Report Number: 19780608045099G

08-JUN-78   TEA, SD

NARRATIVE
PARACHUTIST STRUCK TWO PARKED AIRCRAFT DURING A JUMP. HE WAS NOT INJURED BUT BOTH PLANES WERE DAMAGED.

USPA ANALYSIS:
CURRENT AIRPORT MANAGER CURT ANDERSON REPORTS NO KNOWLEDGE OF A PARACHUTE OPERATION BUSINESS EVER BEING LOCATED ON THE AIRPORT. THE JUMP MAY HAVE BEEN A ONE-TIME DEMONSTRATION CONDUCTED WITH A FLIGHT STANDARDS CERTIFICATE OF AUTHORIZATION. THIS WAS OBVIOUSLY AN OFF-TARGET JUMP, MAKING THIS A CASE OF CANOPY PILOT ERROR.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

Report Number: 19800308046049G

08-MAR-80   TAMPA, FL

NARRATIVE
SHOW PARACHUTE JUMPER MISSED HIS TARGET AND STRUCK 2 SPECTATORS.

USPA ANALYSIS:
THE JUMP MAY HAVE BEEN A ONE-TIME DEMONSTRATION CONDUCTED WITH A FLIGHT STANDARDS CERTIFICATE OF AUTHORIZATION. IT WAS OBVIOUSLY AN OFF-TARGET JUMP, MAKING THIS A CASE OF CANOPY PILOT ERROR.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.
NARRATIVE
CHUTE FOULED AND PARACHUTIST LANDED ON RUNWAY. DID NOT USE RESERVE CHUTE. MINOR INJURY.

USPA ANALYSIS:
WE BELIEVE THAT THE RUNWAY WAS NOT THE INTENDED TARGET, BUT THAT THE PARACHUTIST’S LANDING ON THE RUNWAY RESULTED FROM A MALFUNCTIONED MAIN PARACHUTE THAT WAS DIFFICULT TO CONTROL.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

NARRATIVE
JUMPER MISJUDGED LANDING SITE AND STRUCK A PARKED AIRCRAFT.

USPA ANALYSIS:
NOT ENOUGH INFORMATION TO UNDERSTAND HOW THIS OCCURRED. THE PARKED AIRCRAFT WAS NOT A TARGET, MAKING THIS A CASE OF CANOPY PILOT ERROR.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.
04-AUG-96   JUNEAU, AK

NARRATIVE

USPA ANALYSIS:
THE JUMP MAY HAVE BEEN A ONE-TIME DEMONSTRATION CONDUCTED WITH A FLIGHT STANDARDS CERTIFICATE OF AUTHORIZATION. TWO PARACHUTISTS FAILED TO LAND IN THE PREVIOUSLY APPROVED AREA, MAKING THIS A CASE OF CANOPY PILOT ERROR.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

23-MAR-97   CUSHING, OK

NARRATIVE
(-23) STUDENT SKYDIVER, CHARLES ERIC HUETER, AT 1530 ON MARCH 23, 1997, WAS ON HIS NINTH JUMP WHEN HE LANDED ON TOP OF A T-HANGAR AT CUSHING AIRPORT, OKLAHOMA, AND SUSTAINED SERIOUS INJURIES. THE HANGAR RECEIVED MINOR DAMAGE.

USPA ANALYSIS:
NOT ENOUGH INFORMATION TO UNDERSTAND HOW THIS OCCURRED. THE HANGAR WAS NOT A TARGET, MAKING THIS A CASE OF CANOPY PILOT ERROR.
THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

Report Number: 19990207011859G

07-FEB-99   GRANBURY, TX

NARRATIVE
MR. SHANE BERTHELOT, AN INDIVIDUAL WITHOUT ANY PILOT EXPERIENCE, WAS SKIDIVING NEAR THE GRANBURY AIRPORT, GRANBURY, TEXAS, WHEN HE LOST CONSCIOUS WHILE PASSING THROUGH APPROXIMATELY 2,500 FEET MSL. HE CONTINUED TO DRIFT DOWN AND LANDED NEAR THE LANDING AREA. DURING HIS LANDING, HE RECEIVED SOME MINOR INJURIES, BUT BECAUSE HE WAS UNCONSCIOUS THE POLICE AND MEDICAL PEOPLE WERE CALLED AND THE FAA WAS NOTIFIED. HE REGAINED CONSCIOUSNESS AND SAID HE WAS O.K., BUT THE MEDICAL PEOPLE TOOK HIM TO THE HOSPITAL FOR OBSERVATION. ^PRIVACY DATA OMITTED^ AND CONSIDER THIS MATTER CLOSED. SED.

