

CHECK SHEET - CONCLUSION PROCESSING

FILE REF: 6.742.1044

ACTION	DATE	OFFICER
REVIEW COMPLETED	19.8.75	S.G. SPINKS SIG 4
CONCLUSIONS SUBMITTED		
CONCLUSIONS APPROVED		
DRAFT PROOF READ		
DRAFT TO PPC		
PRINTED CONCLUSIONS FROM PPC		
CONCLUSIONS DESPATCHED TO REGION		

AIR SAFETY INVESTIGATION REPORT REVIEW

Aircraft Type - Registration Parachuting Accident File Reference 6.742.1044

Place and Date Wilton, NSW, 18.8.74 Investigator W.H. BOWLES

INVESTIGATION

Operations - Engineering - Aviation Medicine -

Good.

1. At the witness report at page 33, a witness has stated that the parachutist's wrist altimeter was reading 2000 feet on the ground after the accident. An investigators note to explain this would have been appropriate. I discussed this aspect with GAFS 5 who is convinced it would have had no bearing whatever on the accident. Witness evidence at page 20 shows that the altimeter was working properly at 4000 feet on the descent.

REPORT

Evidence Presentation Good.

1. There is no evidence on the file of this descent being the parachutist's 30th descent. It is just introduced straight into the relevant events.
2. An investigators note giving a resume of the parachutist's training, experience, performance, attitude etc would have been a good piece of evidence to have in the report.

Analysis

Satisfactory.

CA Form 149A ✓

Contraventions Nil.

CAUSAL FACTORS

Agreed. 'I would have wanted it... failed to take timely action to jettison his main parachute and deploy his reserve parachute!'

Date 19.8.75

Signature

[Handwritten Signature]



AIRCRAFT ACCIDENT INVESTIGATION SUMMARY REPORT

AS/742/1044

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

1. LOCATION OF OCCURRENCE

	Height a.m.s.l.	Date	Time (Local)	Zone
Wilton, New South Wales	200 feet	18.8.74	1340	EST

2. THE AIRCRAFT

Make and Model	Registration
Cessna P206	VH-PQD

3. CONCLUSIONS

- (i) At 1340 hours EST on 18 August, 1974, a parachutist was fatally injured on impact with the ground following a free fall parachute descent at Wilton, N.S.W.
- (ii) The parachutist, Sandor Salamon, aged 48 years had previously made 38 jumps including a free fall descent from 8000 feet on the morning of the day of the accident. The morning jump was to practice varying the rate of descent by altering the body position. This jump was in preparation for relative work and it was the fatal jump that was the first attempt at a relative descent.
- (iii) Mr. Salamon was progressing through the requirements of the Australian Parachute Federation to qualify him for an 'A' licence. The successful completion of his fatal descent would have fulfilled the 'A' licence training program.
- (iv) The parachutist was using a Russian manufactured ^{UT} ~~V~~15, Series 2, main parachute and harness which he had recently purchased. This chute had been used on six previous occasions, Mr. Salamon being the user on three of these occasions. The reserve parachute was a flat circular 24 feet diameter parachute owned by the Wilton Parachute Centre. The parachutist had used this equipment on his morning descent with no apparent difficulty. After this descent the parachute was re-packed by a very experienced parachute packer who holds an Australian Parachute Federation parachute packing instructor rating and who had packed this type of parachute on many previous occasions.
- (v) The weather conditions at the accident site were fine and clear. Visibility was in excess of 30 kilometres, there was no significant cloud and the wind was a light north-westerly. Weather is not considered to have had any bearing on the accident.
- (vi) The descent on which the accident occurred was made from a Cessna P206, registered VH-PQD which was flown by Walter Sitzwohl, the holder of a valid Private Pilot Licence. Also on board were four other parachutists, Nigel Longhorn, Phillip Mackin, Laurie Roy and Glenn Bush with whom the relative descent was to be made.
- (vii) Two of the parachutists, Roy and Bush were despatched on dropping runs at 5500 and 6500 feet respectively. The aircraft then climbed to 8000 feet where the remaining three parachutists made their exits. Two of them, Longhorn and Salamon, left the aircraft simultaneously while Mackin exited three seconds later. The attempted relative link between Longhorn and Salamon was almost successful, however, when they had not linked by the time they had descended to 4000 feet, Longhorn gave the separation signal. At this stage the parachutists were about four feet apart.
- (viii) During the latter part of the free fall descent parachutist Mackin was level with Salamon and Longhorn and about 500 yards from them when they took deployment action. In accordance with normal procedure Salamon and Longhorn turned away from each other on Longhorn's separation signal. Salamon was stable and adopted the correct attitude to prepare for the main parachute deployment. All three parachutists pulled their main parachute ripcords at a height of approximately 2500 feet.
- (ix) Salamon's parachute was observed to extend fully from the pack, but the canopy, which was squidding, failed to inflate. The main parachute canopy was not released until the parachutist had descended to a height estimated by witnesses to have been between 600 and 1000 feet above ground level. Several more seconds elapsed after the main parachute canopy was released before the reserve parachute commenced to deploy but by this time the parachutist was very close to the ground. He struck the ground before deployment of the reserve parachute was completed.
- (x) Examination of the main and reserve parachutes after the accident revealed no unserviceability nor ~~was there any~~ indication of any packing error. It was noted at the accident site that the parachutist had secured the main parachute ripcord handle inside the front of his double zippered jumpsuit. ^{To do this he would have had to unzip the jumpsuit.} He pushed the ripcord handle inside the suit and then re-fastened the zip fastener. This time consuming action undoubtedly robbed the parachutist of time he could otherwise have used in completing his emergency procedures. The parachutist was known to be very concerned about the security of this ripcord as there was no spare available to him. He had lost the ripcord during a descent on the weekend prior to the accident and had spent one and a half days looking for it.

4. OPINION AS TO CAUSE

The cause of the accident was that following failure of the main parachute to function properly, the parachutist failed to take timely action to jettison the main parachute and deploy the reserve parachute.

Approved for
publication

I.M. LESLIE
Delegate of the Secretary

Date

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