Newport News Composite Squadron

November 2012 Safety Briefing

13 Nov 12

Overview

- Safety Education Reminders
- November Safety Beacon
  - Food Safety
  - Tips for Cold & Flu Season
  - CDC Health Advisory
  - Laser Hazards
  - Fly like a fighter
  - FAA Safety Team
- Extra Stuff

Safety Education Reminders

- Active members are required to complete safety education monthly and have it documented. Documentation required for participation in activities. SAREX safety briefings **don't** count (ORM based).
- Operational Risk Safety Briefings are mandatory. Documentation not required (yet).
- All current members must complete, *Introduction to CAP Safety for New Members,* ASAP (Prior to any other CAP activity).
- Online Safety Education
- Safety Alerts, Safety Suggestions – Online
- Improvement/Hazard Reports - CAP Form 26 has been phased out
- CAP Form 78 – Online Mishap Notification
- FAA Form 8740-5
- Pre-existing Conditions
- Cadet Medications
- Individuals must be aware of their safety education currency.

CAP SMS Page

CAP - Safety Management System(SMS)
eServices | Sign Out | Jeffrey A. Rowell
About SMS
Overview
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LOG SAFETY EDUCATION
FILE HAZARD REPORT
SAFETY SURVEY
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FILE NEW MISHAP (1)
UPDATE NEW MISHAP (2)
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MAINTENANCE MANAGEMENT
REPORTS
SAFETY ALERTS
CHECK SAFETY CURRENCY
MISHAP/FORM 5 HISTORY
AIRCRAFT GROUND HANDLING
CIVIL AIR PATROL
UNITED STATES AIR FORCE AUXILIARY
CITIZENS SERVING COMMUNITIES

Safety Courses

Elective Monthly Education Courses	Passing Score	Status	
Downed Power Lines	80	PASSED	Certificate
Hurricane Preparedness and Awareness	80	PASSED	Certificate
Flooding	80	PASSED	Certificate
Winter Driving Safety	80	PASSED	Certificate
Wind Chill Index	80	NOT TAKEN	Certificate
Spatial Disorientation	80	NOT TAKEN	Certificate
Fundamental of Fire Extinguisher Training	80	NOT TAKEN	Certificate
Geotagging	80	NOT TAKEN	Certificate
National Safety Officer Brief - Winter Board 2011	80	NOT TAKEN	Certificate
Hydration	80	PASSED	Certificate
Lightning Safety	80	NOT TAKEN	Certificate
Bird Strikes	80	NOT TAKEN	Certificate
Axes, Knives, and Saws	80	NOT TAKEN	Certificate
FY11 Analysis and Recommendations	80	NOT TAKEN	Certificate

Safety Beacon

Food Safety Information

- Buy a fresh turkey only 1-2 days before cooking
- Do not buy a prestuffed fresh turkey
- A thawed turkey can remain in refrigerator for 1-2 days
- Cook turkey to a minimum internal temp of 165° F
- Refrigerate leftovers within 2 hours of cooking
- Use leftover turkey & stuffing within 3-4 days or freeze
- Reheat thoroughly to 165° F or until hot & steaming

Safety Beacon

ENT Tips for Cold and Flu Season

- More than 200 different types of viruses can cause a cold
- Bacterial sinusitis is caused by bacteria
- Stay hydrated
- Antihistamines can cause drowsiness
- Decongestants are stimulants

SIGN/ SYMPTOM	SINUSITIS	ALLERGY	COLD
Nasal Discharge	Cloudy or colored	Clear, thin, watery	Thick, whitish or thin
Nasal Congestion	Often	Sometimes	Yes
Facial Pressure/ Pain / Fullness	Often	Sometimes	Sometimes
Duration of Illness	10 days or longer	Varies	Under 10 days
Double-worsening*	Sometimes	No	No
Fever	Sometimes	No	Sometimes
Pain in Upper Teeth	Sometimes	No	No
Bad Breath	Sometimes	No	No
Coughing	Sometimes	Sometimes	Yes
Sneezing	No	Sometimes	Yes

**Initial improvement followed by worsening within the first 10 days*

Safety Beacon

CDC Health Advisory

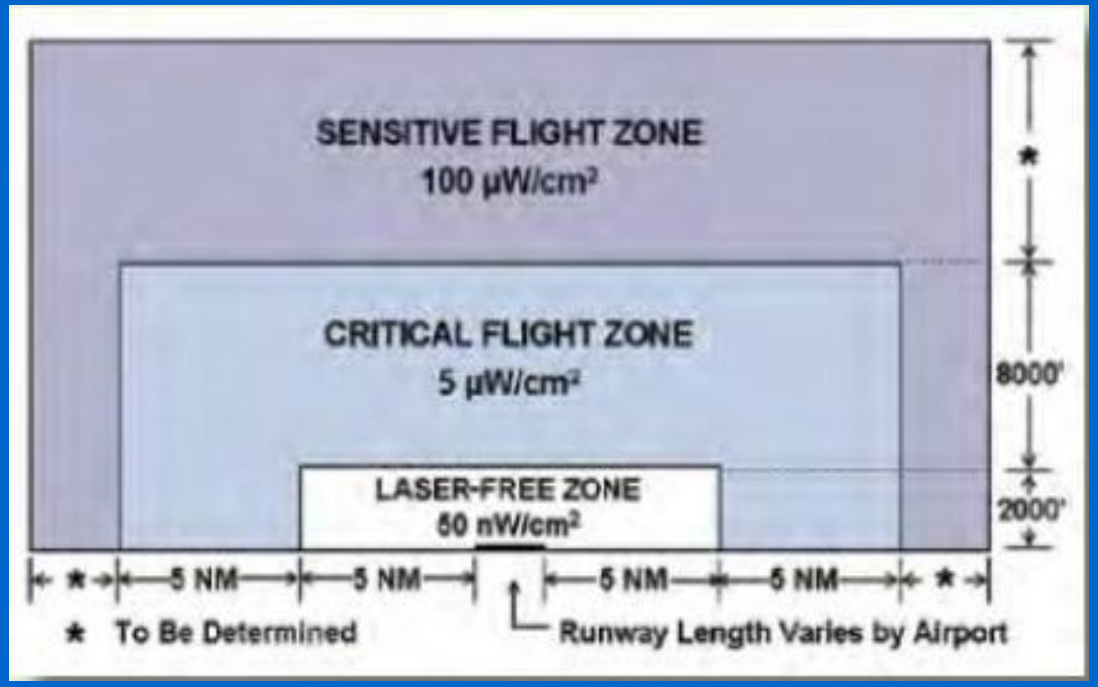
Multistate Outbreak of Fungal Meningitis and Joint Infections associated with contaminated steroid medications

http://www.cdc.gov/hai/outbreaks/clinicians/index.html

Safety Beacon

Laser Hazards in Navigable Airspace

- Increase in number of incidents
- AC 70-2 "Reporting of Laser Illumination of Aircraft
- Also includes mitigation procedures
- Report incident to ATC and then complete questionnaire



