The Civil Air Patrol Safety Program for Group and Wing Level Leaders

Purpose: To understand the safety and risk management responsibilities associated with being at the group or wing level.

Lesson Objectives: This lesson will examine how risk management is intrinsically involved in the informed decision-making process. We will examine how risk management provides us with an opportunity to control unnecessary risk and make good decisions about risks. This lesson will also discuss how leaders have a key role in the process as well as tools used to monitoring and track safety compliance. Note that this lesson relies heavily on excerpts from the regulations.

Desired Learning Outcomes (DLO):

1. Apply foundational concepts related to safety and risk management.
2. Be able to review safety plans/risk management documents and provide input for planners to enhance the activity/lessen risk.
3. Be able to review mishaps and develop action items to improve safety/risk management.
4. Identify the tools used in the tracking and/or monitoring safety compliance.
5. Understand how to respond to mishaps as a leader.

Reading: CAPR 160-1, CAPR 160-2, CAPP 163; CAPF 160 Deliberate Risk Assessment Worksheet

Scheduled Lesson Time: 90 minutes

1. Apply foundational concepts related to safety and risk management.

As we discovered previously, there are four principles which govern all applications of risk management. For risk management to be effective, these principles must be utilized at all times in all activities. The four principles of risk management from CAPR 160-1 3.2 are:

a. Accept no unnecessary risk.
b. Make risk decisions at the appropriate level.
c. Integrate risk management into operations, activities and planning at all levels.
d. Apply the process cyclically and continuously

There are two primary levels of risk management. Deliberate risk management, which is used in situations when the full, formal application for the complete 5-step process is necessary. Deliberate risk management requires use of CAP Form 160. This is normally large activities or complex missions. These are completed well in advance of program execution. Full deliberate risk management occurs when the entire RM process must be completed and documented to

include the signature of the person responsible for the activity or mission. Full deliberate risk management must be utilized for NCSAs, region cadet activities, and wing encampments. Activities conducted for the first time, at a new venue, or with a new group of members require full deliberate risk management. The receipt of new aircraft or vehicles require it. All other activities conducted outside the normal scope of unit activities also require it.

The safety management system has four pillars. The first is Roles and responsibilities. The second is safety risk management. The third is safety assurance. The fourth pillar is safety promotion and recognition. CAP uses these pillars as the structure for its mishap prevention program.

Determining the effectiveness of safety initiatives and the CAP Safety Program is accomplished through the various elements of the SA pillar of the CAP SMS. Elements of the SA pillar will mature as refined tools and best practices emerge. In the near term, it is the intent that leaders at all levels make their best effort to ensure all their safety, RM, and process improvement initiatives fit within the framework of one or more of the elements of the SA pillar of the SMS.

Safety culture is important. A strong RM-based safety culture provides a foundation for the success of the Civil Air Patrol SMS and requires an informed and involved members. Members must be confident in their own role as contributor to, and beneficiary of, the success of the SMS. This informed culture begins with a basic awareness that there are hazards and risks which influence the outcome of planned activities and missions, and these risks need to be addressed in a successful mishap prevention program. There are four important components which need to be emphasized to develop and sustain an informed and involved safety culture:

- First, we must have a reporting culture. CAP members must report mishaps and hazards for the SMS to succeed. The need to report mishaps, deviations, near-misses, lessons learned, observed hazards, and improvement suggestions should be constantly emphasized by group and wing level leaders.

- Second, we must have a just culture. To encourage open reporting by members, members must be confident they will be treated fairly when they report. Leadership should foster an environment of trust where members are encouraged and even rewarded for reporting safety related information. All safety mishap reviews should be conducted solely with the goal of determining “what happened and why” rather than “who is to blame.” This just culture promotes an atmosphere where members can speak freely in cooperation with a mishap review, and will not be punished for blameless errors, but rather be part of the commitment to reduce such errors going forward. Because a just culture requires accountability, everyone in CAP should be confident that members will be held responsible for negligence or failure to abide by laws and regulatory guidance. If there is evidence that a mishap occurred due to negligence or intentional act, commanders will determine the appropriate remedy and handle any disciplinary action outside of the safety review channels. Commanders will reinforce the tenet that a member can be a necessary and appreciated part of improving safety processes while still being held administratively accountable for their actions.

