Aviation Safety Investigation Report 199002047

Cessna C182

26 May 1990

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Occurrence Number: 199002047 **Occurrence Type:** Accident
Location: Corowa Aerodrome NSW
Date: 26 May 1990 **Time:** 1530
Highest Injury Level: Fatal
Injuries:

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

Aircraft Details: Cessna C182
Registration: VH-DBT
Serial Number: 18254061
Operation Type: Private
Damage Level: Nil
Departure Point: Corowa NSW
Departure Time: 1520
Destination: Corowa NSW

Approved for Release: 11th October 1990

Circumstances:

The commencement of parachuting activity on the Corowa Drop Zone was delayed due to extensive cloud in the vicinity of the Corowa aerodrome. About mid- afternoon the cloud base had lifted sufficiently to permit descents from the minimum safe height. The aircraft tookoff carrying four parachutists. Their intention was to exit the aircraft for a "Hop and Pop" jump in which the main parachute deployment sequence is commenced immediately after leaving the aircraft. The four parachutists jumped at several second intervals, from a height of 2200 feet above ground level. Three parachutists main canopies opened normally, the fourth did not. The fourth parachutist, was observed to fall in a face down attitude until he struck the ground, fatally injured by the impact. During his fall the pilot parachute from the main canopy system was seen to deploy and remain attached to the harness. There was apparently no attempt made by the parachutist, to initiate cut away action (to disconnect the main canopy from the harness) or deploy the reserve canopy. An specialist examination of the equipment revealed the line from the pilot parachute passed under the right leg strap preventing deployment of the main canopy. The reserve canopy and its deployment system were in a serviceable condition. The fatally injured parachutist was attempting his 42nd descent, held an "A" licence and was considered to be relatively inexperienced. He was using borrowed equipment which differed significantly from that on which he carried out the majority of his training. He had completed 39 descents with a harness/container system that incorporated a ripcord main canopy deployment and "single operation system" reserve canopy deployment. The borrowed equipment consisted of a throw away pilot chute main canopy deployment system, and a "two stage" reserve deployment arrangement. It was reported the parachutist was trained to use the borrowed equipment. The parachutist incorrectly fitted the borrowed equipment so that the right leg strap passed over the line from the pilot chute to the main canopy. Although the pins which secure the main canopy within the container were checked by another parachutist before the aircraft was boarded, the routing of the pilot chute line was not the subject of a deliberate check. (The reason why the parachutist did not deploy his reserve

parachute was not determined). The descent was conducted from the minimum safe height above ground level and in the event of a complete failure of the main canopy to deploy, a rapid response was required to identify the nature of failure and deploy the reserve parachute.

Significant Factors:

1. Parachutist lack of experience with this equipment.

2. The parachutist incorrectly donned the parachute equipment.

3. Prior to boarding the aircraft a complete check of the parachutists equipment by an independent person, was not conducted.

4. The main canopy failed to deploy because the line from the pilot's chute passed under the right leg strap.

Reccomendations:

The following recommendations were made to the Australian Parachute Federation during the course of the investigation

1. All parachutists should have their complete equipment checked prior to boarding aircraft.

2. Inexperienced parachutists be discouraged from using borrowed equipment with unfamiliar operating systems.