GOVERNMENT OF AUSTRALIA DEPARTMENT OF TRANSPORT

AIRCRAFT ACCIDENT INVESTIGATION SUMMARY REPORT

Publication of this report is authorised by the Secretary under the provisions of Air Navigation Regulation 283(1)

Reference No: AS/742/1065

1. LOCATION OF OCCURRENCE

	Height a.m.s.l.	Date	Time (Local)	Zone
1500 metres west-north-west of Rylstone Aerodrome, New South Wales	1750 feet	29.12.74	0145 hours (Approx.)	ESuT

2. THE AIRCRAFT

Make and Model	Registration
Piper PA31/310 Navajo	VH-EYF

3. CONCLUSIONS

3.1 At approximately 0145 hours Eastern Summer Time on 29 December, 1974 two parachutists were fatally injured by impact with the ground following attempted night parachute descents near Rylstone, New South Wales.

3.2 The parachutists were John Bernard Lahiff, aged 26 years and Frederick William Turner, aged 35 years. Mr. Lahiff's log book indicated that he had previously made 372 parachute descents and that he was experienced in relative work by day. He held a Class 'D' International Parachutists Certificate issued by the Australian Parachute Federation. Mr. Turner's log book indicated that he had previously completed 379 parachute descents and that he also was experienced in relative work by day. He held a Certificate 'D' parachute licence issued by the Australian Parachute Federation. Mr. Turner had made one previous night parachute descent, of the clear and pull type, some years earlier. There is no record that Mr. Lahiff had previously made a night parachute descent.

3.3 For this descent, Mr. Lahiff was equipped with a UT-15 main parachute which he had packed on 24 December, 1974 and a chest-mounted 24 feet diameter reserve parachute which he had also packed during December, 1974. He was not wearing a jump suit but was equipped with a helmet and a chest mounted altimeter. Mr. Turner was equipped with a Thunder Bow main parachute which he had packed on 24 December, 1974 and a "piggy back" Ripstop reserve parachute which was packed by him during December, 1974. Mr. Turner wore a jump suit and helmet and was equipped with a wrist mounted altimeter. The main and reserve parachutes carried by each parachutist were designed to be manually operated by means of a ripcord. Neither of the altimeters carried by the parachutists was illuminated.

3.4 The descent on which the accident occurred was made from Piper PA31/310 Navajo aircraft, registered VH-EYF and flown by Bruce Towers, the holder of a private pilot licence and a class four instrument rating. Also on board were parachutists Graeme Keith Windsor, Frederick William Turner and John Bernard Lahiff, together with a passenger Steven John Davey. The making of parachute descents from an aircraft carrying a passenger were actions which did not comply with the requirements of Air Navigation Orders, Section 29.1.8.8.

3.5 Mr. Davey, Mr. Windsor, Mr. Turner and Mr. Lahiff were all members of the Canberra Skydivers Club. Mr. Windsor had previously made 870 parachute descents and was an "Approved Person" as defined in Air Navigation Orders, Section 29.1. As such he was authorised by the Department of Transport to supervise parachuting operations conducted by members of the Canberra Skydivers Club. The pilot of the aircraft was also an experienced parachutist. With the exception of Mr. Davey, who was still carrying an injury, all on board the aircraft were present at Rylstone for the purpose of participating in the Australian National Parachuting Championships.

3.6 The drop zone for the descent was the aerodrome at Rylstone. It was a moonlight night, with no cloud and good visibility; the surface wind was approximately from the west at five knots. A large number of people associated with the Championships were camped on the north-eastern portion of the aerodrome complex.

3.7 Parachute descents had been carried out on the mornings of 27 and 28 December, 1974, the first two days of the Championships but, on both days the programme was curtailed because of weather conditions. Although Mr. Windsor had made a descent on both days neither Mr. Turner nor Mr. Lahiff had been able to do so.