USPA ANALYSIS:

A PARACHUTIST LOST CONSCIOUSNESS, RESULTING IN MINOR INJURIES.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

Report Number: 20001118030989G

18-NOV-00   STURGIS, MI

NARRATIVE
(-23)AFTER SUCCESSFUL DEPLOYMENT OF THE PARACHUTE, INDIVIDUAL COLLIDED WITH A BUILDING FACADE APPROXIMATELY 1 MILE FROM THE KIRSH AIRPORT, STURGIS, MICHIGAN. UPON COLLISION, INDIVIDUAL BROKE BOTH ANKLES, AND EXPERIENCED MAJOR HEAD TRAUMA WHEN HEAD HIT BRAKES, CAUSING FATALITY.

USPA ANALYSIS:

NOT ENOUGH INFORMATION TO UNDERSTAND HOW THIS OCCURRED. THE BUILDING, WHICH WAS A MILE FROM THE AIRPORT, WAS NOT A TARGET, MAKING THIS A CASE OF CANOPY PILOT ERROR.
THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

Report Number: 20010303007049G

03-MAR-01 MARICOPA, AZ

NARRATIVE
(-23) JUMP WAS DECEASED'S FIRST SKYBOARD JUMP. JUMP ALTITUDE WAS APPROXIMATELY 14,000' AGL, APPROXIMATELY 15270' MSL. THE JUMP PLANE WAS A PILATUS TURBINE PORTER OPERATED BY SKYDIVE PHOENIX. VIDEO OF THE FREE FALL SEGMENT OF THE JUMP SHOWS DECEASED IN REASONABLE CONTROL, PARTICULARLY FOR A FIRST BOARD JUMP. THERE WERE NO DEFINITIVE EYEWITNESSES TO THE JUMP AFTER BREAKAWAY. DECEASED IMPACTED THE GROUND IN A FEET TO EARTH ATTITUDE APPROXIMATELY 1/2 MILE FROM THE INTENDED TARGET LANDING AREA. RESCUE PERSONNEL REMOVED THE PARACHUTE EQUIPMENT. IT WAS NOTED AT THE TIME THAT THE AUTOMATIC ACTIVATION DEVICE WAS ON AND READING "O DOWN". DECEASED WAS PRONOUNCED DEAD AT THE SCENE. DECEDENT WAS FOUND ON HIS BACK ADJACENT THE IMPACT CREATER.

USPA ANALYSIS:

THE DECEASED FAILED TO PROPERLY EXECUTE EMERGENCY PROCEDURES, WHICH LED TO HIS DEMISE APPROXIMATELY ½ MILE FROM THE AIRPORT.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

Report Number: 20031102036229G

02-NOV-03 SUFFOLK, VA

NARRATIVE
(-23) 11/02/03: AT 15:05 LOCAL, THE RICHMOND FSDO RECEIVED NOTIFICATION FROM THE COM CENTER OF AN INCIDENT INVOLVING A PARACHUTIST WHO SUSTAINED UNKNOWN INJURIES WHEN HIS PARACHUTE FAILED TO FULLY DEPLOY. THE AIRCRAFT USED FOR THE PARACHUTE OPERATIONS WAS N9838Z, A B-90. ACCORDING TO SUFFOLK DISPATCH, THE PARACHUTIST WAS FLYING NORMALLY AND WENT LIMP IN THE HARNESS FOR THE LAST 100 FEET. HE HIT
THE RUNWAY ON HIS FEET THEN WENT FORWARD AND SUSTAINED INJURIES TO HIS FACE AND HEAD. WRITTEN STATEMENTS OF WITNESSES OBSERVING ON THE GROUND CONCUR AS ABOVE. THE MAIN PARACHUTE WAS USED FOR THE FLIGHT. THE RESERVE WAS NOT DEPLOYED. NEITHER PARACHUTE WAS A CONTRIBUTING FACTOR. ^PRIVACY DATA OMIT^ (JUMPER) IS EXPERIENCED WITH OVER 40 JUMPS, AND WAS JUMPING UNDER THE DIRECTION OF SKYDIVE SUFFOLK, IN., SUFFOLK, VIRGINIA. ACCORDING TO THE MANAGER OF SKYDIVE SUFFOLK, INC., ^PRIVACY DATA^ HAD BEEN FASTING THREE DAYS PRIOR, WHICH MAY HAVE CONTRIBUTED TO HIM PASSING OUT ON THE FINAL APPROACH.

