CHECK SHEET - CONLUSION PROCESSING

FILE REF: 6/733/1047

ACTION	DATE	OFFICER
REVIEW COMPLETED	30-4-76	SIGN
CONCLUSIONS SUBMITTED		
CONCLUSIONS APPROVED		
DRAFT PROOF READ		
DRAFT TO PPC		
PRINTED CONCLUSIONS FROM PPC		
CONCLUSIONS DESPATCHED TO REGION		

NO. CONCLUSIONS

AIR SAFETY INVESTIGATION REPORT REVIEW

Aircraft Type - Registration C172 VH-MDH File Reference 6/733/1047

Place and Date MOOROODUC, VIC 26-8-76 Investigator M.R. LEWINO

INVESTIGATION Operations - Engineering - Aviation Medicine -

1. Ownership of parachutes not established in evidence.
2. Statement in relevant events that parachutes used on earlier descent not in evidence.
3. Parachute packing data not in evidence.

REPORT

Evidence Presentation

Satisfactory

Analysis Satisfactory.

CA Form 149A Refers to data not in evidence (See investigation above) Cause not the same as the cause written in analysis. (I agree with analysis cause)

Contraventions

Nil

CAUSAL FACTORS

Date 30-4-76 Signature [redacted] 5193

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 Regulations 283 (1)

Reference No. AS/733/1047

1. LOCATION OF OCCURRENCE

	Height a.m.s.l.	Date	Time (Local)	Zone
Moorooduc, Victoria	190 feet	26.8.76	1508 hours	EST

2. THE AIRCRAFT

Make and Model	Registration
Cessna 172	VH-MDF

3. CONCLUSIONS

(a) At approximately 1508 hours Eastern Standard Time on 26 August 1973, a parachutist was fatally injured on impact with the ground following a free fall descend at Moorooduc, Victoria.

(b) The parachutist was , aged 21 years. He had commenced parachute training in Queensland and up to 30 April 1972 had completed five static line descents and five free fall descents. There is no further record of any parachute training until he contacted the Cavalier's Skydivers Club at Moorooduc during August 1973.

(c) During the morning of 26 August 1973, received refresher ground training from the Club's Chief instructor and successfully completed a static line descent with a dummy ripcord full. The next descent which was the fatal descent was planned to be a free fall descent with a three second delay.

(d) The parachutist was equipped with a back mounted, 28 feet diameter, ex-military C9 sleeved parachute and a 24 feet diameter, chest mounted, reserve parachute, each manually operated by means of a ripcord. The main parachute ripcord handle was located on the right-hand vertical strap at breast pocket level, and the reserve parachute ripcord handle was located on the top right hand side of the reserve pack.

(e) At the time of the accident the sky was overcast but the cloud base was approximately 10,000 feet. The wind was a light southerly at about 2 to 3 knots and the visibility was over 45 kilometres.

(f) The descent which resulted in the accident was made from Cessna 172 aircraft registered VH-MDF. The aircraft was flown by , the holder of a senior commercial pilot licence. Also on board the aircraft were parachutist and the club's chief instructor who acted in the capacity of jumpmaster. Prior to take-off, the parachutists were briefed and their parachute equipment was inspected by the jumpmaster.

(g) At a height of 2650 feet, exited the aircraft cleanly and adopted the correct stable free-fall posture. This posture was maintained for the planned three seconds and he was then observed to move his arms in the normal manner for main parachute activation but while his right hand apparently touched the ripcord handle it failed to grasp and pull the handle. Following a further three seconds of stable free-fall the parachutist's head was seen to turn to the right, apparently following the normal procedure of looking over the shoulder to confirm parachute deployment. Immediately following this he appeared to bend forward from the waist and slowly roll to a back-to-earth position. He remained in this position until he struck the ground.

(h) The main parachute was recovered in a packed condition. The ripcord pins had been slightly bent on impact but the parachute was still serviceable and capable of deployment with a ripcord pull of 17 lb. The reserve parachute was found to have burst open on impact, spilling the partly folded canopy across the ground without extracting the lines from their stowage within the pack. The ripcord cable on this parachute had also sustained minor impact damage but there was not to indicate that the equipment was other than serviceable at the time of the descent.

4. OPINION AS TO CAUSE

The cause of the accident was that the parachutist, for reasons which have not been determined, did not deploy either his main or reserve parachutst.

Approved for publication	Delegate of the Secretary	Date