British Parachute Association

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STC COMMITTEE

Minutes of the meeting held on
Thursday 5 August 2010 at 1900
at the BPA Office, 5 Wharf Way, Glen Parva, Leicester LE2 9TF

Present:	John Hitchen	-	Chairman STC
	John Page	-	Skydive London
	Pete Sizer	-	Headcorn
	Paul Hollow	-	Target Skysports
	Richard Wheatley	-	BPS, Langar
	Steve Scott	-	Skydive Weston
	Ray Armstrong	-	Skydive GB
	Jason Thompson	-	UK Para (Beccles)
	Chris McCann	-	UK Para (Sibson)
	Mike Rust	-	NLPC
	Matty Holford	-	Silver Stars
	Alex Busby	-	Tilstock
	Paul Applegate	-	Chairman Riggers
Apologies:	Nigel Allen, George McGuinness, Andy Clark, Dave Wood, Andy Goodall, Kieran Brady, Jason Farrant, Stuart Meacock.		
In Attendance:	Tony Butler	-	Technical Officer
	Trudy Kemp	-	Assistant to NCSO/TO
Observers:	Damian Hewitt, Jez Shazell, Dave Major, Colin Fitzmaurice, Rick Boardman, Instructor A.		

ITEM **MINUTE**

1. MINUTES OF THE STC MEETING OF THE 10 JUNE 2010

It was proposed by Matty Holford and seconded by Richard Wheatley that the Minutes of the STC Meeting of the 10 June 2010 be accepted as a true record.

Carried Unanimously

2. MATTERS ARISING FROM THE STC MEETING OF THE 10 JUNE 2010

Page 1, Item 2, Matters Arising – Incident Reports. The Chairman reported that Kieran Brady the Chairman of the Working Group looking into the qualifications and training of pilots flying foreign registered aircraft had sent a letter to CCIs and CCPs following the last STC requesting input. He stated that so far there had been very little response, but it was hoped that the Working Group would have some proposals in the near future.

Page 2, Item 2, Matters Arising – Proposed Changes to the BPA Operations Manual. The TO reported that at the last STC the meeting was advised that the British Citizen who had a foreign Tandem rating, had been permitted to be evaluated under the previous rules. The TO advised those present that he had since informed the person concerned that he had up to six months in which to be evaluated.

The TO stated that in his opinion he believed there needed to be a specific time limit on this in the same way that Instructors, Riggers Packers etc had to renew their annual ratings. He asked STC if they had any objection to this. There was no objection raised by those present.

Page 2, Item 4, Fatality – Langar. The fatality report resume was a main agenda item for that evening.

3. MINUTES AND MATTERS ARISING FROM THE RIGGERS' SUB-COMMITTEE MEETING OF THE 10 JUNE 2010

There being no matters arising from the previous Minutes, it was proposed by Paul Applegate and seconded by Pete Sizer that the Minutes of the Riggers' Sub-Committee meeting of the 10 June 2010 be accepted as a true record.

Carried Unanimously

Paul Applegate then reported on that evening's meeting and stated that Riggers had discussed a malfunction/deployment incident where it had been found that the safety pin had punctured the main bridle, locking the pin and bridle around the closing loop, causing a pilot chute in tow type malfunction.

The CCI of the Centre concerned reported that the same problem had arisen on two successive weekends to the same jumper on the same set of equipment. He stated that on the first incident the container did clear as the jumper pulled the reserve, but on the second incident it stayed in place and the jumper landed with the pilot chute in tow

Paul Applegate stated that the Riggers Committee had felt that these incidents may have occurred due to a packing problem rather than a manufacturers problem. However, it had been noted that a contributing factor may be if the main container was closed without leaving enough slack in the bridle between the closing pin and the main container flaps above the pin, the closing pin could possibly pierce the bridle after the pilot chute is thrown, which could lock the container closed. This appears to occur when there was little or no slack in the bridle between where it exits the container and goes to the pin, when the pin is oriented towards to top of the container and when the bridle completely covers the pin.

This problem had been noted in the USA on other equipment and they put it on their list of problems to look out for.

