British Parachute Association

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Safety & Training Committee

Minutes of the meeting held on

Thursday 24 September 2015 at 1900

at the BPA Office, 5 Wharf Way, Glen Parva, Leicester LE2 9TF

Present:	John Hitchen	-	Chair STC
	Pete Sizer	-	Skydive Headcorn
	Mark Bayada	-	APA
	Jay Webster	-	Go Skydive
	Ray Armstrong	-	Skydive GB
	Mike Rust	-	SCC Ltd
	Gary Stevens	-	LPS
	Brucie Johnson	-	BSFC
	Bryn Chaffe	-	Skydive St George
	Alex Busby-Hicks	-	Skydive Tilstock
	Paul Yeoman	-	Black Knights
	Andy Guest	-	Skydive Buzz Ltd
	Ian Rosenvinge	-	Peterlee
	Richard Wheatley	-	BPS, Langar
	Dennis Buchanan	-	Skydive North West
Apologies:	Jeff Montgomery, Iain Anderson, Martin White, Matty Holford Noel Purcell, Paul Floyd, Nader Afsharian, Kieran Brady, Phil Collett, Mally Richardson		
In Attendance:	Tony Butler	-	Chief Operating Officer (COO)
	Paul Applegate	-	Chair Riggers' Sub-Committee/Council
	Dr John Carter	-	BPA Medical Adviser
	Trudy Kemp	-	Assistant to COO/STC
Observers:	Steve Saunders, Richard Barron, Gordon Blamire.		

Declarations of interest

The Chair invited declarations of interest relating to items on the agenda for this meeting. None were stated.

ITEM MINUTE

1. MINUTES OF THE STC MEETING OF THE 30 JULY 2015

It was proposed by Brucie Johnson and seconded by Mark Bayada that the Minutes of the STC Meeting of the 30 July 2015 be accepted as a true record.

Carried Unanimously

2. MATTERS ARISING FROM THE STC MEETING OF THE 30 JULY 2015

Page 1. (Item 2 –– Matters Arising - Age Working Group). The Working Group was continuing with their work. Mark Bayada (WG Chair) gave the meeting a brief update of their progress to date.

With regard to medical requirements, the WG are looking at introducing a system of medical self-declarations for all ages and categories of parachutist with the exception of Tandem Instructors who would still require a Doctor's Certificate. The WG are liaising with Dr John Carter (BPA Medical Adviser), and any proposed changes would also depend on input from the BPA Insurers and their legal representatives.

Page 2. (Item 2 –– Guidelines for Tracking and Angle Flying). Paul Floyd had sent his apologies for this evening's meeting. The Chair reported that Paul Floyd had drafted a suggested proposal for Tracking being included in the Grading System, which had been circulated with the STC Minutes. The COO had made some minor amendments to that draft, which had been distributed with the Agenda. The COO asked for comments and input on the latest draft, as this item would hopefully be included as a proposal on the next agenda.

Page 2. (Item 2 –– Tandem Working Group). The COO reported that the Tandem Working Group had now been formed and has 10 members, from Examiners, CIs, Advanced Instructors and very experienced Tandem Instructors. He stated that the WG would look at all aspects of Tandem parachuting. He stated that their first meeting is scheduled for October and that STC would be kept informed of their progress.

3. RIGGERS' SUBCOMMITTEE MEETING OF THE 30 JULY 2015

Paul Applegate (Chair, Riggers' Sub-Committee) was asked for a progress report on the various issues surrounding reserve loops on Next and Next Century Tandem Systems.

Paul reported that the Committee had been advised of damage found on a reserve loop on an Aircare Tandem rig. He stated that investigations were being carried out as to what may have caused the damage. In the meantime, Nicky Johnston had written to Aircare Tandem rig owners, recommending that all reserve loops are inspected every 50 jumps.

Mike Rust reported that he had been trialling the prototype pilot chute that Paratec had produced in an effort to help reduce the wear on the reserve loops.

Paul Applegate stated that he would ask Kim Newton (WG Chair) for a progress report for the next meeting.

Mark Bayada expressed some concern with regard to a set of Student equipment that he had come across on a recent Instructor Course. He stated that in his opinion the equipment had been badly manufactured.

Several CIs commented that there was no control on the way some Student equipment was manufactured or who manufactures it. CIs believed that this was perhaps a matter for the Riggers Sub-Committee to consider.

It was proposed by Pete Sizer and seconded by Bryn Chaffe that the Minutes of the Riggers' Sub-Committee meeting of the 30 July 2015 be accepted.