Safety Beacon

Fly like a fighter

- Discusses a practice rejoin with students in a T-38
- Relates story to general aviation
- “Instant” moves in our memory
- Stall recovery
- Go-around
- Touch-and-go

Safety Beacon

FAAST Blast

- Notice of Proposed Rulemaking for Cessna retractable gear aircraft
- Airworthiness Directive for Piper aircraft
- General Aviation Survey
- WAAS Localizer-Performance-with-Vertical-Guidance (LPV) approaches

Extra Stuff

- Cadet Safety Officer
  - May be a Phase II NCO at the squadron level
  - Assist squadron Safety Officer
- FCC jammer tip line – 1-855-55-NOJAM (or 1-855-556-6526)
- Report the use or sale of illegal GPS, cell phone or other signal jammers.
- It is against the law for consumers to use, import, advertise, sell or ship a GPS or cell jammer or any other type of device that blocks, jams or interferes with authorized communications, whether on private or public property.

Extra Stuff

Mishap Discussion - CAPR 62-2

d. "Mishap" is defined as any unplanned or undesired, operational occurrence, or series of occurrences, that results in, or has the potential to result in, death, injury, or damage to equipment or property.

4. Reporting CAP Mishaps. It is extremely important to report all mishaps. There are lessons to be learned from each mishap which help identify trends and some mishaps, that may first appear to be minor, are found to be more severe upon further discovery. For this reason, all mishaps must be reported using the online safety reporting system. (See Attachment 4, Mishap Process Flow Chart.)

d. Online Mishap Notification (Form 78). Unit/activity commanders are responsible for ensuring an online mishap notification (Form 78) is accomplished within 48 hours of a mishap. The online mishap management database documents all mishaps and is an important legal document that must be completed correctly. Failure to complete an online mishap notification (Form 78) could result in the member being held personally responsible for damages or medical expenses incurred, and loss of government or corporate provided insurance benefits.

Extra Stuff

Mishap Discussion - CAPR 62-2

(1) Accident: is a mishap that results in death (within 30 days), serious bodily injury, or major damage to, or loss of, equipment or property.

(2) Incident: is a mishap, other than an accident or minor mishap, which results in bodily injury or damage to equipment or property.

Note: The following events do not (generally) require a mishap review and will not be counted toward mishap rates, but must be reported and tracked for trend identification, awareness and analysis.

(3) Minor Mishap: is a mishap that interrupts normal procedures or activities but does not result in significant injury or damage. (See attachments 1, 2, and 3.)

Extra Stuff

Mishap Discussion - CAPR 62-2

3. **Bodily Injury Minor Mishap** is a bodily injury which does not meet the minimum criteria to be classified as an accident or incident. These injuries may include:

a. fainting where there is no lasting trauma, i.e., fainting during drill exercises, etc;

b. simple sprains, muscle pulls, muscle spasms;

c. intentional, inflicted injuries, i.e., hitting the wall with the fist, fighting, etc;

d. minor sports or activity injuries such as black eyes, bruises, sore muscles, bloody nose, skinned knees, scrapes, minor cut lips, fishhook in finger, etc;

e. crushing injuries to fingers or toes where no bone is broken, e.g., mashing finger in car door, etc;

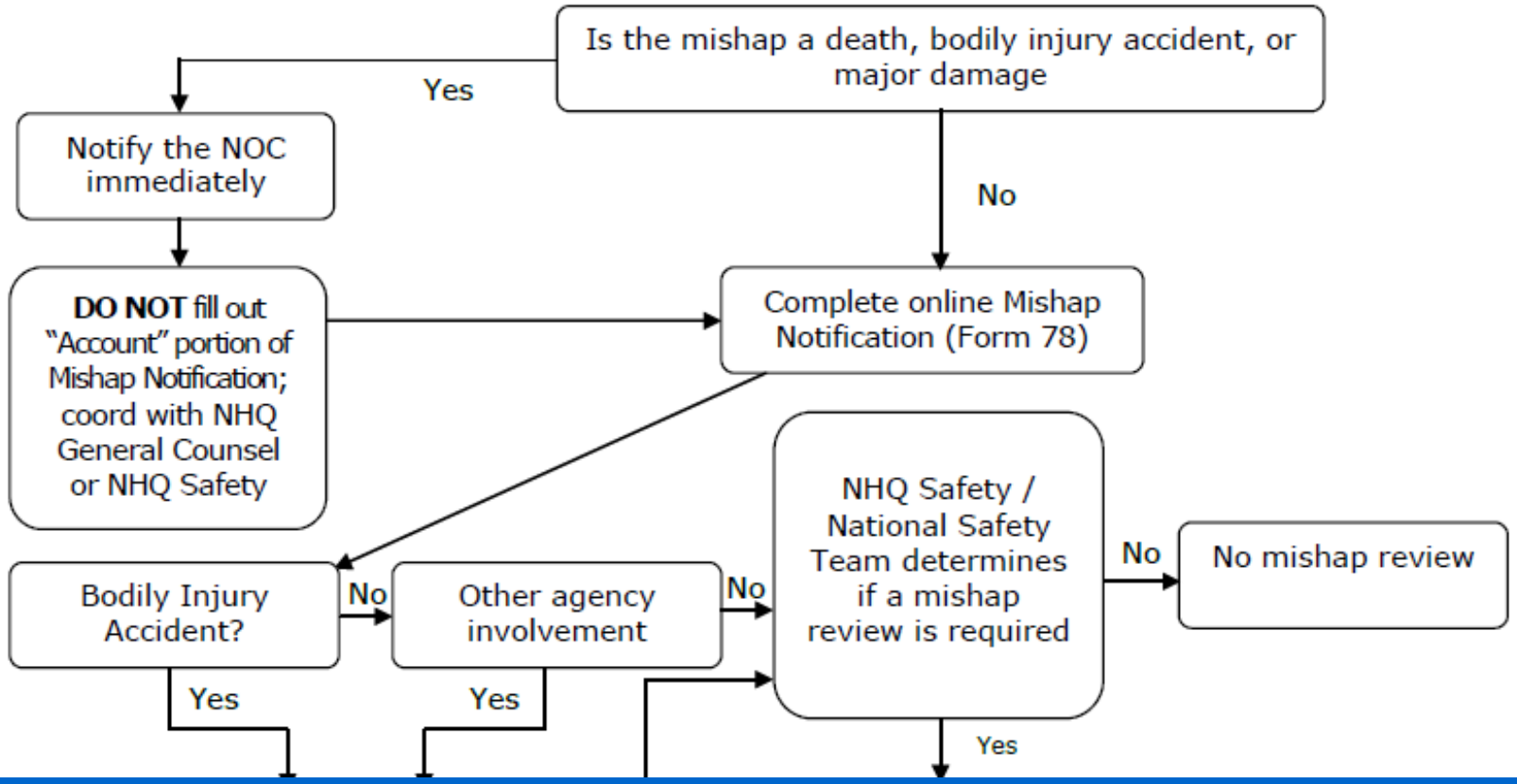
f. other minor injuries of similar nature to those listed above.

