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"DEATH IS, TO A CERTAIN EXTENT, AN IMPOSSIBILITY WHICH SUDDENLY BECOMES A REALITY."

...Johann Wolfgang Von Goethe

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DEAR MEMBER:

In the twenty-four months of 1959 and 1960 five PCA members were killed sport parachuting. In the thirty days of April, 1961, five sport parachutists were also killed!!

In this, the belated April, issue, we sorrowfully devote ALL space to this blackest month in sport parachuting....five parachuting FATALITIES:

One	Failure to pull either ripcord
One	A static line failure and failure to use the reserve in time
One	Faulty canopy manipulation and electrocution in power lines
One	Mid-air collision on opening and parachute entanglement
One	Drowning during accidental water landing without proper precautions.

We sincerely hope that these deaths will have enough impact so that groups throughout the country will sit down with these reports, seriously discuss them, review their own regulations and proceedures, and conclude that SAFETY must be continuous throughout each phase of a jump and that nothing should be left to change..... that common sense must be applied where the general rules leave off..... that men must be evaluated prior to a jump to insure that they are capable of safely accomplishing both the planned and unplanned actions during the entire event..... and that each jumper "chalk-talk" his jump through, including emergency measures for any possible actions which can be anticipated with someone who is capable of constructive correction and suggestion.

FATALITY

1. NAME: Norman Douglas Fellows AGE: 21 PCA Member

2. LOCATION, DATE, and TIME: Lincoln Municipal Airport
Lincoln, California April 2, 1961
2:15 to 2:20 PM

3. WEATHER: Clear, 85 F., Wind to the north 0-5 MPH

4. TYPE OF JUMP INTENDED: 1st Jumper: Norman Fellows, a delayed fall for 20 seconds from an altitude of 5,500 feet, above ground, with an intended opening altitude of 2,500 feet.

PLANE: Cessna 172

5. ACCIDENT: Norman D. Fellows left the aircraft, under the supervision of a qualified jumpmaster, at 5,500 feet in a stable face to earth position then completed two 180 degree turns under apparent control. He approached and passed the 2,500 opening altitude with no attempt made to open either parachute. Some witnesses say that he rolled onto his back around 2,000 feet and maintained a stable spread position, without spinning, until he reached approx. 1,000 feet where he turned face down again. Somewhere between 150 ft. to 300 ft. he seemed to become aware that he was in trouble (moved his arms and legs) then he hit the ground in a face to earth stable position.
Both parachutes were inspected immediately. Both ripcords were still in the ripcord pockets. No attempt was made to open either parachute, by Norman Fellows, during the entire parachute jump.

6. EQUIPMENT: Back Pack: B-4 with Capewells, 28 ft. sleeve deployed Double L, A-3 Pilot Chute. FAA Rigger Packed

Chest Pack: 28 ft. QAC No sleeve, No pilot Chute. FAA Rigger Packed within date.

Instruments: 60 Second Dial Stopwatch
Altimeter: Early model "Sentinel" (not armed because of jumper's request)

NOTE: All equipment was inspected by local FAA and found to be in proper condition.

7. CAUSE OF DEATH: FAILURE TO PULL THE RIPCORD

REASON: UNKNOWN

FATALITY

NAME: Walter Lamb CLUB AFFILIATION: Tidewater Navy Skydivers

PLACE: Oceana, Va. DATE: April 23, 1961

DESCRIPTION:

"On April 23, 1961 at approx 12:15 P.M., two sport parachutists left an SNB-5 Naval aircraft at 7,200 feet for a 30-second delay with a body contact planned. The contact was made and at a pre-arranged signal the parachutists separated. At 2,400 feet, our altitude for pulling the rip-cord, one jumper turned into the other just as the lower jumper's chute opened. The top jumper tore through the apex of the lower jumper's chute and slammed into his chest. By this time the top jumper's main and reserve, an Army T7-A, were both deployed and entangled with the lower jumper's main. Both jumpers were clinging to each other. They fell this way until about 150 feet where the lower jumper managed to reach his reserve ripcord, a 26 foot conical, and activate it. His reserve inflated, tearing the other jumper loose and on into the ground. The lower jumper oscillated once and hit the ground. Injuries incurred were the instant death of the top jumper and torn ligaments and multiple bruises of the lower jumper. An investigation was held by the Navy and we are still jumping with one modification. We are not allowed to do any relative work. Our Constitution has been amended to read that parachutists doing relative work will be separated no lower than 3,500 feet. Also that only qualified "B" license holders and above will be allowed to perform relative work."

P.C.A. COMMENTS:

For the second time this year we are forced to comment on the coordination and maneuvering ability of jumpers doing relative work when their capability to do so proved questionable and caused injury or death. Last month's PARACHUTIST commented on this specific type incident. the qualifications for relative work must include the ability to avoid high speed mid-air collision, particularly just preceding the anticipated opening. The participants must visibly signal and break off relative work at 3,500, regardless of whether or not the planned action has been completed. This affords six seconds to maneuver to a safe interval, obtain ground bearings, check instruments, and open the 'chute. Based on observations, we question whether having a Class B license in the pocket helps a man maneuver. It does guarantee that the individual has at least 30 jumps, but, we have observed men with four times that amount of jumps who had questionable maneuver and, even, stability ability.