Carried Unanimously

Paul Applegate reported on the meeting held that afternoon and stated that the Committee had accepted the wording that Pete Sizer had suggested to the Riggers Technical Manual regarding Soft Links. This had come about as a result of the decision at the previous meeting that only connector links (soft or metal) approved by the canopy manufacturer may be used on reserve canopies.

Paul stated that a BPA Safety Information Bulletin would be generated to publicise the amendment to the Riggers Technical Manual.

4. FATALITY - DUNKESWELL

The Chair reported that unfortunately, there had been a fatal accident at Skydive Buzz, Dunkeswell on the 31 July 2015. This was the first skydiving fatality in the UK for more than two and a half years. He stated that the Board of Inquiry Report resume had been circulated to CIs with the agenda. The resume was also tabled to those present.

At approximately 13.55 hrs on Friday 31 July 2015 at Skydive Buzz, Dunkeswell Airfield, Dunkeswell, Devon, EX14 4LG, Christopher Jones boarded a Beech 99 aircraft along with fourteen other parachutists. This was to be the eighth lift of the day. The aircraft climbed to approximately 3,500ft AGL. Two 'jump runs' were made over the centre of the PLA. Once the aircraft was at the correct Exit Point Christopher Jones dispatched three Student (static line) Parachutists, two on the first pass and one on the second. The aircraft then climbed to approximately 6,000ft AGL where he exited the aircraft, followed a few seconds later by a Student Parachutist, who was dispatched by the second nominated jumpmaster. The aircraft then climbed to approximately 15,000ft AGL where the remaining 10 parachutists exited.

Christopher Jones was carrying out a short freefall delay jump of approximately twenty seconds, in order to have his parachute open between 3,000 - 2,500ft AGL. His parachute was seen to open very quickly. The parachute was then observed to be turning to the right. The parachute continued to turn, gradually increasing in speed during the decent. Christopher Jones' arms appeared to be at his sides and not raised controlling the parachute. He remained in that position until he impacted heavily with the ground.

A BPA Board of Inquiry was immediately instigated. The members of the Board were; Tony Butler – Chief Operating Officer and Jeff Montgomery – BPA Safety & Technical Officer.

Christopher Jones was 61 years of age. He was a 'D' Licenced parachutist and Category System Instructor with 1,021 descents prior to the accident.

When examining the equipment it was noted that the main parachute had been fully deployed. There were no twists in the rigging lines and it had been rigged correctly. The left hand steering/brake toggle had been released from its keeper. This most probably occurred upon deployment of the main parachute. The right hand toggle was still secured in its keeper. The retaining loop which closed the container, housing the reserve parachute, had broken allowing the container to open, exposing the reserve parachute deployment bag. The RSL was also unclipped. It is likely that these occurred on impact. It was also noted that the AAD had not activated, though it was still switched on, indicating that the descent of Christopher Jones under the main parachute was not fast enough to activate the AAD. The Board found no fault with the equipment and it appeared to be in an airworthy condition.

The conclusions of the Board are that Christopher Jones dispatched three Student Parachutists at approximately 3,500ft AGL without incident. The aircraft then climbed to approximately 6,000ft AGL where he exited. He carried out a freefall delay of approximately twenty seconds. At which time he deployed his main parachute. Christopher Jones experienced an almost instant opening of his main parachute. This would likely cause an extremely hard opening, which may have rendered him unconscious or semi-conscious. Christopher Jones had packed his own main parachute.

The reason for the fast hard parachute opening was probably due to the way in which it had been packed. Christopher Jones had experienced a hard opening the past, which resulted in rigging lines braking. Because of the fast hard opening it is likely that the opening shock caused the left steering/brake toggles to release, which resulted in the parachute turning to the right. The speed of the rotation would have increased during the parachute descent, resulting in fast and heavy impact with the ground.

The Recommendation of the Board is that parachutists should be reminded of the importance of packing their parachutes in a manner to minimise the likelihood of openings that could cause injury to the parachutist or damage to the equipment.

The COO was present at the meeting and was able to answer any questions relating to the Report.

Ian Rosenvinge made an observation with regard to the various recommendations in Board and Panel Reports being lost in time. He suggested that the BPA may wish to consider promulgating a poster highlighting the recommendation in this particular Report.

The COO stated that he would look into this.

It was proposed by Alex Busby-Hicks and seconded by Gary Stevens that the Board of Inquiry Report, including the conclusions and recommendation be accepted.

Carried Unanimously

The Chair stated that it is BPA Council policy that a Panel of Inquiry is formed to investigate peripheral aspects of a Board of Inquiry following a parachuting fatality. However, in this instance the Board believe that it is not necessary and recommend that a Panel is not instigated.