- Next, we must have a learning culture. Leaders at all levels should show a willingness to learn from errors as well as successes, inspiring members to follow their lead. CAP

must cultivate and reward a desire among all members to learn about safety RM processes and actively use those processes to learn about their environment to enhance mishap prevention efforts. The key to a learning culture is exemplified in an inquisitive mind; constantly seeking information on what might go wrong or what did go wrong, and what could prevent it.

- Finally, we must have a flexible culture. A flexible culture is realized when the tenets of safety RM are employed at every level and at all missions and activities throughout Civil Air Patrol and in our members' daily lives. Even in situations where there is no direct command supervision, the diverse and localized aspects of CAP operations and activities demand that individuals and groups fully understand and routinely apply safety RM processes as a matter of habit.

2. Understand the role of group and wing level leaders in the safety management system.

Group level leaders have an important role in the SMS.

- Group commanders will assign an SE to manage the group safety program in those cases where the size of the group staff allows, and the scope of the group's oversight dictates. This should be done in the context of guidance from the wing commander to determine structure and shared responsibilities of the wing and group safety staffs.
- When assigned, the group SE works directly for the group commander as a key member of the commander's staff and the commander's expert on safety RM. In cases where the group staff is small, and there is no assigned group SE, the group commander is personally responsible for ensuring all members of group staff comply with all education and training requirements listed herein, using squadron, wing, or online resources. In cases where the group is responsible for a mission, event or activity, the group SE will help the commander ensure compliance with all applicable elements of this regulation. In cases where a group which does not have an assigned SE is responsible for a mission, event or activity, the group commander will designate the most qualified person available as SE for the activity. As a minimum, that SE must meet the qualifications outlined for the wing assistant SE or be a current or former unit SE. The group SE will remain informed by reading the Beacon Newsletter, e-mails, notices and any other program guidance from CAP/SE or any other higher echelon SE and will disseminate that information to subordinate units within the group.

Wing level leaders have an important role in the SMS.

- Wing commanders will review all open and closed mishaps with their SE at least quarterly, to include the status of open mishaps, mishap trends within their region or wing, and the status of process improvements identified through mishap reviews. When appropriate, the commander will designate emphasis items to be addressed through the Plan, Do, Check, Adjust (PDCA) process and include in their Annual Program Review.
- Activity directors for National Cadet Special Activities, wing encampments, and any other CAP activities lasting more than 48 hours will designate an activity SE. The activity SE will be appointed in the planning process to ensure they play a key role on the activity director's staff, guiding RM processes and complying with all regulatory requirements.
- The wing SE works directly for the wing commander as a key member of the commander's staff and serves as the commander's expert on safety RM and the CAP

SMS. The wing SE is the wing commander's key advisor on all elements of the CAP safety programs and consulted on all safety decisions. The wing SE ensures all elements of the CAP SMS are being complied with throughout the wing. Responsibilities may be spread through a staff of safety assistants to ensure adequate coverage and expertise in all wing and mission areas and support functions. Duties include but are not limited to: The wing SE will monitor and assist the wing's squadrons with their safety programs (in coordination with group SEs where applicable). The wing SE will offer assistance and advice to help subordinate units comply with safety program elements and ensure proper application of RM throughout all CAP activities and missions. The wing SE will monitor subordinate unit safety programs and help address areas for improvement. The wing SE will monitor and regularly update the wing commander on the status of mishaps within the wing. Commanders are highly encouraged to receive updates often enough to ensure they have an up-to-date awareness on mishaps and trends. This includes, but is not limited to, a review of recent mishaps, causal and contributing factors, and any safety enhancements that may be warranted based on mishap reviews. This also includes the status of open mishaps, and the status of process improvements and program enhancements arising from mishaps. The wing SE will work with wing DO, DCP, activity directors and all other mission areas and support functions at the wing level to ensure proper application of RM in accordance with the CAP SMS. The wing SE will ensure completion of and compliance with all other SMS elements and RM requirements outlined in this and other CAP regulations. The wing SE will remain informed by reading the Beacon Newsletter, e- mails, notices and any other program guidance from CAP/SE or any other higher echelon SE and will disseminate that information to subordinate units within the wing.