The Committee felt that this was something that packers should be aware of and was some thing to look out for during flight line checks.

4. FATALITY – BPS, LANGAR

The Chairman reported that the Board of Inquiry Report Resume into the fatal accident involving Brian Laithwaite and Emma Bramley had been circulated to CCIs with the agenda.

At approximately 15.00 hrs on Friday the 4 June 2010, Brian Laithwaite an FAI 'D' Certificate (Blue) parachutist, with 1,852 jumps and Emma Rachael Bramley, an FAI 'C' Certificate parachutist, with 254 jumps, boarded a Cessna 208 'Caravan' aircraft operated by British Parachute Schools along with twelve other parachutists; a 6-way group, which both Brian and Emma were part of, a 3-way group, a 2-way group, a solo parachutist and an instructor with a Student parachutist. Brian Laithwaite was the Jumpmaster for the lift. It was the eighth lift of the day.

The aircraft climbed to approximately 13,000ft AGL. A 'jump run' was made over the PLA. Once the aircraft was at the Exit Point, the parachutists on board exited. First to exit were the 6-way group, followed by the 3-way and the 2-way groups, after which the solo parachutist exited and finally the instructor with his Student.

The 6-way group in which Brian and Emma were both part of were carrying out a FS type of jump. The freefall portion of the jump went without incident. At approximately 4,500ft AGL the

parachutists separated and deployed their parachutes. All parachutes were open higher than 2,000ft AGL and all parachutes appeared to be fully deployed. Shortly after deployment Brian's and Emma's parachutes were seen to collide. It appeared that Emma's parachute initially wrapped around the lower part of Brian's body, which caused it to collapse and become further entangled.

Emma was seen to be rotating below Brian. At about this time a reserve parachute was observed to have been deployed, but did not inflate. The only fully inflated parachute to be seen was Brian's main parachute. The other parachutes appeared to be severely entangled.

Initially Brian's main parachute was observed to be fully inflated, but was rotating. At a height of between 100-200ft AGL Brian's parachute appeared to dive towards to ground and remained in that configuration until impact.

A BPA Board of Inquiry was immediately instigated and consisted of the NCSO and Technical Officer.

Brian's main canopy was a PD Stiletto 150 and Emma was jumping a Aerodyne Pilot 150.

On examination of the equipment the following was noted; Brian's main canopy was fully deployed and was still attached to the parachute harness. It was noted that the two reserve canopies were out of their parachute containers, one fully out of its deployment bag and the other only partially out of its bag.

Both Brian's main parachute cutaway pad and reserve parachute ripcord handle were in situ and had not been activated. The steering toggles on both the main and reserve parachutes were stowed in the half brake configuration.

Emma's main canopy had been deployed and was still attached to the parachute harness, but was severely entangled with the reserve parachutes.

Emma's main parachute cutaway pad was not attached to its Velcro keeper and the Teflon cables were still within the cutaway housing, but had extracted by approximately 2 inches. The Main canopy release had not been activated. Her reserve parachute ripcord handle was missing. The steering toggles on both the main and reserve parachute were stowed in the half brake configuration.

The reserve parachute that had fully extracted from its deployment bag was part of Brian's equipment and the reserve parachute that had only partially extracted from its deployment bag was part of Emma's.

The reserve parachute bridle lines and deployment bags of both reserve parachutes were entangled around the Emma's main parachute and the main parachute bridle line and deployment bag from Emma's equipment had passed through the rigging lines of Brian's reserve canopy.

All parachutes excluding Brain's main parachute were extensively entangled.

All parachutes had been rigged correctly and appeared to be in an airworthy condition.

The Conclusions of the Board were that both Brian and Emma made an uneventful free fall descent. They separated at approximately 4,500ft and deployed their main parachutes at a correct altitude. Brian and Emma were probably relatively close to each other when they deployed their parachutes, possibly because they may have tracked in the same direction. It is possible that as their canopies were deploying, one or both of them may inadvertently turned towards the other, which would have resulted in them converging at high speed. They may not have had time to take avoiding action, resulting in their parachutes colliding.