7. **Bodily Injury Safety Deviation** is any mishap that is perceived as an unsought safety act, most commonly defined as any act that is non-compliant with CAP rules, regulations, or other defined policies, as well as local, state, or national laws or regulations, that could result in injury or damage to CAP members. These "at-risk" behaviors that occur in motion that involved CAP members, not to be confused with static risks, defined as hazards, which are identified in CAP's online hazard reporting system, formerly known as a Form 26.

Extra Stuff

Mishap Reporting Flow

Attachment 4 – Mishap Process Flow Chart



Until Next Month

- Discover, report, stop, share, listen, and learn. The things we have read about in this issue already have happened, so you are not allowed to experience these for yourself. Remember to "Knock It Off" and slow down. For streaming dialogues on some subjects, remember CAP Safety is on Facebook and Twitter. Have a good month.

SAFETY BY EXAMPLE

Safety Beacon

Official Safety Newsletter Of The Civil Air Patrol

November 2012

BEACON NEWSLETTER TEAM

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LT COL VAN DON WILLIAMS
MAJOR JAMES RIDLEY, SR.
MAJOR MANUEL CEJA

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United States Department of Agriculture
Food Safety and Inspection Service

Food Safety Information

Countdown to the Thanksgiving Holiday

As Thanksgiving approaches, cooking the traditional turkey dinner gives rise to anxieties and questions. What kind of turkey should I buy? Should I buy a frozen turkey or a fresh one? How do I store my turkey? A few simple steps will not only ease your holiday fears, but will ensure a delicious and a safe meal for you, your family, and your friends. The following information may help you prepare your special Thanksgiving meal and help you countdown to the holiday.

Plan Ahead

Plan your menu several weeks before the holiday. Shopping early will ease the countdown tension for your Thanksgiving meal. Ask these questions to help plan your meal. Do you want a fresh or frozen turkey? Do you have enough space to store a frozen bird if purchased in advance; if not, when should you purchase a turkey? What size bird do you need to buy?

Fresh or Frozen

If you choose to buy a frozen bird you may do so at any time, but make sure you have adequate storage space in your freezer. If you buy a fresh turkey, be sure you purchase it only 1-2 days before cooking. **Do not buy a prestuffed fresh turkey.**

Use the following chart as a helpful guide:

WHAT SIZE TURKEY TO PURCHASE

Type of Turkey	Pounds to Buy
Whole bird	1 pound per person
Boneless breast of turkey	1/2 pound per person
Breast of turkey	3/4 pound per person
Prestuffed frozen turkey	1 1/4 pounds per person -- keep frozen until ready to cook

Thawing

In the refrigerator
Place frozen bird in original wrapper in the refrigerator (40 °F or below). Allow approximately 24 hours per 4 to 5 pounds of turkey. A thawed turkey can remain in the refrigerator for 1-2 days.

THAWING TIME IN THE REFRIGERATOR

Size of Turkey	Number of Days
4 to 12 pounds	1 to 3 days
12 to 16 pounds	3 to 4 days
16 to 20 pounds	4 to 5 days
20 to 24 pounds	5 to 6 days

In cold water
If you forget to thaw the turkey or don't have room in the refrigerator for thawing, don't panic. You can submerge the turkey in cold water and change the water every 30 minutes. Allow about 30 minutes defrosting time per pound of turkey. The following times are suggested for thawing turkey in water. Cook immediately after thawing.

THAWING TIME IN COLD WATER

Size of Turkey	Hours to Defrost
4 to 12 pounds	2 to 6 hours
12 to 16 pounds	6 to 8 hours
16 to 20 pounds	8 to 10 hours
20 to 24 pounds	10 to 12 hours

The Food Safety and Inspection Service (FSIS) is the public health agency in the U.S. Department of Agriculture responsible for ensuring that the nation's commercial supply of meat, poultry, and egg products is safe, wholesome, and correctly labeled and packaged.

USDA Meat & Poultry Hotline
1-888-MPHotline
(1-888-674-6854)

Countdown to the Thanksgiving Holiday

In the microwave
Microwave thawing is safe if the turkey is not too large. Check the manufacturer's instructions for the size turkey that will fit into your oven, the minutes per pound, and the power level to use for thawing. Cook immediately after thawing.

Preparation

The day before Thanksgiving
Make sure you have all the ingredients you need to prepare your holiday meal. Check to make sure you have all the equipment you will need, including a roasting pan large enough to hold your turkey and a food thermometer. Wet and dry stuffing ingredients can be prepared ahead of time and refrigerated separately. This may also be done on Thanksgiving Day. Mix ingredients just before placing the stuffing inside the turkey cavity or into a casserole dish.

Thanksgiving Day
If you choose to stuff your turkey, stuff loosely. The stuffing should be moist, not dry, since heat destroys bacteria more rapidly in a moist environment. Place stuffed turkey in oven immediately. You may also cook the stuffing outside the bird in a casserole. Judging cooking time for your turkey will be easier if the following chart is used. The times listed are for a fresh or thawed turkey in an oven at 325 °F. These times are approximate.

Use a food thermometer to check the internal temperature of the turkey.
A whole turkey is safe cooked to a minimum internal temperature of 165 °F throughout the bird. Check the internal temperature in the innermost part of the thigh and wing and the thickest part of the breast. All turkey meat, including any that remains pink, is safe to eat as soon as all parts reach at least 165 °F. The stuffing should reach 165 °F, whether cooked inside the bird or in a separate dish.

When turkey is removed from the oven, let it stand 20 minutes. Remove stuffing and carve turkey.