**USPA ANALYSIS:**

WE BELIEVE THAT THE RUNWAY WAS NOT THE INTENDED TARGET, BUT THAT THE PARACHUTIST'S LANDING ON THE RUNWAY RESULTED FROM HIS LOSS OF CONSCIOUSNESS AND SUBSEQUENT INABILITY TO FLY HIS PARACHUTE TO THE ASSIGNED PARACHUTE LANDING AREA.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

Report Number: 20040609012489G

09-JUN-04   CANON CITY, CO

**NARRATIVE**

(-23) ACCORDING TO THE PILOT, N9652F DEPARTED THE FREMONT COUNTY AIRPORT (1V6) AT APPROXIMATELY 1730 MDT WITH A LOAD OF APPROXIMATELY 10 SKY DIVERS. THE AIRCRAFT CLIMBED TO 17,500 MSL AT WHICH TIME THE SKYDIVERS DEPARTED THE AIRCRAFT. THE PHOTOGRAPHER^PRIVACY DATA OMIT^ WAS PHOTOGRAPHING 4 TANDEM PARACHUTISTS. ACCORDING TO ^PRIVACY DATA OM^ WITNESS AND OWNER OF SKYDIVE THE ROCKIES, AT BETWEEN 100 AND 300 FEET THE PHOTOGRAPHER MADE A HARD TURN AND TWISTED HIS LINES. HE CUT AWAY THE MAIN CHUTE AND ATTEMPTED TO DEPLOY HIS RESERVE. ACCORDING TO THE FREMONT COUNTY S.O. REPORT THE BODY WAS FOUND 75 FEET EAST OF BUILDING 11 ON THE AIRPORT WITH HIS RESERVE CHUTE PARTIALLY DEPLOYED (ABOUT 30 FEET). THE RESERVE PARACHUTE A PR193, SN# PR193-030678, MFGR'D BY PERFORMANCE RESPONSE WAS PACKED BY SENIOR PARACHUTE RIGGER ^PRIVACY DATA OMITTED^ ON 4/8/04. ACCORDING TO ^PRIVACY DA^ THE AUTOMATIC DEPLOYMENT DEVICE INSTALLED ON THE RESERVE CHUTE A CYPRES BY SSK COULD NOT HAVE INFLATED THE RESERVE UNDER THOSE CONDITIONS. ACCORDING TO THE USPA, ^PRIVACY DA^ HELD BOTH AN A AND D LICENSE WITH USPA. PARACHUTE INCIDENT.
USPA ANALYSIS:

THE DECEASED RELEASED HIS MALFUNCTIONED MAIN PARACHUTE TOO LOW FOR HIS RESERVE TO FULLY OPEN, MAKING THIS A CASE OF CANOPY PILOT ERROR, COMPONDBED BY IMPROPER EMERGENCY PROCEDURES.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

Report Number: 20050216005289G

16-FEB-05   ELOY, AZ

NARRATIVE

(-23) MULTIPLE SKYDIVERS LEFT AIRCRAFT AND WERE FARTHER AWAY FROM LANDING AREA THAN WERE ABLE TO TRAVEL BACK UNDER CANOPY TO LAND. ONE OF THE OTHER SKYDIVERS ON THE LOAD WAS ABLE TO LAND IN A SPOT LOCATED ON AN ACCESS ROAD BETWEEN A SMALL HANGER, A SET OF POWER LINES, AND A CHAIN Link FENCE CORNER. ^PRIVACY DATA^ ATTEMPTED TO FOLLOW THE FIRST SKYDIVER INTO THE SAME LANDING AREA. IN DOING SO HE MISCALCULATED HIS FINAL TURN TO LANDING AND LANDING FLARE. HE IMPACTED THE GROUND AT A HIGH RATE OF SPEED. HIS FEET LANDED IN A SMALL DEPRESSION IN THE ROADWAY. BECAUSE OF THE FORWARD MOMENTUM OF THE CANOPY, HIS LEGS BROKE AND HIS BODY KEPT MOVING FORWARD AND HIS BODY BECAME AIRBORNE AGAIN FOR APPROXIMATELY 20 FEET. WHEN HE LANDED FOR THE SECOND TIME IT WAS ON HIS HEAD. THIS LANDING RESULTED IN SEVERE HEAD TRAUMA AND MULTIPLE BREAKS TO THE NECK. THERE WERE NO MALFUNCTIONS TO THE EQUIPMENT THAT ^PRIVACY DATA^ WAS USING. THE HIGHLY WING LOADED CANOPY HAD A GREATER RATE OF DESCENT BECAUSE OF THE TURNS INITIATED TO GET INTO THE LANDING AREA. ALSO, THE FLARE FOR LANDING WAS INITIATED TOO LATE TO SUFFICIENTLY BLEED OFF EXCESS SPEED AND SINK OF THE MANEUVERS.