The left side of Emma's parachute came into contact with Brian's legs, which resulted in Emma's parachute wrapping around Brian's body and becoming entangled. The impact of the collision may have caused Brian's reserve parachute container to open and the reserve parachute to extract, which then became entangled with Emma's main parachute and Brian's body. At some stage Emma's main parachute pilot-chute, bridle-line and deployment-bag passed through Brian's reserve parachute rigging lines, adding to the entanglement.

It is not known whether Emma was in a position to be able to cutaway her main parachute, or whether she attempted to cutaway her main parachute, but at some stage it is likely that she deployed her reserve parachute, as the reserve handle had been extracted from its keeper. Emma's reserve parachute only partly extracted from its deployment-bag. Her reserve parachute, bridle-line and deployment-bag became entangled with her main parachute. At that time it would not have been possible for either parachutist to separate.

Throughout, Brian may have been trying to communicate with Emma, as his full-face helmet visor was in the open position. However, Emma's visor was in the closed position. She may not have been able to hear Brian.

Initially, Brian's main parachute appeared to be flying relatively well and if it had remained so, it is possible that the landing may have been survivable, though the landing would have been relatively fast and heavy, as both parachutists were suspended under one main parachute. However, at between 100-200ft AGL, Brian's main parachute appeared to dive towards the ground, resulting in a significant increase in its descent rate, causing them to impact with he ground at high speed. This is likely to have been caused by the other entangled parachutes restricting the flying characteristics of Brian's main parachute.

The Recommendations of the Board were that parachutists be reminded that when jumping with others, the importance of good separation prior to deploying their main parachutes.

It was proposed by John Page and seconded by Chris McCann that the report, including its recommendations and conclusion be accepted.

Carried Unanimously

The Chairman reported that the Board also believed that it was not necessary to instigate a Panel of Inquiry in this instance and therefore recommend to STC that one is not instigated.

It was therefore proposed by John Page and seconded by Matty Holford that a Panel of Inquiry was not instigated on this occasion.

Carried Unanimously

5. INCIDENT REPORTS – RESUME

a. There had been 25 Student Injury Reports received since the last STC meeting. 17 male and 8 female. Two were Students who dislocated their shoulders, one possibly in freefall and the other on deployment. All of the other reports were landing injuries, the majority of which were minor.

b. Since the last meeting there had been 13 Injury Reports received for FAI 'A' Certificate parachutists or above, 10 male and 3 female.

c. There had been 13 Student Malfunction/Deployment Problem Reports received since the last meeting. 12 male and 1 female.

d. There had also been 38 Malfunction/Deployment Problem Reports received for FAI 'A' Certificate parachutists or above. 35 male and 3 female.

e. Since the last STC there had been 13 Tandem Injury Reports received, including an instructor who had a minor landing injury. 10 male and 3 female.

f. There had also been 23 Tandem Malfunction/Deployment Problem reports received since the last meeting. Also one Tandem Student took up a 'GoPro' camera attached to his wrist. It was hidden under the sleeve of his jumpsuit.

The Chairman reported that four reports had been received involving Tandem Instructor errors, which would be discussed, in camera, once the resume was completed.

g. One report had been received of an AAD firing. A Category 5 parachutist may have deployed a little low. The reserve was observed to inflate after the main canopy had already deployed.

h. There had been 8 reports received of 'off landings' at clubs.

i. One report had been received of a canopy entanglement on a CF jump.

j. Two reports had been received of camera helmets coming off in freefall.

k. Three reports had been received of display misfires, two injuries and one where a flag prematurely deployed in freefall, without further incident.

l. Two reports had been received of freefall collisions. The parachutists suffered only minor bruising.

m. A report had been received of an aircraft flying down the runway at approximately 50ft shortly after a parachutist had landed. This incident had been reported to the CAA.

n. There had been 4 reports received of Tandem Instructors who had made various errors.

The remainder of this item was held 'in camera' and all observers were asked to leave the meeting.