Timetables for Turkey Roasting
(325 °F oven temperature)

COOKING TIME - UNSTUFFED TURKEY	
Size of Turkey	**Hours to Prepare**
8 to12 pounds	2 3/4 to 3 hours
12 to 14 pounds	3 to 3 3/4 hours
14 to 18 pounds	3 3/4 to 4 1/4 hours
18 to 20 pounds	4 1/4 to 4 1/2 hours
20 to 24 pounds	4 1/2 to 5 hours
COOKING TIME - STUFFED TURKEY	
8 to 12 pounds	3 to 3 1/2 hours
12 to 14 pounds	3 1/2 to 4 hours
14 to 18 pounds	4 to 4 1/4 hours
18 to 20 pounds	4 1/4 to 4 3/4 hours
20 to 24 pounds	4 3/4 to 5 1/4 hours

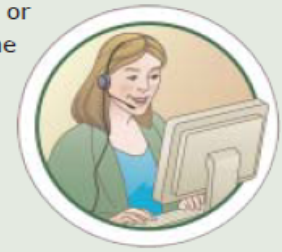
Storing Leftovers

Cut the turkey into small pieces; refrigerate stuffing and turkey separately in shallow containers within 2 hours of cooking. Use leftover turkey and stuffing within 3-4 days or freeze these foods. Reheat thoroughly to a temperature of 165 °F or until hot and steaming.

Food Safety Questions?

Call the USDA Meat & Poultry Hotline

If you have a question about meat, poultry, or egg products, call the USDA Meat and Poultry Hotline toll free at **1-888-MPHotline (1-888-674-6854)** The hotline is open year-round



Monday through Friday from 10 a.m. to 4 p.m. ET (English or Spanish). Recorded food safety messages are available 24 hours a day. Check out the FSIS Web site at **www.fsis.usda.gov**.

Send E-mail questions to **MPHotline.fsis@usda.gov**.

Ask Karen!

FSIS' automated response system can provide food safety information 24/7 and a live chat during Hotline hours.

AskKaren.gov
PreguntaleKaren.gov

FSIS encourages the reprint and distribution of this publication for food safety education purposes. However, USDA symbols or logos may not be used separately to imply endorsement of a commercial product or service.

The USDA is an equal opportunity provider and employer.
Reviewed; no changes November 2010

ENT Tips for Cold and Flu Season

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Maybe it's not a cold

Knowing the difference between sinusitis and cold symptoms

The common cold

More than 200 different types of viruses can cause a cold. The three most frequent symptoms of a cold are nasal stuffiness, sneezing, and runny nose. Throat irritation is also often involved. Adults and older children with colds generally have minimal or no fever. Infants and toddlers often run a fever in the 100 to 102 degree range.

Depending on which virus is the culprit, the virus might also produce a headache, cough, postnasal drip, burning eyes, muscle aches, or a decreased appetite, but in a cold, the most prominent symptoms are in the nose.

Once you have "caught" a cold, the symptoms begin in one to five days. Usually irritation in the nose or a scratchy feeling in the throat is the first sign, followed within hours by sneezing and a watery nasal discharge.

The entire cold is usually over all by itself in about seven days, with perhaps a few lingering symptoms (cough) for another week. If it lasts longer, consider another problem, such as a sinus infection or allergies.

SIGN/ SYMPTOM	SINUSITIS	ALLERGY	COLD
Nasal Discharge	Cloudy or colored	Clear, thin, watery	Thick, whitish or thin
Nasal Congestion	Often	Sometimes	Yes
Facial Pressure/ Pain / Fullness	Often	Sometimes	Sometimes
Duration of Illness	10 days or longer	Varies	Under 10 days
Double-worsening*	Sometimes	No	No
Fever	Sometimes	No	Sometimes
Pain in Upper Teeth	Sometimes	No	No
Bad Breath	Sometimes	No	No
Coughing	Sometimes	Sometimes	Yes
Sneezing	No	Sometimes	Yes

**Initial improvement followed by worsening within the first 10 days*

Sinusitis

Acute bacterial sinusitis is an infection of the sinus cavities caused by bacteria. It usually is preceded by a cold, allergy attack, or irritation by environmental pollutants. Unlike a cold or allergy, bacterial sinusitis requires a physician's diagnosis and may require treatment with an antibiotic to cure the infection and prevent future complications.

Normally, mucus collecting in the sinuses drains into the nasal passages. When you have a cold or allergy attack, your sinuses become inflamed and are unable to drain. This can lead to congestion and infection. Diagnosis of acute sinusitis usually is based on a physical examination and a discussion of your symptoms.

When you have frequent sinusitis, or the infection lasts three months or more, it could be chronic sinusitis. Symptoms of chronic sinusitis may be less severe than those of acute, however, untreated chronic sinusitis can cause damage to the sinuses and cheekbones that sometimes requires surgery to repair.

Ask your otolaryngologist if you believe you have a sinus infection (see sidebar at right). For more information on ear, nose, and throat winter health, visit www.entnet.org.

Allergies

Allergy symptoms appear when the immune system reacts to an allergic substance that has entered the body as though it was an unwelcome invader. Many common substances can be allergens—pollens, food, mold, dust, feathers, animal dander, and chemicals

When an allergen reenters the body, the immune system rapidly recognizes it, causing a series of reactions. It also causes the production of many inflammatory substances including histamine. Histamine produces common allergy symptoms such as itchy, watery eyes, nasal and sinus congestion, headaches, sneezing, scratchy throat, hives, or shortness of breath. Other less common symptoms are balance disturbances, skin irritations such as eczema, and even respiratory problems like asthma. For some allergy sufferers, symptoms may be seasonal, but for others it is a year-round discomfort.

Is it a sinus infection?

1. Facial pressure/pain/fullness?
   ❑ yes ❑ no
2. Nasal congestion or stuffiness?
   ❑ yes ❑ no
3. Cloudy or colored nasal discharge?
   ❑ yes ❑ no
4. Postnasal drip?
   ❑ yes ❑ no
5. Illness lasting 10 days or longer?
   ❑ yes ❑ no
6. Improvement followed by worsening?
   ❑ yes ❑ no

If you answered "Yes" to three or more of the symptoms listed above, you may have an acute bacterial sinus infection. An examination by an ear, nose, and throat specialist may be warranted.