3.8 Following curtailment of the days parachuting activities on 28 December, 1974 Mr. Windsor visited a club in the town of Rylstone where he met and dined with Mr. Lahiff. Both consumed beer during the evening and left the club at about 2330 hours. Mr. Davey and Mr. Turner remained at the aerodrome and during the evening they also consumed beer. When Mr. Windsor and Mr. Lahiff returned to the aerodrome they, and Mr. Davey and Mr. Turner, consumed more beer. At approximately 0100 hours on 29 December, 1974 Mr. Windsor went for a walk with the aim of asking other people back for a drink. He met Mr. Towers whom he had previously known, and brought him over to the group. Mr. Lahiff asked Mr. Towers to take them up for a parachute jump and he agreed to do so.

3. CONCLUSIONS (Cont'd)

3.9 Rylstone aerodrome was not equipped with the required lighting for aircraft operations at night but to provide some runway illumination, vehicles were positioned one at each end of the east-west runway with their headlights set on high beam. In carrying out a night flight in these circumstances the pilot did not comply with the requirements of Air Navigation Regulation 89(1).

3.10 The three parachutists and the passenger boarded the aircraft and, contrary to the requirements of Air Navigation Orders, Sections 20.16.3.3.1 and 20.16.3.4.1, the passenger did not occupy a seat or wear a safety harness or seat belt during the subsequent take-off and landing. Mr. Lahiff and Mr. Turner discussed forming a link and invited Mr. Windsor to join but he indicated that he did not think he would participate.

3.11 The aircraft took-off and, at the request of the parachutists, it was climbed to an exit height of 5,000 feet above the aerodrome. Approaching the selected exit point the pilot throttled back the engines and Mr. Lahiff and Mr. Turner left the aircraft in quick succession, followed a few seconds later by Mr. Windsor. While in free fall Mr. Windsor could vaguely see the other two below him and he deployed his parachute at a height of about 4,000 feet. He descended under his main canopy, landing on the northern side of the area being used for camping. Prior to landing the aircraft made a low run across the aerodrome at a height below 500 feet above the ground. This manoeuvre was carried out by the pilot in contravention of Air Navigation Regulation 133(2)(b).

3.12 A number of persons on the aerodrome heard the aircraft start-up at approximately 0127 hours and subsequently take-off at about 0134 hours, and there is evidence that, contrary to the requirements of Air Navigation Regulation 180(1) the aircraft's navigation lights and rotating beacon were not displayed continuously during the flight. A few minutes later the witnesses on the ground heard the sound of engine power reduce, followed by the sound of a parachute opening. About 10-15 seconds after this a distant thud sound was heard, which suggested to the listeners that someone may have struck the ground without his parachute being deployed. When people on the ground established that three parachutists had jumped from the aircraft and that two were unaccounted for, a ground search was initiated. Approximately ninety minutes later the bodies of the two fatally injured parachutists were located some 1500 metres west-north-west of the aerodrome.

3.13 Impact markings indicated that at the time of ground contact, the parachutists hands were linked and they were facing the ground. The altimeters carried by them were severely damaged in the accident. One of the parachute ripcord handles was out of its pocket, in a manner consistent with dislodgement at impact, but none of the parachute ripcords had been operated. Following the accident the ripcords for the four parachutes were pulled and the respective packs opened normally.

3.14 Pathological examinations of the fatally injured parachutists indicated that both had blood alcohol levels in excess of 0.1 grams per 100 millilitres. This condition would result in a significant deterioration of performance, including decision-making. The reaction times and responses of the parachutists during the descent would have been affected and impairment of visual functions would also be likely.

3.15 Mr. Windsor, as the "Approved Person", was responsible to the Department of Transport for ensuring that all operations conducted by the Canberra Skydivers Club were carried out in accordance with the requirements specified in the Australian Parachute Federation's Operational Regulations, which the club had nominated as its Parachuting Manual. It is apparent that, on this occasion, Mr. Windsor did not ensure that a large number of the Regulations applicable to this type of operation, were observed.

4. OPINION AS TO CAUSE

The cause of the accident was that the parachutists, whose judgement and capabilities were affected by the consumption of alcohol, attempted night parachute descents involving manoeuvres for which they were inadequately trained and equipped.

Approved for publication	(Frank E. Yeend) Delegate of the Secretary	Date 13.3.1975