3. **Be able to report mishaps appropriately, review mishaps appropriately, and develop action items to improve safety/risk management.**

Members at every level are responsible for reporting any mishap when they witness the mishap or see evidence that a mishap has occurred. This includes reporting to leadership as well as reporting in SIRS. Whenever a mishap is observed, the member should ensure that it is called to the attention of the commander or any available member of the leadership staff (i.e., squadron commander, activity director, incident commander, SE, etc.). The commander or the leader of the activity is responsible for ensuring the mishap is reported in SIRS in eServices as soon as possible after the mishap occurs.

All tabs and mandatory fields in the New Mishap section of SIRS must be completed within 48 hours of the mishap or the discovery of evidence that a mishap has occurred. The unit SE, or SE assigned to the activity where the mishap occurred, should verify all necessary information is gathered and entered properly. This includes entering all members involved in the mishap (including witnesses, pilot and all individuals on board a mishap aircraft, driver and all passengers in a mishap vehicle, etc.).

Leaders should be aware that the SIRS entries are a permanent record which must be filled out completely and accurately. They will ensure SIRS entries are reviewed for accuracy.

It is imperative that wing and region leadership is informed of mishaps on a timely basis. To facilitate this process, each region will develop standardized internal reporting procedures for their region and publish the process in a supplement. The supplement covers all the wings in

the region. Have you reviewed your region supplement? If not, check it out! You can find it on the publications page on the national website under supplements.

This section provides guidance for SIRS reporting of mishaps associated with aircraft operations. Any mishap involving a CAP aircraft, or a member-owned aircraft used in a CAP mission or activity, will be reported as an aircraft mishap in SIRS. This includes powered aircraft, gliders, and balloons. Any injuries resulting from an aircraft mishap, including aircrew, passengers, or other individuals not in the aircraft, will be reported as part of the aircraft mishap report. Any aircraft or property damage, or injury, that results from the ground movement of an aircraft will be reported as an aircraft mishap. Any aircraft damage that is discovered during a preflight, or any other time that is not associated with flight, will be reported as an aircraft mishap even when the cause of the damage is unknown. A mishap review will be conducted to determine the source of the damage.

Events which do not result in damage or injury can still reveal hazards. It is important these non-mishap events are reported to assist in identifying trends of certain hazards and risks associated with aircraft operations. These events are not considered mishaps and the reporting of these events does not require the automatic suspension of flying privileges outlined in CAPR 70-1.

To aid in determining aircraft maintenance trends, the following types of mechanical failures and malfunctions of aircraft systems will be reported in SIRS:

- Malfunctions or failures which result in an aborted take-off and/or a flight cancellation after the aircrew has completed the Before Takeoff check.
- Airborne malfunctions or systems failures which result in mission degradation (inability to safely perform the mission as briefed), an aborted or shortened mission, an unplanned divert to a field other than the intended destination, declaration of an in-flight emergency, or priority handling from air traffic control.
- All failures or malfunctions of flight controls, including trim and/or auto-pilot malfunctions.
- In-flight failure of any part of the electrical system of the aircraft that cannot be resolved in flight (e.g., alternator, battery, popped circuit breaker that won't reset, etc.).
- When in doubt, to allow tracking of possible trends, aircrews are encouraged to report any aircraft anomaly that negatively affects the mission or requires a "work-around."
- Any medical issues which occur in flight, which incapacitate an aircrew member or degrade the performance of an aircrew member, will be reported in SIRS. Normal airsickness episodes which do not result in early termination of the mission are not included.
- Any near-midair will be reported in SIRS to allow for tracking and review of the circumstances. Near-midair is defined as anytime in-flight separation between two aircraft, or an aircraft and drone, is less than 500' or the pilot deems it necessary to take evasive action to avoid a collision or hazardous situation.

The term "accident" has specific meaning in aviation and should not be used in conversation as a synonym for mishap or incident. There are specific reporting requirements whenever there is an aircraft accident in CAP, including notification of the National Transportation Safety Board (NTSB) as described below. Whenever a wing commander suspects an aircraft mishap rises to the level of an accident, it must be reported to the CAP National Operations Center (NOC)

immediately, day or night, to allow CAP National Headquarters (NHQ) personnel to guide and assist with the proper notifications and post-accident requirements (SIRS reporting can follow at a reasonable time in coordination with CAP/SE).