- symptoms of upper respiratory infection lasting 10 days or more
- improvement followed by worsening within 10 days
- facial pain, pressure, or fullness
- nasal discharge that is cloudy or colored
- nasal congestion or stuffiness
- post-nasal drip
- cough

At-home treatments for sinusitis:

- nasal sprays that moisturize the nasal cavity, reduce dryness, and help clear thick or crusty mucus
- humidification (moisturizing the air) of living spaces in dry climates will aid the movement of mucus through the sinuses

An otolaryngologist can:

- determine if you have an infection requiring an appropriate antibiotic
- discover if you require intensive medical treatment for a condition such as nasal obstructions, necessitating sinus surgery
- Make treatment recommendations and discuss long-term outcomes

Over-the-counter medications and sinus pain: Know the facts!*

Drugs for stuffy nose, sinus trouble, congestion and drainage, and the common cold constitute a large segment of the over-the-counter market for America's pharmaceutical industry. Even though they do not cure allergies, sinusitis, colds, or the flu, they provide welcome relief for at least some of the discomforts of seasonal allergies and upper respiratory infections. However, it's essential for consumers to read the ingredient labels, evaluate their symptoms, and choose the most appropriate remedy.

Antihistamines - help dry up a runny nose and relieve sneezing. Avoid them during the congested phase of your cold because they can make mucus thicker and more difficult to drain. They are most helpful when symptoms are caused by an allergy. Some older brands may cause you to be sleepy.

Decongestants - can help relieve sinus pressure and a stuffy nose, making it easier for you to breathe. These will also dehydrate you! Take lots of fluids. Avoid at bedtime, since they are stimulants.

Pain Relievers - help relieve the pain associated with a sore throat, and headache, and can reduce a fever. These include acetaminophen (Tylenol), aspirin, ibuprofen (Advil, Motrin) and Naproxen (Aleve).

Always make sure to consult with your doctor about your prescription medications before you start taking an O-T-C product, as some can cause drug interactions.

*note – Information is for adults only.

Maintaining sinus health

Maintaining sinus health during the cold and flu season can help prevent a case of sinusitis. The American Academy of Otolaryngology—Head and Neck Surgery suggests the following ways to keep your sinuses clear:

- Drink plenty of fluids to keep nasal discharge thin and keep your body hydrated.
- You may get some relief from your symptoms with a humidifier, particularly if air in your home is heated by a forced-air system.
- If you are going to fly during the holiday seasons, use a nasal spray decongestant before take-off to prevent blockage of the sinuses, allowing mucus to drain.
- Avoid smoking and drinking alcohol, as both can irritate your nasal passages.
- If you have allergies, try to avoid contact with things that trigger attacks. If you cannot, use over-the-counter or prescription antihistamines and/or a prescription nasal spray to control allergy attacks.

Centers for Disease Control and Prevention
Your Online Source for Credible Health Information

Update: Multistate Outbreak of Fungal Meningitis and Joint Infections Associated with Contaminated Steroid Medications

Centers for Disease Control and Prevention (CDC) sent this bulletin at 10/17/2012 02:14 PM EDT

This is an official

CDC Health Advisory

Distributed via Health Alert Network
October 17, 2012, 13:15 (1:15 PM ET)
CDCHAN-00329-2012-10-17-UPD-N

Update: Multistate Outbreak of Fungal Meningitis and Joint Infections Associated with Contaminated Steroid Medications

Summary

The Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) continue to work closely with state public health departments on a multistate investigation of fungal meningitis and joint infections among patients who received a methylprednisolone acetate injection prepared by the New England Compounding Center (NECC) in Framingham, Mass. Some of these patients who received epidural injections also suffered strokes that may have resulted from their infection. This HAN notice provides updated information on the following:

- Status of the investigation.
- FDA issuance of a MedWatch Safety Alert on October 15 advising clinicians to follow-up with patients who received an injectable NECC product, including any ophthalmic drug that is injectable or used in conjunction with eye surgery, and a cardioplegic solution purchased from or produced by NECC after May 21, 2012.
- Recommendations for clinicians.
- Case definition.

Background

CDC, in collaboration with FDA, state public health departments, and state boards of pharmacy, has been investigating an ongoing outbreak of fungal infections associated with a contaminated steroid medication, preservative-free methylprednisolone acetate (80mg/ml) prepared by the New England Compounding Center, in Framingham, Mass. CDC and state public health departments are actively coordinating outreach to patients who have been exposed to this contaminated medication.

As of October 16, 2012, a total of 233 cases, which includes 2 peripheral joint infections and 15 deaths, have been reported in 15 states (see CDC's website for up-to-date information about case count and distribution by state). The fungus *Exserohilum rostratum* has been reported in clinical specimens from multiple patients with fungal meningitis and with other spinal infections (e.g., epidural abscess). CDC and FDA continue to investigate the possibility of contamination with additional organisms. At this time, one clinical specimen has

tested positive for the fungus *Aspergillus fumigatus*, and another has tested positive for the fungus *Cladosporium*. Fungal meningitis is not transmitted from person to person.

The clinical presentation of infected patients with fungal meningitis remains consistent with that described in previous reports: onset of symptoms is typically between 1 to 4 weeks following injection with a variety of symptoms, including fever, new or worsening headache, nausea, and new neurological deficit (consistent with deep brain stroke). However, fungal infections can be slow to develop, and there are reports of longer periods between injection and onset of symptoms; and, therefore, patients and their doctors need to watch closely for symptoms for at least several months following the injection. Some of these patients' symptoms were very mild in nature. Cerebrospinal fluid (CSF) obtained from these patients has typically had an elevated white cell count (usually with a predominance of neutrophils), and in many cases low glucose and elevated protein. As of October 16, two peripheral joint infections have been reported. CDC expects that through ongoing patient notification efforts, additional patients with infections of the joints may come forward.

On September 26, 2012, NECC voluntarily recalled the following lots of methylprednisolone acetate (PF) 80mg/ml:

- Methylprednisolone Acetate (PF) 80 mg/ml Injection, Lot #05212012@68, BUD 11/17/2012
- Methylprednisolone Acetate (PF) 80 mg/ml Injection, Lot #06292012@26, BUD 12/26/2012
- Methylprednisolone Acetate (PF) 80 mg/ml Injection, Lot #08102012@51, BUD 2/6/2013

On October 6, NECC expanded its previous recalls to include all products currently in circulation that were compounded at and distributed from its facility in Framingham, Mass. More information about this recall is available at the FDA website.

All cases reported as of October 16 have occurred after injections with methylprednisolone acetate products from one of the three lots recalled on September 26.

FDA MedWatch: Additional NECC Products of Potential Concern

On October 15, FDA released a MedWatch Safety Alert announcing that, as a result of the ongoing investigation of NECC, a patient with possible fungal meningitis who had received an epidural injection of triamcinolone acetonide produced by NECC has been identified through active surveillance efforts by CDC and state health departments and reported to FDA. Triamcinolone acetate is a type of steroid injectable product made by NECC. As of October 17, there is no laboratory evidence of fungal infection in this patient. As noted above, all cases of fungal meningitis identified to date have been associated with methylprednisolone acetate, another similar steroid injectable product distributed by NECC.

