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.

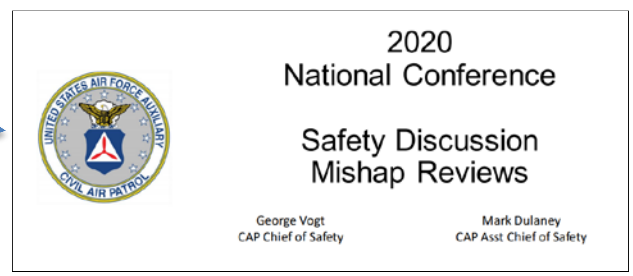
August 2020

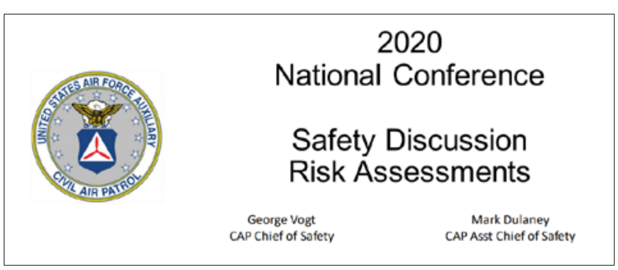
CAP National Conference <u>*Safety Updates*</u>

The only *bad* thing about the recent virtual CAP National Conference was how difficult it was deciding what track to "visit" and which topics to "attend!"
There were tons of great choices!!

If you happened to miss the two Safety Updates; you can find them here.

Click here to see the slides for some simple insights to help you improve the quality of your mishap reviews.





Click here to see the slides for information to help guide your risk assessments.

This Beacon is dedicated to answering some of the questions we received during these National Conference Safety Sessions. Check out the next few pages!

You had questions?

National Conference Update

We didn't get a chance to answer everyone's questions during the two Safety sessions at the National Conference, so we promised we'd answer them here in the Beacon. Here are some of the questions our attendees left in the "chat" forum during each presentation, along with some answers. Keep the questions coming and we'll try to make Q&A a regular feature of the Beacon.

Q - "I just completed a mishap review … I want to give all the relevant info but I was told to give as little as possible, and if 'they need it later they can find it in eServices.' The regs say different. I'm perplexed."

A - Follow the regulation and the training materials on the Mishap Reviews webpage. The key is to put *all* of the *relevant* information in your review, including the sequence of events, all the factors that may have contributed to that mishap, and a summary of the facts that led you to that conclusion. You are writing the review to inform your wing and region commanders about everything that happened so they can make recommendations for corrective actions and try to improve their processes. Do you really want to make them look for things?

Q – "What if a person has privacy concerns and refuses to have their picture taken showing their injury?"

A – The bottom line is to respect their wishes. Sometimes a photo of an injured limb or a scrape or cut can help us understand the injury and help in training efforts. Sometime you can just show the injury and not show the face or other identifying features. But, to be honest, a picture of the injury doesn't do much to help determine the cause. It is better to take pictures of where the injury happened, and any conditions that may have been contributing factors. Remember we're trying to find out what put the member in that situation so we can try to avoid it in the future. That is true regardless of the actual injury.

Q – If multiple people are involved, and we're not supposed to enter personally identifiable info, how do we keep track of who did what in the SIRS notification?

A – The only restriction about not putting identifying information in SIRS is in the section where you first give a brief description of the event when you make your first report in SIRS. Here's is part of what it says:

***Brief Description of Mishap**
Enter a BRIEF factual description of the mishap; one or two sentences should be enough. Do NOT write names, tail numbers, or any other identifying information.

The only reason for that restriction is because that first brief description of the mishap goes to CAP leaders in an auto-email, and we don't want any personal information going out via email. There are other places in SIRS to enter *all* the members' names, CAPIDs, and other information about everyone's role in the mishap.

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Q – eServices photo upload size is limited well below today's smart phone cameras. Might be hard to upload anything panoramic or high resolution.

A- File uploads is SIRS are limited to 5 MB. That is more than adequate to upload any photos that would be required for mishap reviews. If you have a photo file that is more than 5MB, it is easy to downsize it using many online tools. The easiest way that I've found to reduce the size of a photo file (and I am definitely NOT a techy) is to simply email the photo to myself. If you're in using a smart phone camera (I have an iPhone) you can select a photo, opt to share it via email, then send it to yourself. Before it goes, a pop-up window will ask you if you want to send it as Small, Medium, Large, or Actual Size. I usually select "Medium." In any Windows application, you can right click on a picture in your files, select "send to," and do the same thing. I did that with the picture below. The original is 3.11 MB. The one I emailed is only 54 KB. Can you tell the difference?