Aircraft Accident Definition. An aircraft accident, as defined in 49 CFR 830, is any aircraft (including glider) mishap which results in death or "Serious Injury" to a person **or** "Substantial Damage" to the aircraft. Detailed definitions of those terms are in 49 CFR 830.2. They are summarized here:

- "Serious Injury" generally includes broken bones, internal injuries, serious burns, or injuries requiring hospitalization.
- "Substantial Damage" generally includes damage to the aircraft that affects the structural strength of the aircraft or its flight characteristics. That would include internal damage to ribs and spars of the fuselage or wings, or damage to flight controls serious enough to require extensive repair or replacement.

When should you contact the NOC? Any time an aircraft mishap occurs which may meet the definition of an aircraft accident, it must be reported to the NOC as soon as possible after the event, day or night. A CAP leader (e.g., wing commander, director of operations, wing SE, etc.) will call the NOC toll-free at 888- 211-1812, ext. 300 (24 hours/day). The NOC will, in turn, notify CAP and CAP-USAF leadership and appropriate members of the CAP National Staff. The caller should be prepared to offer as much information as possible about the event, but DO NOT DELAY the call if the desired information is not readily available.

- Include a brief description of what happened, where it happened, and the extent of the damage or injuries if known. Do NOT speculate as to cause of the mishap.
- Include tail number, mission number, AFAM status, and other mission information if available.
- Provide the contact information for the wing commander or other designated point of contact for additional information and communication in the period immediately following the event.

This section provides guidance for reporting mishaps associated with CAP sUAS missions or training. Any damage to sUAS equipment which occurs during operation of the equipment, shall be reported as an sUAS mishap. Exception: Simple propeller breaks that are not associated with a crash or other damage do not need to be reported as a mishap. An injury to any person caused by sUAS equipment, or damage to property that results from sUAS operations (including damage from charging batteries), will also be reported as an sUAS mishap. Exception: If injuries are incurred while using CAP Aerospace Education (AE) STEM kit equipment, report the injury as a Bodily Injury mishap. sUAS "accidents" as defined in 14 CFR 107.9 must be reported to the FAA, in addition to being reported in SIRS, by the sUAS pilot. This includes any operation that results in serious injury or loss of consciousness to any person, or damage to property that exceeds $500 in value or costs more than $500 to repair.

A vehicle mishap will be reported any time there is damage to a CAP vehicle (including trailers, utility task vehicles, and temporary use vehicles), whether the vehicle is in operation or damage is discovered on an unattended vehicle, regardless of the cause. A vehicle mishap will also be reported in the following cases:

1. Any mechanical malfunction or breakage that occurs while a CAP vehicle is in motion, requiring the driver to pull over or otherwise stop driving.
2. Any time a person is injured as part of a vehicle mishap, the injuries will be reported as part of the vehicle mishap.
3. Members, when driving privately-owned vehicles, are highly encouraged to report vehicle mishaps that occur on the way to or from a CAP event or activity.

All injuries and illnesses that occur as a result of, or during, any CAP event, mission or activity will be reported as a bodily injury mishap. This includes illnesses or injuries that are believed to have pre-existed before the event or activity. Exception: Any injury that occurs as part of an aircraft, vehicle, facility or sUAS mishap will be recorded as part of that mishap and not reported separately.

Any damage to a building, hangar, or other real property that is used as a part of CAP activities, events, or other CAP purposes that is not the result of a vehicle or aircraft mishap will be reported as a facility/property mishap. Examples include damage from fire, severe weather, failure of structure or utilities, etc.

In addition to the normal mishap reporting requirements, the following guidance ensures appropriate CAP and CAP-USAF leadership at the wing, region and national levels are informed when necessary. Note: The guidelines herein do not usurp or change the death reporting guidance in CAPR 35-2, *Notification Procedures in Case of Death, Injury or Serious Illness*.