USPA ANALYSIS:

THE DECEASED MISCALCULATED HIS FINAL TURN TO LANDING WHILE OFF-AIRPORT, MAKING THIS A CASE OF CANOPY PILOT ERROR.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.
13-AUG-05   OGDEN, UT

NARRATIVE
(-23) PARACHUTE JUMP (PAJA) ACCIDENT ON THE OGD AIRPORT ON SATURDAY 8-13-05 INVOLVING A ^PRIVACY DATA OMITTED^ WHO WAS MAKING HER 1ST TANDEM JUMP WITH A HIGH TIME PAJA INSTRUCTOR. ^PRIVACY DATA OMITTED^ APPEARS TO HAVE MADE A LOW LEVEL TURN TO A DOWNWIND SITUATION TO AVOID HANGARS AND LOST LIFT/CONTROL. JUMPERS IMPACTED BLACKTOP RAMP HARD AND INSTRUCTOR ^PRIVACY DA^ LANDED ON TOP OF ^PRIVACY D^ AND THEY SKIDDED ALMOST 30 FT. ^PRIVACY D^ DIED OF HEAD AND NECK TRAUMA. ^PRIVACY DA^ SUSTAINED SERIOUS INJURIES.

USPA ANALYSIS:

WE BELIEVE THAT THE RAMP WAS NOT THE INTENDED TARGET, BUT THAT THE RAMP LANDING RESULTED FROM A LOW-LEVEL TURN AND THE PARACHUTIST'S SUBSEQUENT INABILITY TO CONTROL HIS LANDING.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

29-JAN-06   OSAGE CITY, KS

NARRATIVE
(-23) THIS JUMP OCCURRED EARLY AFTERNOON ON SUNDAY, JANUARY 29, 2006. THE WINDS WERE FROM THE WEST, STRONGER AT ALTITUDE, BUT ABOUT 7 TO 20 MPH ON THE GROUND. BECAUSE OF STRONGER UPPERS, THE JUMPER FOUND IT NOT POSSIBLE TO LAND IN THE REGULAR LANDING AREA. HE CHOSE TO LAND JUST ON THE OTHER SIDE OF THE RUNWAY IN A FIELD EAST OF THE DROP ZONE. HOWEVER, HE WAS DETERMINING HIS LANDING DIRECTION ACCORDING TO THE WINDSOCK THAT WAS ABOUT 250 YARDS AWAY, AND FACED WEST FOR LANDING, ALTHOUGH HIS CANOPY WAS BEING PUSHED FROM HIS LEFT, A STRONGER SOUTH WIND IN THE FIELD HE CHOSE. HE WAS CRABBING ON FINAL APPROACH, AND DID NOT FLARE PAST HIS SHOULDERS FOR LANDING. HENCE, THE CANOPY DID NOT SLOW ITS DESCENT OR FORWARD SPEED WHEN HE HIT THE GROUND WHICH CAUSED HIM TO TIME HIS FLARE INCORRECTLY. ALTHOUGH HE CHOSE CORRECTLY TO LAND IN A SAFE, ALTERNATE LANDING AREA, HE FAILED TO USE HIS OWN PERCEPTION OF HIS DIRECTION
UNDER CANOPY, INSTEAD OF A WIND SOCK THAT INDICATED SOMETHING DIFFERENT THAN WHAT HE WAS EXPERIENCING. JUMPER NAME: *PRIVACY DA*, 120 JUMPS WITH A USPA A LICENSE, NO CLUB AFFILIATION, MAIN PARACHUTE AERODYNE TRIATHALON, PACKED JUST BEFORE THE JUMP BY JUMPER. RESERVE NOT USED PACKED 15 JAN 2006.

USPA ANALYSIS:

BECAUSE OF STRONGER THAN EXPECTED WINDS, A PARACHUTIST LANDED SAFELY ON THE OTHER SIDE OF THE RUNWAY FROM THE DZ'S REGULARLY ASSIGNED PARACHUTE LANDING AREA.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

Report Number: 20060527023189G

27-MAY-06 LOUISA, VA

NARRATIVE

(-23) NAME OF SPORT JUMPER: *PRIVACY DATA OMIT* EXPERIENCE/TRAINING: HIGHLY EXPERIENCED; REPORTED TO HAVE OVER 3,000 CIVILIAN SPORT JUMPS AND ALSO A FORMER MILITARY JUMPER. CLUB AFFILIATION: MEMBER OF USPA (SAFETY AND TRAINING ADVISOR) DESCRIPTION OF PARACHUTE PACKING RECORDS: A RAM AIR, RECTANGULAR TYPE, MANUFACTURED BY ICARUS CANOPIES, MODEL: CROSSFIRE 2, SERIAL NUMBER: 96314319. RESERVE CHUTE PACKED 05/15/06, IDENTIFIED BY SEAL SYMBOL SDG, *PRIVACY DATA OMIT* WITNESS OBSERVED *PRIVACY DATA* HAVING A NORMAL DEPLOYMENT OF THE MAIN CANOPY. HOWEVER, UPON APPROACH TO LANDING, HE INITIATED A LOW ALTITUDE TURN WHICH HE REPORTEDLY HAD INSUFFICIENT ALTITUDE TO RECOVER FROM TO ALLOW HIMSELF TO SLOW HIS AIRSPEED. *PRIVACY DATA* WAS REPORTED TO HAVE HIT THE GROUND (ASPHALT RUNWAY) WHILE IN THE TURN, IMPACTING WITH THE UPPER TORSO FIRST.

