

AIRCRAFT ACCIDENT INVESTIGATION  
SUMMARY REPORT

Reference No.  
AS/702/1039

LOCATION OF OCCURRENCE

Two miles west of Wilton, New South Wales.	Height a.m.s.l. (ft) 700 feet	Date 24.5.70	Time (Local) 1127	Zone EST
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2. THE AIRCRAFT

Make and Model Cessna 182H	Registration VH-KMM
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3. CONCLUSIONS

At approximately 1127 hours EST on 24th May, 1970, a parachutist was fatally injured on impact with the ground after his parachutes had failed to correctly deploy during a free fall descent near Wilton, New South Wales.

(ii) The parachutist, Kevin Clifford NIELSEN, was 26 years of age and had previously made 780 descents, including nine descents on the morning of 24th May, 1970.

(iii) The parachutist was equipped with a main parachute and a reserve parachute in accordance with Air Navigation Orders Part 29.1.

(iv) The main parachute was a Para-commander "Crossbow" Mark 1 manufactured by the Pioneer Parachute Company Incorporated, in August, 1967. This type of parachute is operated manually by a ripcord, the handle of which is stowed on the right side of the wearer's chest, near the shoulder. A feature of this parachute is a steering facility which enables the parachute to be manoeuvred by manipulation of steering toggles located on the front risers close to the harness attachment points.

(v) The main parachute had been packed by qualified parachutists and there is no evidence of any error or omission in packing, which may have contributed to the accident.

(vi) The reserve parachute was a "Navairfac" type manufactured by the Switlik Parachute Company Incorporated, in April, 1957. There is no evidence of any error or omission in packing or any defect in the parachute which may have contributed to the accident. Both parachutes were worn on the back, fitted in a "piggy back" pack and harness.

(vii) The descent on which the accident occurred was made from a Cessna 182H aircraft, registered VH-KMM, owned by R. A. Jessup. The aircraft was being operated by the Wilton Parachute Centre and was flown by Valerian Lysenko, who was the holder of a valid Private Pilot Licence and had been approved to pilot aircraft engaged on parachuting operations. There were two parachutists and one photographer on board the aircraft in addition to the pilot when the aircraft took off from Wilton on the flight on which the accident occurred.

(viii) The first parachutist, Kevin William LUNNY, left the aircraft at an altitude of 2200 feet and he was followed almost immediately by Kevin Clifford NIELSEN.

(ix) Kevin Clifford NIELSEN made a good exit and correctly operated the ripcord which opened the main parachute pack. The pilot parachute was seen to emerge and hesitate in turbulent air close behind the back and shoulders of the parachutist, in the immediate vicinity of the packed position of the wooden steering toggles. The main canopy enclosed in the launching sleeve was then observed to deploy but not inflate and, still encased in the launching sleeve, it remained oscillating rapidly in a position above the parachutist. At a height of approximately 500 feet above the ground the reserve parachute was deployed and immediately became entangled in the main parachute to the extent that it could not effectively reduce the rate of descent of the parachutist.

## CONCLUSIONS (Cont'd)

(x) Examination of his equipment at the accident site revealed that the upper bridle attaching the pilot parachute to the launching sleeve of the main parachute had become entangled with the left hand steering toggle. This restricted the opening operation of the main parachute to the extent that the pilot parachute was unable to separate the canopy and the launching sleeve. There was no reason for the failure of the reserve parachute to deploy correctly other than its entanglement with the malfunctioning main parachute.

(xi) The standard operating procedure for a parachutist, operating with a "piggy back" configuration and encountering a main parachute malfunction, is to jettison the main parachute before the reserve parachute is deployed. This procedure is facilitated by the attachment of the main parachute to the wearer's harness by means of quick release catches. A static line is normally and was in this case attached between the left hand risers of the main parachute and the reserve parachute ripcord and would have ensured the automatic deployment of the reserve parachute had the main parachute been jettisoned. The quick release catches were serviceable and capable of normal operation and the reason for the departure from standard operating procedure by the parachutist has not been determined.

## 4. OPINION AS TO CAUSE

The cause of the accident was that following a malfunction of his main parachute, the parachutist did not jettison the main parachute before attempting to deploy his reserve parachute.

Release approved  (D.S. GRAHAM)	Designation Assistant Director-General (Air Safety Investigation)	Date 18.3.1971
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