1. The NOC may be reached 24 hours/day at 888-211-1812, extension 300.
2. In addition to the aircraft accident reporting requirements explained above, other serious mishaps should also be reported to the NOC in a timely manner. Wing and/or region leaders should call the NOC whenever they feel National leadership should be informed based on the perceived degree of damage/injury, the possibility of widespread visibility or media attention, or any other extenuating circumstances they feel should be brought to the National Command Team's attention. It is often hard to determine the degree of damage or injury immediately following a mishap. The following are general guidelines, but leaders should not hesitate to call the NOC when they feel it is appropriate. Additional items which should be reported to the NOC include, but are not limited to:
    a. Safety Stand-downs. Report anytime a wing or region commander decides to suspend operations of a type of CAP mission, or suspend the operations of CAP aircraft or vehicles, based on mishaps or any safety concerns.
    b. Report anytime a powered aircraft is required to make an off-airport landing due to mechanical or other issues (weather, fuel planning, etc.).
    c. Report anytime a powered aircraft unintentionally departs the prepared surface of a runway or taxiway. Report anytime a glider unintentionally departs the prepared surface of a runway or taxiway, resulting in damage to the aircraft or airport property.
    d. Report any aircraft engine stoppage that occurs while airborne.
    e. Report anytime a CAP aircraft is the subject of an FAA-reported near mid-air.

f. Report anytime there is a media inquiry regarding a mishap or other safety-related CAP event or occurrence, or if the event might be expected to bring negative media (including social media) attention to CAP.

g. Report anytime there is an inquiry from a General Officer or equivalent civilian of any military or other uniformed service, including the National Guard, Coast Guard and Public Health Service, related to any CAP mishap or safety concern.

h. Report anytime there is a safety-related inquiry from a Federal, state or local government official regarding a specific CAP activity or occurrence. Routine contact from a local FAA Flight Standards District Office is excluded from this requirement.

i. Report any information the wing or region commander wants to bring to the immediate attention of the CAP and CAP-USAF Command teams.

The first step of the RM process is to identify hazards that result in risks. However, not every hazard is identified through a formal risk assessment, and not every process improvement needs to come as the result of a mishap. Hazard reporting and safety suggestions are a proactive way of reducing risk. Every member is encouraged to be alert to their surroundings to identify hazards or situations which pose a risk of mishap if not addressed. Notify. Anytime a member notices a hazard or hazardous situation, they should expeditiously report it to their leadership or SE for action. In some cases, it may require immediate action such as a “knock it off” call or suspension of the activity.

1. In the SIRS portion of eServices, the member should select the link titled “Make a Suggestion / Report a Hazard.” Select the appropriate unit, and the option to report a new hazard, or the option to make a safety suggestion. Enter all applicable information on the hazard or suggestion. The report may be anonymous, but members are encouraged to give their names to receive recognition for reporting the hazard as well as assisting in remedying the situation.

2. The SE of the unit involved in the hazard report or suggestion will ensure timely action is taken to eliminate or control the risk associated with the hazard/suggestion and will enter a journal note in SIRS noting what action was taken. Hazard reports and suggestions should be briefed to members regularly, highlighting the RM steps used to control the risk associated with the hazard. Wing SEs should routinely review (at least annually) the open and closed hazard reports and suggestions with the wing commander to ensure appropriate action has been taken, trends have been noted, and hazard information shared via the Annual Program Review if appropriate.

Once a mishap has been reported, the next step is to determine why that mishap occurred. By analyzing why it occurred, we can take action to improve our risk controls or correct the factors that contributed to the mishap. Those contributing factors may be previously undetected hazards, or inadequately controlled risks, that should be addressed with corrective actions. The sequence, which begins with the mishap and continues through the implementation and monitoring of corrective actions, is the mishap review process. A solid mishap review process is a key step in the continuous improvement emphasized in Safety Assurance, the fourth pillar of the CAP Safety Management System.

1. The following are the three key principles that guide the CAP mishap review process.

    a. We look for the cause; we don't find fault. Safety mishap reviews are conducted solely to determine what went wrong and what can be improved to prevent it from going wrong again. If, during the mishap review, it appears that there may have been some level of culpability or malfeasance on the part of one or more members, that information will be referred to the chain of command and will not be addressed as part of the mishap review process.

    b. Every mishap review is important. The amount of energy expended in discovering the causes of mishaps has nothing to do with the amount of damage they cause. A minor injury may reveal the same hazards as a serious injury; our efforts are focused on finding those hazards no matter how they are revealed. It is accepted that some mishaps are more complex than others and require more time and resources to review; however, the commitment to find answers must be the same regardless of the mishap.

    c. Value the member. In some cases, a mishap may be caused by an error or act of a member. We do not blame the member. Our goal is to analyze the sequence of events leading up to the mishap and determine what improvements can be made to protect a member from finding themselves in that situation, or to better prepare them to respond should the situation occur again.