Q - I would like more info on the purpose and recommended process for the corrective action Validation step, e.g. who can validate, and should documentation of CA completion should be maintained?

A – Good question. As part of the mishap review and risk management loop, we try to determine what went wrong, *and what we can do to prevent it from happening again.* The Corrective Action part of the mishap management page in SIRS is a tool to help wing and region commanders with their mishap prevention efforts. If the review determines that something was a contributing factor to the mishap, the commander should try to address that specific contributing factor with a corrective action. Sometimes that might be additional training to help the member. Sometimes the commander might direct a change in guidance or even a warning sign for a hazard. The commander uses SIRS to assign that action to a specific member and that member "validates" when it is done. There is no specific requirement to keep additional documentation. Wing directors of safety should monitor these corrective actions on behalf of their commander to ensure they are accomplished in a timely manner.

Q - My difficulty with RM has always been how far do we go. I run through an entire plan with situational awareness in mind but after 20 plus encampments I could write a book worth of RM.

A - Good question. The more we hold a certain type if event, the smarter we become with our risk controls. Those proven risk controls become part of the plan for the next event as you continuously update and improve your plan. CAPR 160-1, paragraph 3.3.1.2., has a good explanation of how to use the CAPF 160 from last year's encampment, including the lessons learned that you put in Block 14 on the Form. That form, and those lessons learned, should be referred to and attached to the new CAPF 160 for this event as you look at all the things that might have changed and the new risks that might not have been there last year.

Q - Do we have to fill out a CAPF 160S for every cadet meeting?

A - No. The CAPF 160S is a shorter version of the CAPF 160 and is very useful for those smaller events or activities where you definitely want to perform a risk assessment, but don't need the "big" form. As the regulation says, the CAPF 160S can help guide that process. The emphasis is on the risk assessment *process* more than the actual form. If I were conducting a meeting with a new activity, or at a new venue, I think it is important to use the form and document the process. If the meeting is very similar to other meetings, it is good to use the form as a guide to make you think about different risks or hazards that may be present, or to help you brief everyone on the risks and what to look out for before the meeting. Remember in cadet and composite squadrons, one of our duties is to equip "cadets with risk management skills so they can fulfill their goals while keeping risk as low as reasonably possible" (CAPR 60-1, para 1.9.4.). Emphasis should be placed on cadet involvement in the risk management process at every meeting, so it becomes a habit.

Q - When our respective squadrons open up and we start to have activities how are we to effectively make a risk assessment for Covid-19?

A – Prior to "opening up," each wing follows CAP's rigorous COVID-19 Remobilization Planning process. The link will let you learn more about it. Your wing will develop plans for your "opening" and refer you to the checklists you'll need to follow. I think the biggest task for a local unit is to look at their unique situation, facility, membership, and other factors and use the risk assessment process to determine how you can apply the COVID-19 risk controls and reduce the risk of exposure in *your unique situation*. Like any other event, it's a good technique to review the plan for all the places where risk might present itself and determine what risk controls you will use. Remember, in the case of COVID-19, there will be situations where the risk is just "not worth it" and some events may be canceled, or some members may opt to stay home. That is okay.

Q - The language you're using implies that mishaps are more frequent than they are and that we can prevent all mishaps by using risk management. I would submit that mishaps in CAP are relatively rare and that not all mishaps can be prevented if we only had better risk management. There is risk involved in everything we do in life. We strive to accurately quantify risk so that we can determine if it's worth taking.

A – This is an interesting discussion topic. There is no promise that risk management can "prevent all mishaps." The very basis of risk management begins with the recognition that it is impossible to remove or avoid all risk, so it is imperative that we use the risk management process to *minimize* the risk. Since risk is always present, and always changing, that risk management process must be continuous. We must constantly ask ourselves what can go wrong, and what we can do to reduce the risk of that happening. We do that, without thinking, each time we cross the street and look both ways or climb in our cars and fasten our seat belts … we recognize that risks are there, we assess them, and we implement risk controls. Sometimes when events or activities are larger, with more people involved, that same process is formalized a bit to make sure we do a good job of recognizing as many of the hazards as we can, so we can all get on the same page with how we're going to reduce the risks. Then, when we have assessed the risk and determined how we can reduce it to a level *as low as reasonably possible* (ALARP), we determine if that risk is acceptable. As you say, we decide "if it's worth taking." Once you get started, that process continues.

Any more questions? Let us know!

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