Aviation Safety Investigation Report 199302866

Cessna Aircraft Company 182E

11 September 1993

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Aviation Safety Investigation Report

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Occurrence Number: 199302866 **Occurrence Type:** Accident
Location: Kambalda
State: WA **Inv Category:** 3
Date: Saturday 11 September 1993
Time: 1115 hours **Time Zone** WST
Highest Injury Level: Fatal
Injuries:

	Fatal	Serious	Minor	None	Total
Crew	0	0	0	0	0
Ground	0	0	0	0	0
Passenger	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**

Aircraft Manufacturer: Cessna Aircraft Company
Aircraft Model: 182E
Aircraft Registration: VH-TSH **Serial Number:** 18254356
Type of Operation: Miscellaneous Parachute Jump
Damage to Aircraft: Nil
Departure Point: Kambalda WA
Departure Time: 1050 WST
Destination: Kambalda WA

Approved for Release: Wednesday, May 8, 1996

Following the completion of 27 jumps over a 9-month period using a student rig, the parachutist commenced conversion training to his own rig. This training consisted of three dual training jumps and two solo jumps. After a further five jumps using his own rig the student took a two and a half months holiday during which he made no jumps. Two weeks prior to the accident he made three jumps using his own rig.

The accident jump was part of the student's training towards a "B" licence. The training consisted of a "B relative" jump requiring him to perform certain manoeuvres relative to a tutor during the free fall period of the jump. He used his own rig for this jump. On completion of the free fall component of the jump the two parachutists separated for the deployment of the parachutes. When his main parachute had deployed the tutor looked down and noted that the student's main parachute had not deployed normally and was being discarded. The tutor did not see the reserve parachute deploy before the student hit the ground.

No defect was found in the equipment which could have caused either the main parachute problem or the non-deployment of the reserve parachute. Damage to the Spandex pocket in which the main pilot parachute is kept suggested that the main pilot parachute throw-away procedure was mishandled resulting in the need for the main parachute to be discarded.

The main parachute was released at sufficient altitude for the reserve parachute to deploy. If correctly followed, the procedure taught for the rig in use should have ensured that the reserve deployed immediately after the main parachute was discarded.

It is possible that under the stress of the abnormal event the parachutist reverted to an earlier training awareness by waiting for some time for the reserve to automatically deploy following the release of the main parachute, as it does on the student rigs. Student rigs have a reserve static line (RSL) or an automatic activation device which automatically deploys the reserve parachute should the main parachute be discarded.

On-scene evidence indicated that the parachutist remembered too late that he had to manually deploy the reserve. If an RSL or an automatic activation device had been attached the accident may not have occurred.

SAFETY ACTION

Paragraph 5.1.16 of the Safety Requirements section of the Australian Parachute Federation Operational Regulations has been amended to read:

'All descents made by parachutists who do not hold a Certificate "E" must be made with equipment fitted with a functional reserve static line or an automatic activation device. The DZSO may permit exemptions to this rule for specific descents.

Note: This regulation became effective on 1 February 1994 where the descent is being made with a harness/container manufactured after 30 July 1993, or on 1 February 1995 where the descent is being made on a harness/container manufactured before 1 August 1993.'