USPA ANALYSIS:

WE BELIEVE THAT THE RUNWAY WAS NOT THE INTENDED TARGET, BUT THAT THE PARACHUTIST'S LANDING ON THE RUNWAY RESULTED FROM A LOW TURN, FOLLOWED BY THE PARACHUTIST'S SUBSEQUENT INABILITY TO CONTROL EITHER THE DIRECTION OR SPEED OF HIS LANDING.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.
AAS Data from Aviation Safety Reporting System

Report Number: 544140

200204 HDH.AIRPORT, HI

Synopsis
UNDETECTED CHANGING WIND CONDITIONS AND GPS PROBS RESULT IN PARACHUTE JUMPERS LNDG IN THE INCORRECT LNDG AREA ON THE ARPT CAUSING A CONFLICT WITH NO RADIO GLIDERS.

USPA ANALYSIS:

THE NARRATIVE SPECIFICALLY STATES SHIFTING WINDS CAUSED THE OFF-TARGET LANDING. THE REPORT OF A "CONFLICT" IS ANECDOTAL AND SUBJECTIVE.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

Report Number: 616472

200404 D73.AIRPORT, GA

Synopsis
A GLIDER PLT IS CONCERNED WITH THE NUMBER OF PARACHUTE JUMPERS THAT LAND ON THE ARPT SURFACE AT D73 WITH OTHER ACFT LNDG AT THE SAME TIME.

USPA ANALYSIS:


THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.
Synopsis
INBOUND ACFT PLT VOICES CONCERN OVER THE NEWLY ESTABLISHED DROP
AREA FOR PARACHUTE ACTIVITY 3 TO 4 NM E AND ON CTLINE OF RWY 26R AT
SDM, CA.

USPA ANALYSIS:
THIS IS ANECDOTAL REPORTING, GIVEN WITHOUT DESCRIPTION OF A
CONFLICT. IT APPEARS THAT THE PARACHUTE OPERATIONS WERE BEING
CONDUCTED OFF THE AIRFIELD. PARACHUTE OPERATIONS AT SAN DIEGO-
BROWN FIELD MUNICIPAL AIRPORT ARE CONDUCTED UNDER THE
DIRECTION OF THE CONTROL TOWER.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE
ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO
THE INITIATIVE.

Synopsis
RPTR HAS OBSERVED PARACHUTE JUMPING ACFT OPERATING NEAR V85 AND
WITHIN THE DEN MODE C VEIL AND ALLEGES THAT THEY ARE IGNORING SOP'S
IN AND AROUND THIS UNCTLED FIELD. FURTHER, THEIR JUMPERS LAND ON
BOTH SIDES OF THE RWY OFTEN IN CLOSE PROX TO THE RWY ITSELF.

USPA ANALYSIS:
THIS IS ANECDOTAL REPORTING, GIVEN WITHOUT DESCRIPTION OF A
CONFLICT. PARACHUTE OPERATIONS AT LONGMONT’S VANCE BRAND
AIRPORT ARE CONDUCTED UNDER A LETTER OF AGREEMENT WITH THE
DENVER TRACON AIR TRAFFIC CONTROL FACILITY.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE
ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO
THE INITIATIVE.
Synopsis
A PA-28 INSTR PLT RPT ON THE HAZARDOUS PROCS USED DURING PARACHUTE JUMPING ACTIVITY AT LAUREL, DE, A NON TWR ARPT, WITH DROPS LNDG NEAR THE RWY AT N06, DE.

USPA ANALYSIS:

THIS IS ANECDOTAL REPORTING, GIVEN WITHOUT DESCRIPTION OF A CONFLICT. THE ENTIRE NARRATIVE CONSISTS OF THE REPORTING PILOT ADMITTING TO HIS OWN MULTIPLE FAILURES TO USE GOOD JUDGEMENT.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

Synopsis
C172 STUDENT TRAINING FLT ENCOUNTERS SKYDIVERS DURING TOUCH-AND-GO TKOF CLB AT E80

USPA ANALYSIS:

THIS IS ANECDOTAL REPORTING, GIVEN WITHOUT DESCRIPTION OF A CONFLICT.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.
AIRCRRAFT 1 FINAL REPORT
A PIPER PA-28, N3011F, WAS IN VFR CRUISE FLIGHT HEADING EASTBOUND AT ABOUT 5700' MSL, AS A CESSNA 210 (PARACHUTE JUMP PLANE) HAD JUST COMPLETED A CLEARING TURN TO A WESTBOUND HEADING, INTO THE SUN, AT 7300' MSL. A PARACHUTIST JUMPED FROM THE JUMP PLANE & STRUCK THE VERTICAL STABILIZER OF THE PA-28 AFTER A FEW SECONDS OF FREE FALL.

