CHECK SHEET - CONLUSION PROCESSING

FILE REF: 6.7.2.1045

ACTION	DATE	OFFICER
REVIEW COMPLETED	12.9.75	S.G. SPINKS SUG 4
CONCLUSIONS SUBMITTED		
CONCLUSIONS APPROVED		
DRAFT PROOF READ		
DRAFT TO PPC		
PRINTED CONCLUSIONS FROM PPC		
CONCLUSIONS DESPATCHED TO REGION		

4. OPINION AS TO CAUSE

The cause of the accident was that following a malfunction of his main canopy, the parachutist adopted an incorrect technique for deploying the reserve parachute.

Approved for publication	(I.M. LESLIE) Delegate of the Secretary	Date

AIR SAFETY INVESTIGATION REPORT REVIEW

Aircraft Type - Registration Parachute accident File Reference 6.742.1045

Place and Date Wilton NSW 1.9.74 Investigator S. LENNOX

INVESTIGATION Operations - Engineering - Aviation Medicine -

1. There is plenty of eyewitness evidence to this accident so the investigation has been able to obtain a clear picture of what happened.

2. However, I think there is one important piece of evidence missing and that is a detailed history of the parachutists experience. We know that he had nearly 400 jumps and about 200 of them using the equipment he was using when the accident occurred.

REPORT

Evidence Presentation It may have helped to know how many previous malfunctions he had experienced and how he had reacted. This may have been his first malfunction.

3. The point is that there is no logic as to why he adopted incorrect emergency procedures when he had plenty of altitude to play with. He was an experienced ~~Analysis~~ jumper & an instructor & would have been used to teaching emergency procedures to others but this may have been the first real life malfunction he had met.

Analysis The analysis launches straight into what the equipment examination disclosed yet there is no evidence of an equipment examination in the report. Similarly there is no evidence re ~~CA Form 149A~~ APF emergency procedures which are referred to on the 149A (section 7). I have confirmed that these are recommended procedures with GAFSS.

Contraventions

CAUSAL FACTORS Agree.

Date 11.9.75 Signature

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.742.1045

1. LOCATION OF OCCURRENCE

	Height a.m.s.l.	Date	Time (Local)	Zone
Wilton, New South Wales	700	1.9.74	1120	EST

2. THE AIRCRAFT

Make and Model	Registration
Cessna 182K	VH-KRE

3. CONCLUSIONS

(i) At approximately 1120 hours EST on 1 September 1974 a parachutist was fatally injured by impact with the ground following a free fall descent at Wilton, New South Wales.

(ii) The parachutist Garry Evan Richards was making his 391st jump and it was his third jump for the day when the accident occurred.

(iii) The main parachute was a Para-Plane Cloud which the parachutist, as an experienced packer, had packed himself. The reserve parachute was a 26 feet Super Steerable canopy. The main parachute used by the parachutist in this accident is a high performance chute on which malfunctions are not uncommon. Richards had made approximately 200 jumps with this type of parachute prior to the accident.

(iv) Weather conditions at the accident site were fine and clear with about $\frac{3}{8}$ cumulus cloud, base 5000 feet and a very light westerly wind. Weather was not a factor in this accident.

(v) The descent was made from a Cessna 182K aircraft registered VH-KRG which was flown by Maurice William Notley, the holder of a valid Private Pilot's Licence. On board the aircraft were three other parachutists; Ross Millard, Norman Casey and Phillip Onis.

(vi) The aircraft took off from Wilton and climbed to 3000 feet for an accuracy jump exercise. Richards was the first to leave the aircraft and his manner of exit is reported to have been normal. The aircraft then made two further circuits, one parachutist jumping on the first and two jumping on the second at a three second interval.

(viii) After a free fall of about four seconds, Richards activated his main parachute but only one side of the canopy deployed. This resulted in a fairly fast anti clockwise rotation as seen from the ground. After about five seconds the main canopy was cut away. At this time the parachutist was at about 2500 feet and was still spinning anticlcokwise in a face down attitude.

(viii) After falling for a further three seconds the pilot chute of the reserve parachute was seen to spring out. When Richards activated the reserve parachute he was facing towards the ground and falling flat. He then tumbled forward onto his back. At this stage it was observed that the pilot chute was fully inflated but did not appear to be pulling the reserve parachute out. The parachutist then started tumbling head over heels and was moving his arms as if to pull the parachute away from his body. Between 1800 feet and 1000 feet the parachute started leaving his body but did not get completely away. From the ground it was evident that the reserve parachute was caught in the parachutists equipment. Richards was now falling on his back in a slow left hand spin

He remained in this position until impact with the ground. All the way down he appeared to be searching for where the reserve parachute was caught in his equipment.

(ix) Examination of the main parachute at the accident site revealed that several of the reefing tabs and rings of the right hand side of the canopy had passed through the retardation bridle orifice in the ~~parachute pack~~ deployment bag. No reason could be found as to why this had happened. On site examination of the reserve parachute showed that the No.5 gore had caught in the open left hand cape-well release. The bulk of the reserve parachute was on the left of the parachutist's body. The trapping of the gore and the position of the canopy were consistent with activation whilst the parachutist was face down and spinning to his right. This in turn was consistent with ground witness descriptions of the descent.

(x) In their emergency procedures the Australian Parachute Federation stress the need to guard open capewells and also stress the merits of releasing front mounted canopies from the face up position.

4. OPINION AS TO CAUSE

The cause of the accident was that following a malfunction of his main canopy, the parachutist adopted an incorrect technique for deploying the reserve parachute.

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