4. **Identify some tools used in the tracking and/or monitoring safety compliance.**

Targeted surveys can be a valuable tool for leaders to use when assessing the health of their safety programs. As such, commanders are encouraged to use survey tools to solicit members' thoughts on culture, programs, compliance, or any other issues the commander may want to assess. Region and wing commanders are encouraged to use online or e-mail surveys to assess member opinions or inputs on specific issues. Commanders are encouraged to share the survey results as part of the Annual SMS Program Review.

One of the most crucial means of assessing the effectiveness of risk controls is the consistent reporting and review of mishaps, near-misses, deviations and hazards. The analysis of mishap causes and contributing factors is an essential part of determining how CAP programs and processes could be improved. You can learn more about this in CAPR 160-2, *Safety Reporting and Review,* and on the safety pages of gocivilairpatrol.com for additional guidance on the reporting of mishaps and hazards, and the requisite review of each.

Commanders at all levels must remain informed of the mishaps which have occurred and the hazards which have been reported within their command. This should include a review of causes of the mishaps, the factors which may have contributed to the mishap(s), and recommended revisions to plans, programs or processes to address the contributing factors.

Region and wing SEs will regularly (no less than annually) provide their commanders with summaries of the mishaps that occurred in their area of responsibility.

Based on the summary of mishaps, commanders are encouraged to use a PDCA process to determine and document the plan for addressing those risks which can reasonably be reduced. A summary of these risk reduction efforts should be provided to the next higher echelon of

command as part of the Annual SMS Program Review. Sharing the results with staff can also help with planning and risk management.

Once the mishap review has been completed and the review uploaded into SIRS, the wing commander and region commander will have opportunities to review, comment, and assign corrective actions. Wing and region commanders are highly encouraged to use their SE to review all mishap information and make recommendations on whether the report needs further attention or if it sufficiently summarizes the event and the contributing factors. Based on their training and experience, the SE may also make further recommendations as to possible corrective actions.

Based on the review and the recommendations of their staff, the wing commander (region commander for region mishaps) will assign corrective actions to specific members. These corrective actions should be specifically targeted towards contributing factors identified in the review. For further guidance on developing suitable corrective actions, refer to CAPP 163.

After assigning corrective actions and inserting comments (if desired) in SIRS, the wing commander will submit the mishap to the region commander. Subsequently, the wing commander will ensure corrective actions are completed as prescribed and will notify the region SE or CAP/SE of any corrective actions with region or national implications .The region commander will review the mishap package and will either comment and submit the mishap to CAP/SE for closure or return the review to the wing for further action or information.

After the mishap review is submitted to CAP/SE by the region commander, CAP/SE staff will peruse the mishap review and accompanying information to determine if the review adequately identifies and addresses the contributing factors, and the corrective actions directed by the wing commander adequately address the contributing factors. CAP/SE will either make summary comments and close the mishap or will send the review back through command channels with specific requests for additional information.

In all cases wings and regions will make every effort to keep the mishap review process moving so revealed risks may be addressed in a timely manner. All mishap reviews should arrive at NHQ within 60 days of the mishap.

Information used in the review of mishaps is sensitive in nature and must be protected. For example, the SD card which is carried in the upper slot of the multifunction display (MFD) in CAP G1000-equipped aircraft is capable of recording data that can be useful in the mishap review process. Aircrews must verify the SD card is in place and functioning prior to flight, or it will be written up as an aircraft discrepancy in WMIRS. Only a maintenance officer, or person designated by the maintenance officer, may remove the card to perform database updates or to facilitate maintenance, and the card will then be reinstalled. The data from the card will NOT be downloaded without the express permission of CAP/SE in support of safety programs.