The Chairman gave the meeting details of each incident, after which CCIs discussed each one individually:

i. The first incident concerned a Tandem Instructor who had carried out 40 Tandem jumps. He completed the freefall part of the descent without deploying the drogue, though he thought he had deployed it. This resulted in him deploying his reserve canopy. His CCI initially grounded him and after consultation with the NCSO & TO he attended a Tandem Instructor course which was running a couple of weeks later and carried out suspended harness drills, after which he made a couple of jumps, one with a bag. This was observed by the Examiners on the course. The Tandem Instructor concerned was not present at that evening's STC meeting.

ii. The second incident concerned another Tandem Instructor with 133 Tandem descents, who also completed the freefall part of the descent without deploying the drogue, again he also thought that he had deployed it. His CCI initially grounded him and after consultation with the NCSO had him carry out extensive suspended harness drills before permitting him to carry out further Tandem descents. The Tandem Instructor concerned was not present at that evening's STC meeting.

The Chairman reported that neither of the two instructors concerned have had similar problems in the past and it was felt that in both cases these were genuine mistakes. However, all Tandem instructor courses in the future would include a 'drogue out' check as part of the freefall drills.

Following further consideration of these two incidents by those present, it was proposed by John Page and seconded by Richard Wheatley that the Tandem Instructors concerned be sent letters by the Chairman of STC reminding them of their responsibilities, which would be kept on file so that should there be any subsequent incidents involving them, this would be taken into consideration.

For: 10 Against: 0 Abstention: 1

Carried

iii. The third incident involved a Tandem Instructor (Instructor A) who had made in excess of 1000 Tandem jumps and who only hooked up his Student on one side and did not spot the error until after the canopy deployed. The instructor did not know why he made this error.

The Chairman reported that over the last few years Tandem Instructor courses have included an 'in door' drill where the instructor checks the hooks, as well as handles, prior to exiting. He stated that the instructor concerned may have gained his rating before the revised drills were included on courses.

This incident was considered at some length and many CCIs present stated that they were appalled that a Tandem Instructor could allow this to happen.

Following further consideration, it was proposed by Paul Hollow and seconded by Ray Armstrong that the Tandem Instructor concerned be sent a letter by the Chairman of STC reminding him of his responsibilities, which would be kept on file and that his CCI continue to carry out remedial training with him. Should there be any other contravention of Tandem rules then he is to be immediately grounded until the matter is brought before STC.

For: 10 Against: 0 Abstention: 1

Carried

The Chairman reported that a letter had been prepared to go to all Clubs requesting that Clubs include as part of their written procedures the drills/checks to be carried out prior to moving to the door and in the door of the aircraft and also in freefall. A copy of the draft letter was circulated to those present. The TO stated that it had also been suggested that instructors may wish to consider having their Students physically check that they have been attached, much in the same way that static line Students check their static lines once they are in the aircraft. The TO and NCSO believe that these drills should be part of every Tandem Instructors drills.

The Chairman asked the Committee if they had any objection to this letter being circulated to CCIs. There was no objection raised by those present.

iv. The fourth incident involved a Tandem Instructor whose AAD had not been switched on prior to carrying out a Tandem descent. This was also not picked up on the flight line.

The Tandem Instructor who was also a CCI was present at the meeting explained what procedures the Centre had now put in place to try to ensue that this does not happen again.

The Chairman reported that since this incident, himself and the TO had watched various Tandem Instructors on flight lines being checked and some get a full flight line check, yet others only get asked if their AAD is on. He stated that it was their belief that the intention was that all Tandem Instructors should have a full flight line check including a visual check of their AADs. They believe that as they are attached to a Student, an independent check should take place. Therefore it was their intention to propose, at the next STC meeting, that this is included in the Operations Manual

The Tandem Instructor concerned was asked to leave the meeting room to enable STC to consider this matter further.

Following further consideration of this matter, was proposed by Matty Holford and seconded by Jason Thompson that the Tandem Instructor concerned be sent a letter reminding him of his responsibilities, which would be kept on file so if there are any subsequent incidents involving him this matter would be taken into consideration.

Carried Unanimously

The CCI concerned was invited to return to the meeting where they were advised of STC's decision concerning him.

Instructor A was then asked to return to the meeting where they were also advised of STC's decision concerning him.

The meeting then resumed in open session.

