Safety Beacon BRIEFS

September 2017

Beacon Briefs! It takes a lot of time to put out a full Beacon newsletter each month. I decided to look for a way to keep our commanders, our safety officers and all our CAP members informed about the CAP Safety Program while saving a little of the time and effort for other important tasks and program improvements. I came up with the concept of Beacon Briefs. The still-developing plan is to have a full edition on the Safety Beacon Newsletter every other month with some in-depth articles, pictures, etc. In the months I don't publish a Beacon, you will receive this "Beacon Briefs" e-mail. My hope is that I can still provide you with timely updates on emphasis items in the program. Let me know what you think!

"Close the Loop" A major area of discussion in all my briefings at the recent Command Council and National Conference had to do with "closing the loop." As you recall, the Risk Management process is defined by a "loop" to signify that the process is on-going and cyclic. It needs to be used to assess how well we did in our planning rather than just using risk management as a planning tool. There are two steps you'll be hearing more and more about…

Step 5, Supervise & Evaluate: EVERY plan for *every* event (missions, activities, flight academies, encampments, etc) MUST designate a person or people who are in charge of monitoring how well the plan is working and whether or not the risk controls you decided upon need to be adjusted as conditions change. This person (or people) must be given the responsibility and authority to call "knock it off" when things don't go as planned and adjust the risk controls to control risks and hazards as they appear. This shouldn't necessarily be the duty of a safety officer … this duty should go to someone who is extremely knowledgeable about the mission *and the plan*. Does your activity plan include that?

After Action Assessment: Have you noticed the arrow that goes from Step 5 back over to Step 1? That is meant to remind you that the process isn't over when the activity is done. It is the director's (or commander's or supervisor's) responsibility to review the activity with staff and participants to see what worked, what didn't work, and what could be improved to reduce risks if and when the plan is dusted off and implemented again. The activity is not over until you review what happened and improve the plan.

Hydration We see quite a few minor mishaps that involve cadets (and sometimes senior members) becoming dehydrated as they pursue their missions and CAP activities on hot summer days. Invariably, the commander will write that the cadet was "reminded" to hydrate, and that they covered hydration in

the “safety briefing.” Some even reference an “e-mail” they sent emphasizing hydration. Rarely do any of them ask where the plan went wrong. Remember the loop. Review the plan after the event. You can add a step that includes a briefing the day before or a telephone recall telling the cadets to begin hydrating the night before. Direct them to eat a good breakfast and drink two or three cups of water before they leave home. When they get to the event, ask them individually if they did what they were asked to do. Like so many other things we do, it isn’t enough to just tell someone “what” to do; we need to tell them “how” and we need to assess how well they did. We are teachers.

Whose Mishap is This? If you are a safety officer, and that mishap happened in your unit, that mishap belongs to YOU! As the safety officer of your unit, you should be reviewing and managing every mishap that involves someone or something in your unit. You should keep your commander informed about the mishap and where it is in coordination. Above all, you should personally take pride in making sure the mishap entry in SIRS includes a thorough explanation of HOW the mishap happened, WHY it happened, and WHAT could be done to prevent it. The vast majority of mishaps I see, especially minor bodily injuries, only tell what the injury was and what the treatment was. Your job is to figure out WHY it happened. Ask the person what went wrong. Look at the plan. Look at the conditions. Look at the supervision before and during. Look at the risk management to see if hazards were missed or risks over-looked. Remember the Loop. How good was the plan and how can we make the plan better?

Safety Survey! I am on schedule (for now) to get the annual safety survey live in eServices sometime during the day on October 1st. This will be similar to last year’s survey with each squadron safety officer filling out the survey in cooperation with their commander. Then the wings and regions will review them and report up the chain of command on the health of their safety programs. It is also a chance for open and honest communication about what can be better, what training might be needed, what resources are needed, and where we can all improve. Squadron Safety Officers, this one also belongs to you; your chance to show off, and your chance to ask for help. More to come…

I’m Backing Up! One of the more common vehicle mishaps we see involves a CAP member backing a CAP vehicle into a stationary object. In many of those cases, there were passengers in the vehicle, or other CAP members standing nearby. CAPR 77-1 states, in para 2-2.h., “In areas where a vehicle operator cannot see clearly behind the vehicle, the use of a spotter is required when backing to eliminate the chance of a mishap.” I preach about avoiding mishaps by using Everyday and Real-time risk management. Compliance is also an important part of safety. In this case, the risk management is done for you. CAP has determined that backing up without a spotter is an unacceptable risk, so they have made a rule against it. Saying this solely as my personal opinion, if you back up your van into another vehicle without using available spotters, you have failed in your risk management, and you have disobeyed a CAP regulation, and commanders should seriously consider whether or not you should be allowed to drive a CAP vehicle. Any thoughts on this? Safety@capnhq.gov

Thanks. As always, I want to thank you all for what you do to advance safety and risk management awareness in CAP. As always, drop me a line if you have questions or suggestions.

Cheers,
George

George C. Vogt
CAP Chief of Safety
safety@capnhq.gov