All information entered or uploaded into SIRS is for the sole purpose of reviewing CAP mishaps to determine what can be done to prevent future CAP mishaps. Access to SIRS will be restricted to CAP members and staff members with a verified need to access SIRS to perform their assigned safety duties. Other than case-by-case approvals by CAP/SE, access will be based on specific duty titles entered in eServices. Commanders are responsible for ensuring all members with access to SIRS have the requisite qualifications and training outlined in CAPR 160-1. Information in SIRS will only be used for the review and tracking of CAP mishaps.

Exercises:

1. Request a summary or recap of mishaps either in your group/wing or at your activity (wing encampment) for the previous year. Please note you are not requesting a specific report but rather a recap from group or wing SE. Analyze the information using the pillars of the SMS as a framework. Write a background paper (see the publications page on the website for the appropriate template) that summarizes your analysis of safety and risk management at the event as well as makes recommendations for improvement. Consider sharing your report with the next higher-level commander or SE.

2. If you have not done so before, complete a CAPF160 for a group or wing activity in which you might participate. If you have previously completed a CAPF160 for a group or wing activity, review it. Did you miss anything? How has your vision changed since you completed the form?

3. Which of the following would require an entry in SIRS?
    a) You are flying a sortie at a SAREX on a hot day and you RTB without completing your mission when your AP passes out.
    b) A drone comes within 500 feet of the aircraft and the pilot deems it necessary to take evasive action.
    c) A cadet at encampment tells the training officer he or she has a stomachache. The cadet is able to continue training with the discomfort.
    d) A pilot hits his head on the wing of the aircraft during pre-flight. He has a cut on his head.
    e) A cadet has a cramp in his calf after running the mile. He walks it out and is fine a few minutes later.
    f) A rock flies up on the highway and cracks the windshield in the corporate vehicle.
    g) When putting an aircraft away after o-rides, the aircraft is damaged by the hangar door.
    h) When the WA arrived at the wing headquarters for work, he noticed a recent storm must have broken a branch off a tree. The branch broke a window and there is water damage in the building.
    i) Two members at sUAS training crash a drone when they mistakenly hit the “kill” command.
    j) You are assigned a corporate vehicle. You park it in the street in your neighborhood. When you go out to inspect it for the month, it has a flat tire.
    k) You are assigned a corporate vehicle. You park it in the street in your neighborhood. When you go out to inspect it for the month, it has been vandalized and a mirror is missing.
    l) For each of the above items that would require a report in SIRS, what kind would it be: bodily injury, vehicle, property, or aircraft? Be prepared to discuss these in class.
4. Does each situation require deliberate risk management?
    a) Region Honor Academy

b) You received a new C-182 aircraft.
c) Every month highway cleanup with the usual crew.
d) Your unit received a new van.
e) The wing encampment.
f) A gym offers to let you use their facility free of charge for cadets to do PT in the winter.
g) The group CAC had a goal of 100% Curry awards in 8 weeks for new cadets. The reward for meeting their goal is a day at the local water park for the CAC and the new cadets. They met their goal.

5. In your current role at the group or wing level or in a future role at one of those echelons, how do you or will you support each of the pillars of the SMS?
    a. Roles and responsibilities
    b. Safety risk management
    c. Safety assurance
    d. Safety promotion and recognition
    e. Which pillar can you better support? How might you improve your support of that pillar?
    f. Think about the four components of safety culture. Which is the strongest in your current role/area and which is the weakest? Why? What can you do to improve the weakest part of your culture?
6. Should the NOC be called?
    a. 3rd degree burn from a campfire at a bivouac
    b. A propeller breaks on the drone during training
    c. A vehicle is vandalized
    d. The wing commander suspends operations
    e. A drone is lost on a search and rescue mission
    f. Damage to the spars of an aircraft
    g. A sunburn
    h. The adjutant general asks about a mishap or safety concern.
    i. Hail dents the corporate vehicle.
    j. A powered aircraft departs the prepared surface of the taxiway.
    k. A cadet breaks an arm on the obstacle course at encampment.

Lesson Summary and Closure

Leaders at all levels have a responsibility to participate actively in and advocate for the SMS. To continue your development in this vital area that supports all of CAPs missions, it is recommended that you further your knowledge by taking the Advanced Risk Management Course and the Mishap Review Officer Course. These skills will serve you well as a group and wing level leader.