It was proposed by Mike Rust and seconded by Jason Webster that a Panel of Inquiry not be instigated.

Carried Unanimously

5. INCIDENT/INJURY REPORTS – RESUME

i) There had been 11 Student Injury Reports received since the last STC meeting. 8 male and 3 female. One student dislocated a shoulder reaching for the steering toggles. The remaining injuries were on landing.

ii) Since the last meeting there had been 20 Injury Reports received for 'A' Licence parachutists or above. 14 male and 6 female. One report was a freefall collision' where a cameraperson landed on his 4-way team, tearing a muscle in his arm and another was a cameraperson who dislocated her arm on exit. One report involved a low turn injury to a jumper with 745 jumps. He was practising high performance landings and was badly injured and was in intensive care for period. He is now making a recovery. Another serious injury was to a competitor at the CP Nationals.

iii) There had been 7 Student Malfunction/Deployment Problem Reports received since the last meeting. 4 male and 3 female.

iv) There had been 59 Malfunction/Deployment Problem Reports received for 'A' Licence parachutists or above. 53 male and 6 female. 5 were on wingsuit jumps.

v) Since the last STC there had been 18 Tandem Injury reports received. 7 male and 11 female. These included one where the Tandem student felt faint under canopy. 2 where the students hurt their necks on deployment. 2 where the students were hard to control in freefall, causing very minor injuries to the students and one minor injury to the Instructor. There was also an incident where the Tandem pair had an off landing and because the Instructor was concentrating on the landing area and forgot to use the secondary handles for landing. This resulted in a heavy landing and the Student breaking her ankle.

vi) There had been 22 Tandem Malfunction/Deployment Problem reports received.

vii) A report had been received of a Tandem hang-up. The Tandem Instructor fitted the aircraft restraint when he boarded the Cessna Caravan, however he forgot to unhook the release on the way to altitude. The Tandem pair exited the aircraft at altitude still attached by the restraint and were hung-up just outside the door. One of the camerapersons on board immediately saw the problem and cut the restraint webbing, releasing the pair, who continued the jump without further incident. Upon investigation it appears that at some time previously to the lift in question, someone had moved the restraint further down the aircraft, closer to the door, which allowed the Tandem pair, who were first out of the aircraft, to get as far as the door without the restraint stopping them. It is quite easy to move the restraints in some Cessna Caravans. Procedures have now been put in place to ensure that restrained jumpers cannot get as far as exiting the aircraft if they are still restrained. Also, further checks are now part of aircraft procedures.

The COO stated that those Clubs that operate Cessna Caravans may wish to note that some of the restraints are easy to move up and down the cargo rail and sometimes the jumper may move them especially if they feel that it is a bit tight without informing anyone. This appears what to have happened in this instance. The COO suggested that CIs may wish to consider having a system in place whereby the restraints can't be moved up and down by the jumpers themselves.

viii) One report had been received of an AAD fire. A wingsuit jumper with 263 jumps could not find the deployment toggle at opening height. His arm/hand got caught in the suit wing. However he continued to try to locate the toggle (hackey-sack) until his Cypres AAD fired. He made no attempt to deploy his reserve.

The CI of the PTO where the jump took place was able to give further details. He stated that the jumper concerned had been given a wingsuit by a BPA Roadshow Coach. The jumper had not carried out any dummy pulls prior to the jump. The CI has spoken to both the jumper and coach concerned.

Wingsuit Coaches should be aware that when lending out their wingsuits to another jumper, they should make them aware of any possible difference in handle location etc.

ix) There had been 23 'off landings' reports received since the last meeting. One on a display and the rest at PTOs.

x) Eighteen reports had been received of items coming off jumpers or being dropped, on exit, in free fall and under canopy. 1 camera, 2 Tandem leather helmets, 7 helmets, 3 trainers, a student radio, a flag, an altimeter, a pair of ski goggles and a Tandem student threw a pair of gloves away to get a better grip of her jumpsuit legs for landing.

xi) There had been 4 reports received involving aircraft. One has already been mentioned – the Tandem Hang-up. One involved a Twin Otter, where a 'top hatch' (a small escape hatch of around 18 inches) blew off the aircraft at approximately 6,000ft AGL. The aircraft landed with all on board. There was no damage to the aircraft and the police were informed. Another report involved a G92 which suffered a loss of electrical power to the radios on climb up at approximately 4,000ft AGL. The aircraft landed with all on board. The final report was a PTO who encountered severe chatter on 129.90 effecting parachuting operations. It appeared to be a formation/acrobatic team who when contacted claimed it was a 'company frequency'.

