Aviation Safety Investigation Report 198800133

Cessna 172

11 September 1988

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NOTE: All air safety occurrences reported to the ATSB are categorised and recorded. For a detailed explanation on Category definitions please refer to the ATSB website at www.atsb.gov.au.

Occurrence Number: 198800133 **Occurrence Type:** Accident
Location: 4 km North-East Wickham WA
Date: 11 September 1988 **Time:** 1106
Highest Injury Level: Nil
Injuries:

	Fatal	Serious	Minor	None
Crew	0	0	1	1
Ground	0	0	0	-
Passenger	0	0	0	3
Total	**0**	**0**	**0**	**4**

Aircraft Details: Cessna 172
Registration: VH-TDA
Serial Number: 17267535
Operation Type: Private
Damage Level: Substantial
Departure Point: Wickham WA
Departure Time: 1100
Destination: Wickham WA

Approved for Release: March 13th 1989

Circumstances:

As the first student parachutist climbed out on the wheel strut for his parachute descent his main chute deployed prematurely. The parachute risers became entangled with the horizontal stabiliser causing increased drag damage to the stabiliser and a locked elevator. The entangled student and the other student and instructor safely evacuated the aircraft by parachute. The pilot who was also prepared to evacuate the aircraft carried out a series of handling checks and was able to establish a means of controlling the aircraft. He was able to land the aircraft safely on a salt lake with the parachute still attached. The parachutist was using a type of equipment which only requires a 10lb pull to activate the pilot chute. The static line to the pilot chute is tucked under an elastic band to prevent it trailing in the slip stream. If the line becomes loose from the band the slipstream can deploy the pilot chute which in turn will deploy the main chute. The instructor did not see the line work loose but it is probable that this is what occurred. This accident was not the subject of an on-scene investigation.

Significant Factors:

The following factors were considered relevant to the development of the accident

1. A possible design defect in the deployment system.

2. Premature deployment of the pilot chute.

3. Unavoidable collision and entanglement between aircraft and parachute.

Reccomendations:

1. It is recommended that the pilot's actions in saving the aircraft should be publicly commended in the Aviation Safety Digest.

2. It is recommended that the manufacturer and the Australian Parachuting Federation be notified that there could be a problem with single pin low deployment pull parachutes which can result in premature deployments.