CONTROL OF THE PA-28 WAS LOST, & IT CRASHED IN AN UNCONTROLLED DESCENT. THE JUMP PLANE WAS IN RADAR & RADIO COMMUNICATION WITH AIR TRAFFIC CONTROL (ATC) IN ORDER TO RECEIVE TRAFFIC ADVISORIES PER THE FAA ATC CONTROLLER'S HANDBOOK. THE PA-28 WAS RECORDED ON RADAR. NO ADVISORIES WERE ISSUED TO THE JUMP PLANE AFTER THE PILOT CALLED '1 MINUTE PRIOR TO JUMP.' TESTS SHOWED THAT ONE TRANSCEIVER IN THE PA-28 WAS TUNED TO 120.30 MHZ; A WARNING FOR PARACHUTE JUMPING WAS GIVEN OVER THIS FREQUENCY.

A 1/8' PARACHUTE SYMBOL (COLORED BLUE) WAS DEPICTED ON THE SECTIONAL CHART AND WAS SUPERIMPOSED OVER A RIVER (ALSO COLORED BLUE). THE CONTROLLER WAS RECEIVING ON-THE-JOB TRAINING FROM A FULL PERFORMANCE CONTROLLER.

CAUSE REPORT
FAILURE OF THE AIR TRAFFIC CONTROL (ATC) FACILITY TO IDENTIFY AND PROVIDE THE REQUIRED TRAFFIC INFORMATION TO THE JUMP AIRCRAFT BEFORE RELEASE OF THE JUMPER(S). A FACTOR RELATED TO THE ACCIDENT WAS: INADEQUATE VISUAL LOOKOUT BY THE PILOT OF THE JUMP AIRCRAFT.

USPA ANALYSIS:
WE FAIL TO SEE HOW PLA STANDARDS WOULD HAVE PREVENTED AN ACCIDENT THAT OCCURRED AT 5700' MSL. ALSO DO NOT SEE HOW THE PLA STANDARDS WOULD HAVE HELPED THE ATC FACILITY TO IDENTIFY AND PROVIDE REQUIRED TRAFFIC INFORMATION TO THE JUMP AIRCRAFT.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.
AIRCRAFT 1 FINAL REPORT
After a parachute drop flight, the airplane taxied back to the ramp area. The airplane was parked on the ramp, with the engine running, while the next group of parachutists were boarding the airplane. During that time, a parachutist who had just landed, contacted the propeller and sustained a serious injury. Witnesses reported observing the parachutist descending toward the airplane without altering her course. One witness reported he "tackled" the parachutist to the ground; however, the parachute became entangled in the airplane’s propeller and subsequently dragged the parachutist into the propeller. The parachutist had completed an estimated 18 prior jumps, which included 4 jumps at the accident airport. Winds reported at the airport, about the time of the accident were calm.

AIRCRAFT 1 CAUSE REPORT
The parachutist’s failure to obtain the proper touchdown point, which resulted in contact with the operating propeller of a parked airplane.

USPA ANALYSIS:
THE REPORT INDICATES THAT THE ACCIDENT AIRPLANE WAS PARKED ON THE AIRPORT RAMP. THE PILOT ESTIMATED THAT THE NORMAL PARACHUTIST LANDING ZONE WAS BETWEEN 50 TO 300 FEET FROM THE RAMP AREA. THE CAUSE CITED IN THE REPORT: THE PARACHUTIST'S FAILURE TO OBTAIN THE PROPER TOUCHDOWN POINT, WHICH RESULTED IN CONTACT WITH THE OPERATING PROPELLER OF A PARKED AIRPLANE. NOT REPORTED, WAS A STATEMENT BY THE INJURED PARACHUTIST THAT SHE HAD INTENTIONALLY FLOWN AWAY FROM THE DESIGNATED PARACHUTE LANDING AREA TOWARDS THE OPERATING JUMP PLANE IN ORDER TO “IMPRESS HER FRIENDS” WHILE THEY WAITED TO BOARD THE AIRCRAFT.

WE DO NOT SEE HOW THE PLA STANDARDS WOULD HAVE AFFECTED THE PARACHUTIST’S FAILURE TO OBTAIN THE PROPER TOUCHDOWN POINT.
THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.