6. TANDEM INCIDENT PANEL OF INQUIRY

The Chair reported that a Tandem incident involving Stephen Howes at UK Parachuting, Sibson, resulted in a Panel of Inquiry being formed. The Panel Report had been circulated with the Agenda.

The Panel was chaired by Richard Wheatley and the other members were Noel Purcell and Hans Donner.

The BPA STO was informed on 31 July 2015 by the CI of UK Parachuting, Sibson, Chris McCann, of an incident which had occurred on that day, involving Tandem Instructor Stephen Howes.

The instructor concerned had carried out a Tandem descent with a Tandem student. He had failed to hook up both of the top two hooks of the student Tandem harness before take-off and did not hook them up until approximately 7000 feet AGL. After realising his mistake, he hooked up his student and proceeded with the rest of the skydive without incident.

Following the incident Chris McCann grounded Stephen Howes from Tandem jumping at Sibson. Following the reporting of this incident to the BPA, it was decided to suspend the instructor's Tandem Instructor's rating until the next STC meeting on 24 September 2015.

A Panel of Inquiry was instigated to investigate breaches of the BPA Operations Manual and any possible breaches of Sibson's SOPs.

Whilst investigating it was discovered that the instructor also failed to carry out his 'systems checks' in freefall and that there was no evidence that he had practiced his Tandem Reserve Drills in the 2 months prior to the jump.

The Panel concluded that Stephen Howes had breached the following Operations Manual requirements:

- Section 10 - *Safety*, Paragraph 1 - *Safety in the Aircraft*, Subparagraph 10:

1.10. All Student Tandem Parachutists, or parachutists acting as Student Tandem Parachutists are to be attached to the Tandem Instructor before take-off and must remain attached, except in the event of an aircraft emergency landing, where Tandem Instructors may have to separate from their Students inside the aircraft.

- Section 10 - *Safety*, Paragraph 4 - *Safety in Freefall*, Subparagraph 6:

4.6. Tandem Instructors should conduct a systems check after the drogue is deployed; check drogue is inflated, then check handles.

- Section 4 - *Instructors*, Paragraph 5 - *Tandem Instructor Currency*, Subparagraph 8.3:

5.8.3. All current TIs must have practised Tandem Reserve Drills in a suspended harness within the previous 2 calendar months. The harness handle configuration must be as per the equipment to be used. It is the responsibility of the TIs to ensure that the reserve drills are observed and signed for in their log book by a CI, or CI nominated TI.

The Panel also noted that the CI, Chris McCann had a Tandem Currency Record sheet, though the sheet was considerably out of date. No supporting evidence that Stephen Howes' drills were in date during 2015 could be provided. At the time of the Panel's visit to UK Parachuting, Sibson, a BPA Audit was also being completed and the Panel noted that the inaccuracy of this record sheet was also being considered by the audit personnel.

The Panel noted that Stephen Howes came across as being a very open and honest about the incident. The Panel considered it to be commendable that it was he himself that had immediately reported the incident to his CI upon landing.

The Conclusions of the Panel were that what could have become a very serious incident was prevented by the Tandem Instructor realising his error and subsequently correctly attaching the student harness to his own. However, ultimately, it is the responsibility of the Tandem Instructor to ensure the full safety of their student at all times and ensure the full application of all BPA rules appertaining to the type of jump they are completing. In this respect, Stephen Howes failed in his duties on this jump.

It was noted that it was Stephen Howes himself that immediately reported this incident to his CI and that it is possible that without his honesty this incident may have passed unnoticed.

The Panel also considered that, as per in another recent Tandem incident at a different PTO, there may have been the opportunity for others on board to have prevented the take-off of the aircraft whilst the Tandem student was not fully attached to Stephen Howes. It is appreciated that Stephen Howes was sitting directly near the pilot and therefore the view of the harness hooks would have been very restricted. From some locations further down the aircraft, even with good observation, it would have been difficult to see that the student was not fully attached to the instructor. However, the incident, once again, highlights the need for vigilance by all jumpers on board.

The Panel was concerned that the investigation uncovered two further breaches of the BPA Operations Manual in respect of the completion and recording for suspended harness drills and the completion of in freefall drills. It is clear that it is the responsibility of the Tandem Instructor to complete suspended harness drills and record them. The Panel also considered that the centre's lack of up to date records did nothing to prevent Stephen Howes from jumping whilst these drills were out of date.

