break in the nose landing gear (NLG) strut mount.
 - The aircraft had been flying for about a month with a gradually worsening "rudder trim" problem that was written up but deferred. When flown by a pilot from a different unit, it was written up again for needing significant left rudder trim to maintain straight and level flight. Upon investigating the cause of the rudder trim problem, the mechanic found that the NLG strut mount was cracked on each side of the mount, causing the rudder trim problem. It is possible an undocumented hard landing contributed to the problem, but another contributing factor could have been metal fatigue in an older aircraft. *Note: If something is wrong with your airplane, make sure you know what it is before accepting it...you're the one in the airplane.*

- While in landing flare a wind gust occurred and the aircraft (T206H) bounced while landing, dragging the rear tie down area resulting in shearing off tie down ring.
 - Surface winds at the time of the incident were 15 kts gusting to 18 kts at 230°, approximately 80° to the landing runway (runway 31), within the manufacturers published maximum crosswind component of 20 kts. On the first landing attempt, the pilot kept the aircraft high and used full flaps in accordance with the local noise abatement procedures. A wind gust occurred during the landing flare, resulting in a bounced landing followed by a go-around. No crew members felt a tail strike at the time of the bounce. After the go-around, the pilot performed a second landing attempt using only 10° flaps resulting in a normal landing. On post flight inspection, the aircrew noticed the missing tail tie down ring. Repair to the aircraft consisted of replacement of the tail tie down ring, fabrication of a doubler, and painting of the damaged section.



- Members washing aircraft (C-172P) noticed a series of dents on the underside of the left horizontal stabilizer. First dent is appx 3" x 1/4", second approx 1" x 1/4", third 1/2" x 1/4". Depth of the largest dent approx 1/16". Crew noticed a yellow residue indicative of FOD damage or organic material.
 - Aircraft evaluated by mechanic and deemed airworthy; only cosmetic damage. No known cause of damage. Aircraft has not demonstrated adverse flight characteristics or abnormal conditions.



- Post flight inspection (C-182T) revealed significant damage to one propeller blade, and minor damage to the other two after a night, solo return from cadet O-rides.
 - Pilot stated he was distracted by a radio call while taxiing, however no radio call noted on tower tapes. Departed the taxiway centerline by a large margin and apparently hit a taxiway edge light with the prop. Pilot reported no sound or feeling of an impact prior to departure. Parking area at home airfield was dark, so damage wasn't discovered until the next morning. Requires propeller replacement.

Note: A lot of people might say "oh this could never happen to me," but it can happen quickly. Night taxiing, while solo, on a poorly lit and poorly striped airport, can be very hazardous. Full attention on the taxi route is required. If you need to stop to accomplish a cockpit task, then stop.

- After landing, the engine (T-182) quit on taxiway. Upon restart, a stack fire occurred. Engine shutdown accomplished and the crew evacuated the aircraft.
 - No visible damage to aircraft other than some soot present on cowling by exhaust stack. The consensus among experienced high altitude pilots is that the fuel mixture was too rich for the altitude (9,100') which caused engine stop when brought to idle. Wing adopting practice of maintaining at 1000 RPM following landing at high elevation airports to prevent engine stoppages, with emphasis on proper high altitude restart procedures. *Note: The observer was reaching for the checklist as the pilot attempted the restart from memory. There is NEVER a hurry to restart an engine while you're sitting on the ground. Checklist!*
- Inner tube on main gear wheel (L23) failed resulting in flat tire
 - Maintenance determined that the wrong part number inner tube was installed which led to the failure.

- While raising the glider (L23) onto a dolly, cadets on the tail over lifted, causing the aircraft to impact the dolly corner, puncturing the fuselage.
 - Cadets briefed on correct aircraft ground handling procedures.
- Upon post flight inspection (C-182R), a flat spot was noticed on the left main tire prior to pushing aircraft back into slip. Spot not noted on preflight inspection. Crew did not recall actions on sortie that might have caused the flat spot.
 - *Small flat spots on tires are caused by the same things that cause big flat spots on tires (see last month's Beacon). Report them all so we can monitor trends.*
- Bird strike on center of windscreen (C-182T) on final approach.
 - No damage to aircraft. Bird died.
- During climb with autopilot on (T206), the aircraft continued to slowly climb past its assigned altitude. The Primary Flight Display (PFD) indicated an "Elevator Error". The pilot disengaged the autopilot at which time the aircraft pitched up. Trim was jammed in aft position requiring pilot to exert a great amount of forward yoke pressure to sustain level flight. The manual trim wheel would not budge forward or backward.
 - Pilot contacted air traffic control for preferred clearance through airspace, and then also notified the control tower of jammed trim to obtain expedited landing clearance. Landed without incident. Maintenance discovered trim wheel internal parts were jammed. Repaired.

Vehicles

- Senior member backed corporate vehicle into privately owned vehicle breaking the headlight of the POV.
 - No spotter was used, even though another member was sitting in the passenger seat of the CAP vehicle when the mishap occurred. *Note: We have not seen a single backing mishap where a spotter was used. Use a spotter!*
- Senior member driving POV struck deer enroute to CAP Activity.
 - Member was driving east at approximately 30 mph when the collision occurred. Clear weather, just before dawn. The vehicle is electric and therefore unusually quiet. This may have been a factor in the deer running into the vehicle. Post collision, the vehicle was drivable, with damage to right front of car.
- Van rear window broken when struck by glider wing rigger equipment.
 - Member was trying to remove a glider wing rigger from the front of a glider trailer while the trailer was attached to a CAP van. Member pulled on rigger, it dislodged, and the force of it dislodging caused it to shatter rear window of the van.
- Van vandalized while parked. Broken driver side mirror and hole punched in gas tank.
- Staff members were traveling in a COV for a unit visit when a rock hit the windshield, causing a crack.
- Cap vehicle suffered a flat tire that resulted in side wall damage that will be unrepairable. Spare tire installed, which also went flat within an hour.
 - The vehicle without a spare was parked for the duration of this training mission. *Note: Lucky no one was hurt. Old tires? Dry rot? Wrong tire pressure? Expect increased emphasis on proper tire care on our CAP vehicles.*