EVENT ID: 20001211X12786

7/24/1993   Lebanon, NH

AIRCRAFT 1 FINAL REPORT
OPENING ACT WAS FOR 3 JUMPERS TO EXIT FROM JUMP-PLANE (J/P) AT 3500’ AGL; 2 JUMPERS WERE TO JOIN AT 2000’ TO DISPLAY FLAG, WHILE 3RD JUMPER WAS TO CIRCLE ABOVE. N90BC & N31485 WERE TO CIRCLE JUMPERS IN OPPOSITE DIRECTIONS. N90BC WAS TO CIRCLE CLOCKWISE, OUTSIDE TURN RADIUS OF N31485, WHICH WOULD CIRCLE COUNTERCLOCKWISE. WHEN 2 OF 3 JUMPERS EXITED FROM J/A, PILOT OF N31485 BANKED LEFT INTO SPIRAL, APPARENTLY UNAWARE OF 3RD JUMPER. 3RD JUMPER DELAYED UNTIL N31485 WAS CLEAR, THEN JUMPED AS J/A CONTINUED ON SAME HEADING. PHOTO SHOWED N90BC WAS TO THE RIGHT & AT AN UNDETERMINED DISTANCE BEHIND N31485 AS 1ST 2 JUMPERS EXITED. AFTER 3RD JUMPER EXITED, HE & N90BC COLLIDED. N90BC WAS DAMAGED, WENT OUT OF CONTROL & CRASHED. AFTER ACCIDENT, SOME PARTICIPANTS OF PRESHOW BRIEFING DID NOT RECALL A 3RD JUMPER BEING MENTIONED, ALTHOUGH OTHERS REMEMBERED. 3RD JUMPER WAS NOT PRESENT FOR PRESHOW BRIEFING, BUT AC 91-45C ALLOWED FOR ONLY 1 MEMBER FROM EACH TEAM TO ATTEND PRESHOW BRIEFING, THEN BRIEF OTHER TEAM MEMBERS.

AIRCRAFT 1 CAUSE REPORT
INADEQUATE CREW/GROUP COORDINATION.

USPA ANALYSIS:

WE FAIL TO SEE HOW PLA STANDARDS WOULD HAVE PREVENTED AN ACCIDENT THAToccurred AT AN AIRSHOW THAT WASTHE OPERATING UNDER AN AVIATION EVENT WAIVER ISSUED BY THE FAA. WE ALSO DO NOT SEE HOW THE PLA STANDARDS WOULD HAVE IMPROVED THE INADEQUATE CREW/GROUP COORDINATION.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.
AIRCRAFT 1 FINAL REPORT
The pilot stated that after the 14 jumpers left the airplane at 13,500 feet, southwest of the airport, he started his descent to the northeast. He approached the airport from the northeast overflew the airport, and made a left turn to enter the downwind leg for runway 23. He saw some parachutes on the ground and some in the air. He saw a tandem jumper toward the southwest and believed he had accounted for all jumpers. As he turned left, he saw a flash of colors, felt an impact and drag from the left wing. He got the airplane on the ground as soon as possible.

Radar data indicated that the airplane was about 1,300 feet msl when it was approaching runway 5/23 from the northeast. The airplane flew over runway 23, near mid field, about 1,100 feet msl and was between 900 to 800 feet msl during the left bank entering the downwind for runway 23; last capture was at 300 feet as it approached runway 23. One jumper stated the parachutelanding zone was located on the airport adjacent to the left side of runway 30. The video equipment that was carried by the cinematographer captured the collision. The cinematographer jumps with the last tandem jumpers. The tandem chute deploys at 3 minutes and 7 seconds into the video, 13 seconds later the cinematographer’s chute deploys. During his descent, he removes the helmet-mounted camera and looks into the view making a few remarks about the jump. He places the camera back to its original position and continues to capture; the sky is overcast and visibility is good. The view pans to the right and captures three skydivers with chutes deployed at an altitude above him. At approximately 4 minutes and 54 seconds into the video, a sound similar to an airplane engine can be heard at an increasing level for 5 seconds. At 4 minutes and 59 seconds, the view pans slightly left and a sound similar to an impact is heard. The view becomes blurry and pans rapidly. At 5 minutes and 2 seconds, three frames capture what appears to be
an aircraft inclose proximity banking away and to the right of the camera's view. The view continues to pan rapidly for about 6 seconds showing shots of the ground, sky, and parachute. The camera stabilizes and records until impact with the ground at 5 minutes and 46 seconds. One of the master tandem jumpers on that jump stated that the pilot did not give a briefing on which runway or approach he was going to use. The norm is for the jumpers to avoid crossing runways below 1,000 feet and to stay away about 300 feet from the runways, and the pilot to avoid jumpers at all time. Due to the amount of jumps that are performed per day there is no briefing before each flight. Approaches and runway selection depends on the individual pilot. A representative of the operator stated that only verbal guidance is given to the pilots to follow the FAA rules and it up to their discretion for approaches and runway selection. The acting airport manager stated that there is no agreement for airport operations between the skydive operator and the city, only the lease agreement. The city did develop a voluntary noise abatement procedure outlining areas to avoid. The several pilots at the airport stated that for several years they communicated with the city regarding safety concerns with approaches and runway selection by the skydive operator. They stated the city did not correct the situation.