Therefore, we recommend that each man be evaluated on individual attitude and performance in the air. There are reckless drivers who cause accidents..... So also we have reckless parachutists and these types should be recognized as such and treated with the same caution that is given to the driver who passes on hills or curves.

In Summary: For Relative Work: Know your partners proficiency in the air.
Prior to enplaning talk the jump through completely, including actions to be taken in case all doesn't go as planned.
Stipulate the breakaway altitude, signals, and what each jumper will do at that time.
Know where the other jumper is when you pull the ripcord.

FATALITY

NAME: Clarence W. Long CLUB AFFILIATION: Puerto Rican Parachuting Assn.

PLACE: Caguas, Puerto Rico, Auto Race Track DATE: April 16, 1961

DESCRIPTION:

At 11:45 A.M. the club dropped three members at the opening of the Caguas Auto Racing Track. The deceased made a routine static line jump following the dropping of a wind-drift indicator, which showed no unusual conditions. The X was placed in the center of the track between two stretches of asphalt runway and about 350-450 yards up-wind from a small pond that was used for watering livestock. This pond measured 30 by 45 yards and was waist deep in most areas, except for the center, where there was a depth of 15 to 17 feet of water and thick mud. It should be noted that of the other two jumpers, one landed 6 yards from the X and one, 200 yards downwind of the target and well to one side of the pond.

CAUSE OF THE ACCIDENT: Long was headed in towards the target, but at approx 300 to 400 feet, he turned his 'chute downwind and held it in that direction until he landed into the pond that was downwind to the marker. Other club members stated that they had been informed that the pond was no more than waist deep. However, an experienced skin diver reported that an area in the pond's center was 15 feet deep with considerable mud. (Long's body was found submerged to his waistline in mud). As soon as Long hit the water, his canopy stayed inflated and commenced to drag him to the far bank. Undoubtedly, due to the slippery nature of the bottom, he couldn't hold the canopy and was dragged towards the center. When his canopy hit the bank on the other side, he

was left quite some distance from shallow water and he commenced to sink. Another club member, who was not a good swimmer, entered the water with his boots and jump suit and immediately got into difficulties himself. Long then shouted to him to get help but before two more club members reached the pond, Long had already sunk. His canopy was immediately pulled from the water but Long had ejected his shoulder releases. Several persons then dived into the water in an effort to locate the body, but they all encountered extremely difficult conditions. There was absolutely no vision and they had to grope their way along the bottom. After an hour's search, they located the body and brought it to the surface. Long still had his reserve attached but had ejected his helmet and canopy during his fight to stay afloat.

INDICATED P.C.A. VIOLATIONS:

1. No flotation gear was used when jumping within a mile of a body of open water.
2. Persons other than B license holders were jumping at a public function.
3. The DZ did not measure up to P.C.A. standards.

P.C.A. NOTE: Concerning flotation gear, it is conceivable that the majority of experienced jumpers would not have considered the two ponds on the DZ a hazard, especially when they believed them to be nothing more than small shallow livestock watering ponds. We might note here that this is the second drowning fatality in a livestock watering, which jumpers felt was not a hazard. It is about time that jumpers stop considering whether something is or is not a hazard and recognize a hazard as such. Long had indicated, previous to this jump that he would like to make a water jump, and it is the opinion of some of the club members that he deliberately landed in the pond. Needless to say, a water jump should be treated with respect and the details planned in advance.

Contributing factors to this man's death were: (a) Lack of common sense on the part of the deceased, (b) Failure to positively check the depth and condition of the pond, prior to the jump, (c) Improper planning by the individual in preparation to the jump, (d) Improper planning on the part of the club officials in that there was a hazard in the DZ area but no preparations were made in the event that someone landed in the hazard, (e) Improper Prepare-To-Land action for water landing.

FATALITY

NAME: Jerome O. Bueller CLUB AFFILIATION: Beaver Sport Parachute Club

PLACE: Salem, Oregon DATE: April 16, 1961

DESCRIPTION:

Jerome Odell Bueller, 21, of Salem, Ore., jumped from a four place aircraft from 2,600 feet over a farm field 10 miles southwest of Corvallis, Oregon. The static line did not function, and the emergency cord was not pulled in time. This death was caused by a static line failure. The normal static line was made from a rip cord using the four pins and swedged together through the static line loop. Upon exiting from the plane, the cable came loose and slipped through the static line loop. The student was on his second jump and did not pull his reserve until 100 feet from the ground.