6. EQUIPMENT LIFING

Rick Boardman of the Riggers Committee had been chairing a Working Group looking into the Lifing of Parachuting Equipment. He was present that evening to make a presentation to the Committee on the progress the Working Group had made so far.

Rick Boardman reported that the long term intention of the Working Group remained that of coming up with a more robust policy with which to equip our members, and to try to enhance the protection from litigation which a Packer or Rigger should be getting from the BPA regulations they work to. He stated that the Working Group had met frequently over the past year and had received input from parachute manufacturers in regard to their lifing/warrantee policies as well as input from Riggers, Packers, CCIs etc. and other various sources.

Rick Boardman advised those present that the Working Group had decided at the meeting held that afternoon that the project would no longer be referred to as equipment lifing, but would in the future be referred to as 'Inspection Policies'. He reported that the Working Group was considering looking to a policy where the responsibility is split across the ratings. For Student & Tandem Equipment – if the equipment was less than 10 years old then an Advanced Packer would undertake the inspection. For equipment older than 10 years old, then the responsibility moves to a Parachute Rigger and for equipment over 20 years old then an Advanced Rigger would undertake the inspection.

For other licensed parachutist's equipment (not student or tandem), again the Working Group were also looking at splitting responsibility across the ratings. For equipment less than 15 years old an Advanced Packer would undertake the inspection. For equipment over 15 years old a Parachute Rigger would become involved. If over 25 years old then an AR would be required to undertake the inspection.

The Working Group are also considering whether or not inspections (on the older systems) should be checked and countersigned by the relevant higher ratings, as well as the AP doing the job, or actually only carried out by those with higher ratings.

Rick stated that at the moment there was very little in the BPA Advanced Packing Syllabus regarding lifing of equipment, and this was another area, which the Working Group would be addressing.

Rick Boardman stated that the Working Group were still a long way off from making any firm proposals as yet, and considered the project to be a work in progress and invited input from CCIs.

The reaction from members present was generally positive. Rick was able to clarify a number of points raised by the Committee in relation to the project.

The Chairman expressed his thanks for Rick Boardman for his presentation that evening.

7. INSTRUCTOR COURSES

a. The Association wished to thank UK Parachuting (Beccles) for hosting the AFF, Tandem & Pre-Advanced Instructor Assessment Course, which took place from the 28 – 30 June. The course report had been circulated with the agenda and was for information only.

b. There had also been a Tandem & Pre-Advanced Instructor Assessment Course that had taken place that week at Skydive Weston, which was now completed. The

Association was grateful to the club hosting the course. A copy of the course report was circulated to those present and was for information only.

8. PERMISSIONS

A letter from John Page had been circulated with the agenda requesting that Ash Booth be reinstated as Category System Basic Instructor for a period of 1 year. Mr Page's letter had stated that due to military commitments Ash had been unable to attend a CSI course prior to his CSBI rating expiring on the 31 May 2008. Despite the time period that has elapsed since the expiry of his CSBI rating Ash had been working with the Freefall Training Flight so has been constantly training parachutists in this time. Mr Page was able to provide further details of this request.

Following some discussion, it was proposed by John Page and seconded by Jason Thompson that the above permission be accepted.

Carried Unanimously

9. A.O.B

The Chairman reported that the Communications Committee had created a series of 8 posters in order to enhance communication to the membership covering a range of topics. Two were educational posters that had been created to summarise the key points for the BPA Committee's and the FAI Certificates and Grading System. Six were 'Stay Safe' posters and had been created to help educate the membership with the aim of improved awareness and individual responsibility.

The Chairman stated that both the TO and BPA Examiner Paul Floyd had assisted in technical checking to ensure accuracy of the information. The Posters were available for CCIs to take away that evening. These posters had been financed by the Mansons Insurance Brokers and Liberty Insurance Underwriters.

The Chairman stated that also, over the next week or so Clubs would be sent a Canopy Handling video that had been produced on behalf of the Development Committee and paid for from the 'Airkix Fund. This video was to assist in the training of Students working towards their CH Grades.

Date of next Meeting: Thursday 30 September 2010
BPA Offices, Glen Parva, Leicester
at 7.00 p.m

10 August 2010

Distribution:
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