**AIRCRAFT 1 CAUSE REPORT**
The pilot's inadequate visual lookout.

**USPA ANALYSIS:**

THE REPORT INDICATES THAT THE ACCIDENT AIRCRAFT WAS ON A VFR APPROACH IN THE AIRPORT TRAFFIC PATTERN AND THAT JUMP PILOTS WERE AWARE OF THE [PARACHUTE] LANDING ZONES ON THE AIRPORT.

WE DO NOT SEE HOW THE PLA STANDARDS WOULD HAVE IMPROVED THE PILOT'S INADEQUATE VISUAL LOOKOUT.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.
AIRCRAFT 1 FINAL REPORT

AIRCRAFT 1 CAUSE REPORT
THE STUDENT PILOT DISPLAYED POOR JUDGEMENT IN NOT MAINTAINING PROPER ALTITUDE. A FACTOR CONTRIBUTING TO THE ACCIDENT WAS THE PILOT’S OVERALL LACK OF EXPERIENCE.

USPA ANALYSIS:

WE FAIL TO SEE HOW PLA STANDARDS WOULD HAVE PREVENTED AN ACCIDENT THAT OCCURRED DURING CRUISE. ALSO DO NOT SEE ANY CERTAINTY THAT A PARACHUTIST WAS INVOLVED IN THIS ACCIDENT. USPA CHECKED WITH THE AIRPORT OWNER AND HE CLAIMS THAT PARACHUTE OPERATIONS HAVE NEVER BEEN CONDUCTED ON HIS AIRPORT.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.
The parachute jump plane was substantially damaged when it collided with a parachutist on final approach for landing. The pilot was not able to maintain directional control and the airplane impacted trees and terrain near the airport. The pilot stated that he was on final approach for landing, when a parachutist "made a rapid descent and accelerated from behind [his] right wing." The parachutist hit the right wing and the airplane entered an unrecoverable descending right turn, subsequently striking a tree line. The parachutist involved in the accident stated that he "couldn't quite make it to the landing area" because the "spot was a little long." He noted that as a result he intended to land in front of the hangar. He reported he did not hear or see the jump plane. The parachutist stated: "I have a very high performance canopy and I descended quickly over the [airfield]. I crossed the far north edge of the grass runway for only an instant. I came from above and when my canopy leveled out, I was in front of the right wing." The drop zone for experienced parachutists was located north of the turf runway and west of the hangar buildings. Jump planes normally used the adjacent turf runway for landing. Advisory Circular 90-66A, Recommended Standard Traffic Patterns and Practices for Aeronautical Operations at Airports without Operating Control Towers, stated: "When a drop zone has been established on an airport, parachutists are expected to land within the drop zone. . . . Pilots and parachutists should both be aware of the limited flight performance of parachutes and take steps to avoid any potential conflicts between aircraft and parachute operations." Helmet-mounted video cameras from the parachutist involved in the accident, as well as a second parachutist on the accident jump, revealed that both parachutists descended through a cloud prior to canopy deployment. Federal regulations stated that parachute operations may not be conducted "into or through a cloud."
AIRCRAFT 1 CAUSE REPORT
Failure of the jump plane pilot to maintain clearance from the parachutist descent area/drop zone until assured that all jumpers had landed, and the parachutist's failure to maintain an adequate visual lookout for the jump plane during all phases of the jump. Contributing factors were the inability of the pilot to maintain directional control of the airplane after collision with the parachutist, the airplane's low altitude at the time of the collision, the parachutist, and the trees. An additional factor was the proximity of the runway to the drop zone.

USPA ANALYSIS:

IMMEDIATELY FOLLOWING THE 05/26/2005 ACCIDENT, THE DROP ZONE BUSINESS OPERATOR COLLABORATED WITH THE AIRPORT OWNER, A USPA SAFETY AND TRAINING ADVISOR AND A FLIGHT STANDARDS INSPECTOR TO CHANGE THE LOCATION OF THE DZ LANDING AREA. THE DESIGNATED DZ LANDING AREA WAS MOVED NORTH OF RUNWAY 26R AND ALL AIRCRAFT WERE ASSIGNED TO USE RUNWAY 26L DURING PARACHUTE OPERATIONS.

BY THE PARACHUTIST'S OWN ADMISSION, HE DID NOT LAND HIS PARACHUTE IN THE DESIGNATED DZ AND THROUGH HIS ACTIONS, CAUSED THE ACCIDENT. SINCE THE AIRPORT IS NOT FEDERALLY OBLIGATED, IT'S DOUBTFUL THAT PLA CRITERIA WOULD EVER HAVE BEEN ADOPTED.

THE ESTABLISHMENT OF AN FAA PLA AT THIS AIRPORT WOULD NOT HAVE ALTERED THE OUTCOME, THEREFORE THIS REPORT HAS NO RELEVANCE TO THE INITIATIVE.