In addition, FDA received a report of one cardiac transplant patient with *Aspergillus fumigatus* infection who was administered NECC cardioplegic solution, which is used to prevent injury to the heart during surgery. Investigation of this patient is ongoing; there may be other explanations for this patient's *Aspergillus* infection.

This is preliminary information and CDC does not have firm evidence that infections have been caused by exposure to NECC products beyond the three previously listed lots of methylprednisolone acetate. Out of an abundance of caution, FDA has advised clinicians to follow up with patients to whom they have administered an injectable product, including an ophthalmic drug that is injectable or used in conjunction with eye surgery, and a cardioplegic solution purchased from or produced by NECC after May 21, 2012.

Clinicians should perform a thorough diagnostic evaluation to exclude infection in those patients who report signs and symptoms of infection following high-risk exposure to one of these NECC products (e.g., exposure of product to sterile body site). If the evaluation of these patients is suggestive of fungal infection, please consult existing CDC treatment guidance http://www.cdc.gov/hai/outbreaks/clinicians/index.html. Consultation with an infectious disease specialist is strongly encouraged to help make treatment decisions in these cases.

Products from NECC can be identified by markings that indicate New England Compounding Center by name or by its acronym (NECC), and/or the company logo that can be accessed here. Additional information about the MedWatch Safety Alert notice is available on the FDA website.

Federal Aviation Administration

Laser Hazards In Navigable Airspace

Laser Targeting of Aircraft

An American Airlines 757 is on final approach to Boston Logan Airport's Runway 4 R after flying for nearly three hours in nighttime conditions, when the captain is suddenly hit with a dazzling green laser light that obliterates his vision! The laser beam had hit the captain's left eye with such intensity that he feels as if he has been "punched in the eye." He ducks down, closes his eyes, and tells the first officer he has been hit by a laser beam and not to look at the light. The pilot experiences pain, spasms, and spots in his vision. The flash was so bright that he believes the aircraft may be the target of a terrorist attack! So distraught by the event that occurred and visibly shaken, he gives up control of the aircraft to the first officer, who, fortunately, has not been hit by the laser beam and is able to land the plane successfully.

The captain's symptoms persist in the hotel that night. Upon waking in the morning, he perceives that the vision in his left eye is noticeably more blurred with or without his glasses, and his "eye hurts and feels strained." The pilot goes to an eye doctor that afternoon and is diagnosed with accommodative spasm, sluggish pupil responses, and increased light sensitivity, which continue on for several days before finally clearing up. For a while, though, the pilot thinks that his flying days may be over.

This laser incident is fictitious but is based on actual events and personal interviews with pilots that have been exposed to laser beams while flying here in the United States.

Although lasers have many legitimate outdoor uses, such as in astronomical research, deep-space communications, orbital satellite imaging, and outdoor displays to attract and entertain the public, the misuse of laser devices poses a serious threat to aviation safety. Aviators are particularly vulnerable to laser illuminations when conducting low-level flight operations at night. The irresponsible or malicious use of laser devices can threaten the lives of flight crews and passengers.

Why Should I Be Concerned?

Federal Aviation Administration researchers have compiled a database containing more than 3,000 reports of aircraft laser illumination events over a 20-year period. These reports describe the illumination of military and civilian aircraft by lasers, including law enforcement and medical evacuation flights. No accidents have been attributed to the illumination of crewmembers by lasers, but given the sizeable number of reports and debilitating effects that can accompany such events, the potential does exist.

Sudden exposure to laser radiation during a critical phase of flight, such as on approach to landing or departure, can distract or disorient a pilot and cause temporary visual impairment. Permanent ocular damage is unlikely since the majority of incidents are brief and the eye's blink response further limits exposure. In addition, considerable distances are often involved, and atmospheric attenuation dissipates much of the radiant energy.

FAA flight simulator studies, however, have shown the adverse visual effects from laser exposure are especially debilitating when the eyes are adapted to the low-light level of a cockpit at night. Similar to a camera flash at close proximity or the high-beam headlights of an oncoming

car, recovering optimal visual performance after exposure to laser light may take from a few seconds to several minutes.

Besides startle and distraction, the three most commonly reported physiological effects associated with laser exposures are:

Glare – Obscuration of an object in a person's field of vision due to a bright light source located near the same line of sight.

Flashblindness – A visual interference effect that persists after the source of illumination has been removed.

Afterimage – A transient image left in the visual field after an exposure to a bright light.

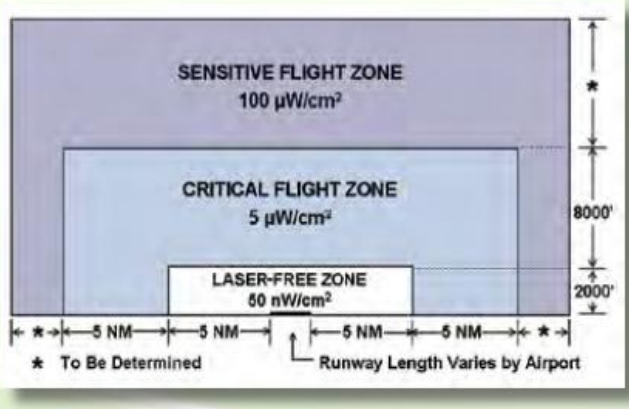


Figure 1:
Protected Flight Zones for a Single-Runway Airport

Is Anything Being Done?

In 1995, an increase in the number of laser illuminations (mostly from laser light shows) resulting in the disruption of cockpit operations, prompted the FAA to revise FAA Order 7400.2 (Part 6. Miscellaneous Procedures: Outdoor Laser Operations). The revised Order established exposure limits to prevent temporary visual impairment in three new zones that become more restrictive at lower attitude and closer proximity to airport runways.

The new zones and exposure limits include:

Sensitive Flight Zone – 100 microwatt per square centimeter (µW/cm2),

Critical Flight Zone – 5 µW/cm2, and

Laser Free Zone – 50 nanowatts per square centimeter (nW/cm2).

While FAA Order 7400.2 has all but eliminated reports of incidents associated with legitimate laser operators,

such guidelines cannot prevent misuse due to ignorance or maliciousness. Inappropriate use of lasers has become more prevalent and dangerous as handheld lasers have become less expensive, more powerful, and increasingly available to the general public.

