Aviation Safety Investigation Report 198403585

Cessna 180B

22 April 1984

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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: 198403585 **Occurrence Type:** Accident
Location: Alice Springs NT
Date: 22 April 1984 **Time:** N/A
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 180B
Registration: VH-PKW
Serial Number:
Operation Type: Parachuting
Damage Level: Nil
Departure Point: Alice Springs NT
Departure Time: N/A
Destination: Alice Springs NT

Approved for Release: 8th August, 1984

Circumstances:

Mme Doussaud was one of eighteen persons undergoing a two-day initial parachuting course at the Alice Springs Parachute Club. The first day consisted of intensive theoretical and practical training, and was followed by revision, further practical training and a written examination on the second day. Mme Doussaud answered all examination questions correctly and was reportedly looking forward to the static line (automatic parachute opening system) parachute descent which would complete the course. Before boarding the aircraft, Mme Doussaud and another student, who was to be the first of the pair to jump, again practised the correct exit procedure, which involved moving from the aircraft cabin and hanging onto the wing strut with both hands until the instructor gave the order to let go. After releasing, the technique was to arch backwards, count to six and check that the parachute had deployed. If the main parachute had not opened, the reserve was to be immediately activated by the parachutist. The first student made a normal exit and descent from 2500 feet above ground level. As Mme Doussaud then moved to grasp the wing strut she appeared to lose her grip. As she fell she did not adopt the correct arched position and the static line pulled the pilot parachute and main parachute around the left side of her body. She was observed to clutch the parachutes to her chest, thus preventing them from deploying. Witnesses observed that the pilot parachute and main parachute bag were released when the parachutist was about 1000 feet above the ground, however the main parachute failed to deploy. No apparent attempt was made to activate the reserve parachute. Subsequent investigation revealed that the main suspension lines had been extensively tangled by flapping and twisting in the airflow, and one of the lines had fouled the bridle holding the pilot parachute to the main parachute bag. This fouling had prevented the deployment of the main parachute. CONCLUSIONS 1. The parachutist had been adequately trained and briefed for the intended parachute descent. 2. She evidently lost her grip on the aircraft wing strut as she moved outside the cabin. 3. She did not adopt the correct position to allow normal deployment of her

parachute. 4. As the pilot parachute was pulled around her body the parachutist probably panicked. 5. The parachutist did not follow either the standard or emergency procedures which she had been taught.