Stephen Howes appeared to be fully aware that in freefall drills were required as both part of the centre's SOP's and the BPA Operations Manual. He could provide no reason as to why these drills were not completed on this particular jump.
This is an incident which fortunately did not result in an injury or worse. The honesty and the openness shown to the Panel by Sibson staff, the CI and Stephen Howes was appreciated and have allowed this incident to be dealt with in a timely manner. It is to be commended that an incident that could easily have not been reported was dealt with appropriately and openly.

The Recommendations of the Panel based on the conclusions drawn from evidence and interviews regarding Stephen Howes are:

a. Stephen Howes has his Tandem Instructor rating suspended for four months from the date of the incident. After such a period he should complete a Tandem currency jump as required in the BPA Operations Manual. This jump should be videoed and should clearly show all required drills being carried out. Once this jump is completed to the satisfaction of his CI he may return to completing Tandem Instructional jumps. The BPA COO and/or the STO should be informed when the currency jump has been completed.

b. Stephen Howes be written a letter by the BPA COO and/or STO reminding him of his responsibilities as a BPA Tandem instructor. Particular mention should be made to the need for constant vigilance when carrying out any jumps with students as well as the importance of completing the required freefall checks laid out in the BPA OM. It should also note the importance of personal record keeping for procedures such as suspended harness drills.
A copy of this letter should remain on file at the BPA.

The Panel made the following recommendations regarding Chris McCann:

That Chris McCann (CI) is reminded in writing by the BPA COO and/or STO of his responsibilities as Chief Instructor and a Tandem Instructor Examiner, to ensure that all Tandem Instructors at UK Parachuting, Sibson, are not only current with their suspended harness drills but that the completion of these drills are adequately recorded.

The Panel also made the following general recommendations:

a. That the recently formed BPA Working Group which is to look at all aspects of Tandem jumping consider the following:

   i) The production and adoption of a pre take-off systems check to ensure all hooks are attached. This may be introduced into the Tandem Safety Brief and include the student being asked to confirm that they are fully attached prior to take off. A similar system is currently in use with Static Line students where they verbally and physically confirm the attachment of their Static Line to the aircraft prior to the aircraft taxiing.

   ii) Does the role of the Jumpmaster need to be updated or changed when Tandem jumpers are on board? Should an independent check be taking place prior to taxiing the aircraft?

   iii) Consider the production of a standard record sheet that is retained by the PTO for each Tandem Instructor to ensure suspended harness drills are recorded. When electronic logbooks are used by Tandem Instructors, should a duplicate of this record sheet also be retained by the Instructor?

b. All Chief Instructors should encourage maximum vigilance by all qualified jumpers on board the jump aircraft to ensure that all safety procedures are applied. It may be appropriate for the BPA to consider producing a poster for BPA PTO's to display.

The Chair reported that both Stephen Howes and Chris McCann accept the Panel's recommendations with regard to them.

The Chair stated that Richard Wheatley (Panel Chair) was present at the meeting, should CIs have any questions regarding the Report.

Mike Rust stated that he was surprised that the Tandem Instructor concerned was not present that evening, as he would have liked to have had the opportunity of asking him a number of questions.

Mark Bayada stated that he felt that Stephen Howes' Tandem currency jump should be overseen by an Independent Examiner and that this maybe something that future Panels may wish to consider.

The COO stated that both himself and the STO would liaise with the CI concerned prior to the currency jump taking place.

It was proposed by Brucie Johnson and seconded by Ray Armstrong that the Panel Report including the Panel Recommendations be accepted.

Carried Unanimously

The Chair expressed his thanks to the Panel for their Report.

7. INSTRUCTOR COURSES

a. Instructor Course 3-2015

The Association wished to thank Skydive Headcorn, for hosting the course, which took place from the 10 – 21 August 2015. The course report had been circulated with the agenda and was for information only.

b. AFF/Tandem/Pre-Advanced Instructor Assessment Course

The Association also wished to thank British Parachute Schools, Langar, for hosting the course, which took place from the 7 – 20 September 2015. The course report had been circulated with the agenda and was for information only.

Following further consideration, it was proposed by Ray Armstrong and seconded by Alex Busby-Hicks that once Ray Armstrong was satisfied with the canopy, it may be used for general parachuting and that Phil Wayper be permitted to jump the canopy.

Carried Unanimously

iii) Bryn Chaffe asked for an update regarding the CAA's proposal for the deregulation of sport parachuting in the UK. The COO was able to provide information on the current situation.

Date of next Meeting: Thursday 19 November 2015
BPA Offices, Glen Parva, Leicester. LE2 9TF
at 7.00 p.m

28 September 2015

Distribution: Chairman BPA, Council, CIs, All Riggers, Advanced Packers, CAA, Editor – Skydive, File