On January 12, 2005, in response to the rapid increase in laser illumination reports involving aircraft, the Department of Transportation published advisory circular AC 70-2 entitled, "Reporting of Laser Illumination of Aircraft." This document provides mitigation procedures and information on how to report laser illumination events. In addition to providing an official reporting mechanism, AC 70-2 also improved coordination between local and federal law enforcement agencies responsible for the apprehension and prosecution of violators. Frequently, prompt reporting has led to the capture of perpetrators.

Where Are We Now?

Laser activity in navigable airspace is continually monitored to better define the nature of the threat from outdoor lasers. Reports of illumination events have increased significantly since the issuance of AC 70-2. The number of laser events increased over 300% from 2005 to 2008. This increase may be due to heightened awareness of the problem by flight crewmembers, the introduction of an authorized reporting process, and the increased availability of high-output, handheld laser devices.

Once only marketed as "laser pointers" and used for pointing out topics of interest in slide presentations with output power from 1 to 5 mW, handheld laser devices can

now be purchased over the Internet with output power as high as 500 mW. While the Food and Drug Administration prohibits the sale of "laser pointers" that exceed 5 mW, it does not prohibit the sale of more powerful, handheld lasers, if they are equipped with the appropriate labels and safety mechanisms.

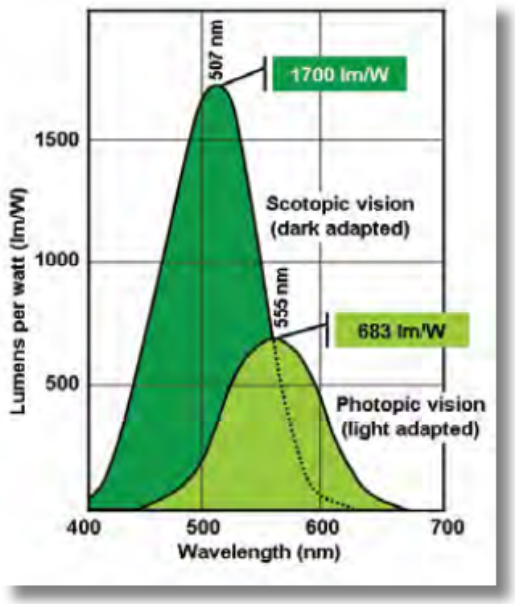


Figure 2:
Light and Dark Adapted Sensitivity by Wavelength of the Human Eye

Figure 3:
Example of a Powerful, Handheld Laser Device Available On-line

The latest reports indicate that aircraft illuminations by handheld lasers are primarily green (91%) in color, as opposed to red (6.3%), which was more common a few years ago. This is significant because the wavelength of most green lasers (532 nm) is close to the eye's peak sensitivity when they are dark-adapted. A green laser may appear as much as 35 times brighter than a red laser of equal power output. Due to this heightened visibility and increased likelihood of adverse visual effects, illumination by green lasers may result in more events being reported.

Illumination reports often describe several types of adverse effects. These include visual effects (8.2%), pain and/or possible injury (1.6%), and operational problems (3.2%). Operational problems include momentary distraction, disorientation resulting in another pilot assuming control, aborted landings, loss of depth perception, and shutting down of runways due to multiple laser strikes. While only 16.5% of all cockpit illuminations occurred below 2,000 feet (Laser-Free Zone), these incidents accounted for 31% of all visual effects, 42% of all pain or injuries, and 42% of all operational problems reported. Low-attitude illuminations, therefore, result in a greater risk to aviation safety.

Laser events can occur anywhere but have been noted most frequently in the Western Pacific and Southern regions of the United States. They are most frequently reported near airports and are often observed in clusters. Cluster laser attacks are multiple strikes on one or several aircraft that appear to originate from a specific location. These attacks may last a few minutes or be spread out over several days or weeks.

Studies have also shown that almost 70% of all incidents occurred between 2,000 and 10,000 feet AGL, 22% occurred in November and December, and 70% happened between the hours of 7 and 11 pm.

What Actions Can I Take?

Continuing research and interviews with pilots who were victims of lasing events have provided a list of recommended actions to minimize the effects of laser illumination:

Anticipate – When operating in a known or suspected laser environment, the non-flying pilot should be prepared to take control of the aircraft.

Aviate – Check aircraft configuration and (if available) consider engaging the autopilot to maintain the established flight path.

Navigate – Use the fuselage of the aircraft to block the laser beam by climbing or turning away.

Communicate – Inform Air Traffic Control of the situation. Include location/direction of the beam, your present location, altitude, etc. Once on the ground, request and complete a "Laser Beam Exposure Questionnaire" (i.e., AC 70-2).

Illuminate – Turn up the cockpit lights to minimize any further illumination effects.

Delegate – If another crewmember has avoided exposure, consider handing over control to the unexposed crewmember.

Attenuate – Shield your eyes when possible (hand, clipboard, visor, etc.). Do not look directly at the laser beam and avoid drawing other crewmembers' attention to the beam.

Do Not Exacerbate – Avoid rubbing of eyes and possibly inducing further injury.

Evaluate – If any visual symptoms persist after landing, get an examination by an eye doctor.

Can More Be Done To Protect Aviation Safety?

Continued monitoring of laser issues and effective reporting of illumination events provide data necessary to define the changing nature of the threat and develop better strategies for mitigating the problem. Strategies may include educating the public regarding the risks of lasers to aviation safety and encouraging the reporting of malicious behavior, restricting the sale of certain laser devices to the general public, encouraging manufacturers to attach warning labels on laser devices that address aviation concerns, performing studies on the use of laser eye protection as an option in the aviation environment, and investigating the value of deploying laser detection and recording systems on civilian aircraft. While no single strategy may completely end this threat, the FAA will continue to examine and recommend ways to best protect aviation from this serious hazard.

To request copies of this brochure and others listed below, contact

FAA Civil Aerospace Medical Institute
Shipping Clerk, AAM-400
P.O. Box 25082
Oklahoma City, OK 73125
(405) 954-4831

Other Pilot Safety Brochures Available

Number	Title
AM-400-94/2	Alcohol and Flying: A Deadly Combination
AM-400-03/2	Deep Vein Thrombosis and Travel
OK-06-148	Information for Pilots Considering Laser Eye Surgery
AM-400-98/2	Pilot Vision
AM-400-05/1	Sunglasses for Pilots: Beyond the Image
AM-400-01/2	When There are Questions About Your Medical Certification Application

To view these pilot and passenger safety brochures, visit the Federal Aviation Administration's Web Site

www.faa.gov/pilots/safety/pilotsafetybrochures/

Physiological Training Classes for Pilots

If you are interested in taking a one-day aviation physiological training course with altitude chamber and vertigo demonstrations or a one-day survival course, learn about how to sign up for these courses that are offered at locations across the U.S. by visiting this FAA Web site:

www.faa.gov/pilots/training/airman_ed

Medical Facts For Pilots

Publication AM-400-10/3
Written by
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Federal Aviation Administration
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Vision Research Team

Fly like a fighter: Backseat landings

By Larry Brown

U.S. Air Force T-38 pilot training students spend a lot of time practicing formation maneuvers, including rejoins. During tactical maneuvering our rejoin airspeed is 350 knots, and the flight lead will

use 45 degrees of bank in level flight if a turning rejoin is desired. The wingman normally rejoins to the low wing on the inside of the turn, but the student also needs to practice rejoining to the high wing on the outside of the turn. To accomplish this correctly, the wingman needs to accelerate to about 380 knots on the inside of lead's turn, about 30 to 45 degrees off the lead's tail, and slightly below the lead's altitude. Within a few hundred feet of the lead, the wingman should pass behind and then stabilize next to the lead, co-altitude, co-speed, on the outside of the turn, before he then climbs the few feet to the fingertip position with three feet of spacing between wingtips.

On one mission I was flying solo as lead and my wingman was a student with an instructor in the back seat. Toward the end of the sortie the student needed to practice a rejoin to the high wing, so I set up a right turn, and he flew the rejoin as described—until he crossed behind me and flew to a position abeam me.

He had a little too much airspeed and didn't pause at the co-altitude position to settle in place before climbing slightly to my wing. When I looked left and saw him outside my turn but pulling back into me, I knew I needed to get out of the way in a hurry. This was one of those moments when you have to make a panic move: left hand full forward (to light the afterburners) and right hand full back (to pull back on the stick and climb). I climbed until the wings started buffeting as I slowed to below 200 knots. By then my panic had subsided enough for me to realize we didn't collide, so I stopped pulling up and rolled left to take a peek and find my wingman. Fortunately, his instructor had also gone into panic mode and was in a hard left turn away from me, now also stopping his turn to take a peek to find me.

Everyone is familiar with the panic stop in a car—right foot off the gas and stomp on the brake pedal. There are a few “instant” moves for an airplane that all of us should have in our memory for quick recall. One is stall recovery. In the Air Force we use “max—relax—roll.” From the left seat in a general aviation airplane, this means right hand full forward (full power), left hand slightly forward (unload the yoke), and left hand up or down along with rudder to level the wings.

A second is the go-around, which is typically full power, carburetor heat off, pitch to slow or stop the descent without slowing to a stall, then possibly partially retracting the flaps. In a high-performance turbocharged airplane, the sequence might be pushing forward in sequence the mixture (red), prop (blue), and throttle (black) controls.

For a touch-and-go, I generally teach “feet—flaps—throttle.” There is no point in adding power if you aren’t aligned properly with the runway, hence the feet, or rudders, first.

What should your muscle memory be for instant recall in the airplane(s) you fly? Share your ideas on the AOPA Facebook page.

FAA Safety Team | Safer Skies Through Education

FAAST Blast
Notice Number: NOTC4190

FAAST Blast — Week of Sep 17 – Sep 23, 2012
Biweekly FAA Safety Briefing *News Update*

FAA Issues Cessna NPRM; Piper AD
The FAA has issued a Notice of Proposed Rulemaking (NPRM) for select Cessna retractable gear models (182, 210, and 303) that was prompted by a report of a cockpit fire that appeared to originate from the area of the landing gear's hydraulic power pack system. The NPRM, issued on Sep. 11, 2012, would affect nearly 3,000 airplanes of U.S. registry and require inspection of the aircraft's hydraulic power pack wiring for correct installation. To view the NPRM, go to http://go.usa.gov/rtCG. Comments on this proposed Airworthiness Directive (AD) must be received by Oct. 26, 2012.
The FAA also issued an AD on Sep. 17, 2012, that affects 3,100 Piper PA-24, PA-24-250, and PA-24-260 airplanes, and was prompted by reports of cracks developing in the stabilator horn assembly. This AD requires replacement of the stabilator horn assembly and/or repetitive inspections of the stabilator horn assembly for corrosion or cracks, as applicable. For more on these inspection and replacement details, see the AD at http://go.usa.gov/rtY9.

GA Survey Underway
The FAA's annual General Aviation and Part 135 Activity Survey for calendar year 2011 is now underway. Aircraft owners and operators who received a postcard invitation or survey by mail should respond as soon as possible by completing the survey on-line at www.aviationsurvey.org (use aircraft N-Number to login) or by mail with the postage-paid envelope.
This annual survey is the FAA's only source of information on the GA fleet. The data collected will include the number of hours flown and the ways people use GA aircraft. This data helps determine funding for infrastructure and service needs, assess the impact of regulatory changes, and measure aviation safety. The GA survey data also allows the FAA to track the success of its safety initiatives, identify areas for improvement, focus its resources, and better serve the GA community. The survey closes on November 30, 2012.

WAAS Happening!
Are you up to speed on Localizer-Performance-with-Vertical-Guidance (LPV) approaches? The LPV approach is just as accurate at 30 miles as it is over the runway threshold. By comparison, Instrument Landing System (ILS) approaches become less accurate as distance from the runway increases. The FAA has also published more than 2,800 LPV approach procedures for use at nearly 1,400 airports since the Wide Area Augmentation System (WAAS) was operationally enabled in 2003. To learn more about LPVs, see page 22 of the current *FAA Safety Briefing* at http://1.usa.gov/FAA_ASB.

Produced by the *FAA Safety Briefing* editors, http://www.faa.gov/news/safety_briefing/
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Follow us on Twitter @FAASafetyBrief or www.twitter.com/FAASafetyBrief

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The Official Safety Newsletter of the Civil Air Patrol-November 2012

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WWW.GOCIVILAIRPATROL.COM

Discover, report, stop, share, listen, and learn. The things we have read about in this issue already have happened, so you are not allowed to experience these for yourself.

Remember to "Knock It Off" and slow down. For streaming dialogues on some subjects, remember CAP Safety is on Facebook and Twitter.

SUMMARY

CAP's safety awareness and program management has significantly improved with the addition of NHQ safety staff working in conjunction with the National Safety Team (NST). The NST is comprised of the National Safety Officer and volunteer assistants assigned as subject matter experts for flight and ground safety. Region and Wing Commanders are moving away from a punitive safety program towards a behavior-based safety program that has shown significant improvement in using safety mishaps as an educational opportunity to raise awareness and prevent risk exposure.

Got a great safety article that you would like to see in a future Beacon newsletter? Please send it to Lt Col Sharon Williams at safetybeacon@capnhq.gov.

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