P.C.A. COMMENTS:

It is indicated that the swedging holding the rip cord attachment loop to the

static line was faulty. It behooves everyone jumping static line students to check these swedges, along with each pin at every repack. It is possible not to detect any flaws at this inspection, but the probability of catching it in advance leaves nothing to chance. We have information indicating that some groups made up their static line swedges by taking a piece of copper tubing and crimping it over the rip cord wires with a pair of pliers! It is mandatory that this swedge be placed on this connection with at least 300 pounds of pressure, using the proper swedging material. In this particular fatality, it is important to emphasize the equipment check to be made prior to a jump, looking specifically for things which may not function properly during the jump. Actually, cause of this fatality is that the student did not activate his reserve at the proper time. Again, we would like to stress that the reserve activation procedure must be drilled into each student, along with his counting and stable fall position training, from the moment he starts in the program. Beginning students must make their normal count, and, if nothing has happened by the end of the count, immediately open the reserve in the proper manner. There is no substitution for proper training and the drilling of each student in reserve procedure. And remember, even automatic openers sometimes fail to function properly.

FATALITY

The death of Frank Huminsky, caused by landing in power lines, was reported so well that we are reproducing the report made by Mr. Don Morrow, the Club SO for the Midwest Skydiving Club, and it indicates the thoroughness with which many clubs function. It also indicates no attempt to cover up or make excuses, and it is a fair and factual report from which other jumpers can understand, perhaps, what we have been trying to say for over three years.....

"As Club Safety Officer for the Midwest Sky Diving Club, South, and the nearest Safety Officer to the scene of the accident, it is my unhappy duty to report the death of one of our members. You will note that the Area Safety Officer has countershigned this report, and we are submitting it jointly.

ACCIDENT REPORT - DEATH

Data on individual killed

Name: Frank E. Huminsky
Address: 338 West 101 Place
Chicago, Illinois

Married - 2 children
26 years old - male
Medical: Current, good physical condition

Standing in Club Dues not paid and was, therefore, not an active member. Intended to move out of State within three weeks, and was resigning from Club. No official action had been taken to terminate his membership by either Mr. Huminsky or the Club at the time of his death.

P.C.A. Membership 1960 - Membership #1265
1961 - Unknown because he was not an active member of the Midwest Sky Divers and no proof of P.C.A.membership could be found subsequent to accident.

Jump Experience and Ability Demonstrated prior to fatal jump

Military: Ex-Paratrooper - 37 Static Lines
Civilian: 5 Static Lines
25 Free Falls and Delayed Falls including several 20 and 30 second delays.

Individual had demonstrated complete stability and control during free fall, could hold

a heading and was working on slow turns. His spotting and canopy work was always inconsistent. Some jumps he displayed excellent accuracy on target, while for no apparent reason, he badly misjudged on other jumps. Three weeks previous to fatal jump, individual requested that he be granted permission to jump from two place aircraft and that such permission be noted in his log book. Permission to jump from two place aircraft was refused by Club Safety Officer because jumper had not shown sufficient proficiency in either spotting or canopy manipulation. On a few occasions individual was allowed to jump a two place aircraft, but in each case a jumpmaster had dropped a winddrift indicator just previously so opening spot was accurately marked and winds were under 10 M.P.H.

In short, individual had very nearly completed the qualifications for a "B" License, but was weak in spotting and canopy manipulation.

Data on fatal jump:

The undersigned was not present at time of jump but arrived on the scene within 25 minutes of accident. The following is based on a compilation of his observations and statements obtained from eye witnesses.

Date: Sunday, April 23, 1961
Time: 10:55 A.M. (time of death)
Place: Peotane Airport, Peotane, Illinois
Weather Conditions: Clear to partly cloudy
Wind: 15 m.p.h. from the Southeast
Plane: Cessna 140 (two place)
Pilot: Over 200 hours, commercial license
Other jumpers or P.C.A. license holders present: None

Winddrift indicator was dropped and all facts indicate that spotting was good.

Jump Altitude: 5,400 Feet
Delay: 20 seconds
Opening Altitude: 2,500 Feet
Equipment: T-10 canopy with TU gore (First jump with new canopy - not TSO-C23 stamped or rigger checked. Safety Officer or other Club Officers had no knowledge of his canopy.)

B-4 harness and container
T-7 Reserve with Areo Indicator Panel, Altimeter and Stop Watch. Helmet, goggles, gloves, coveralls and boots.

According to eye witnesses everything went exactly as planned up to and including opening at 2,500 feet. The deceased then ran with the wind too long but did hold against the wind part of the time. Upon approaching the target, he again ran with the wind (he may have been trying to avoid tied down airplanes which were near his target) going past the target by approximately 250 yards before striking an electrical power line (2,400 volts in each of the two wires.) One line burned through and he fell on the live wire. Death resulted upon contact with the two wires. Efforts to revive deceased were made by local police, firemen and a doctor. Efforts were to no avail.

Violations of P.C.A. Safety Regulations:

1. Jumping without a P.C.A. license holder present.
2. Target less than 300 yards from nearest hazard. (Area more than meets distance from hazards req uirements, but target placed close to north edge of DZ rather than

in center of DZ).
3. No ground crew present.
4. Jumping from a two place aircraft.
5. Canopy not TSO-C23 stamped or rigger stamped for sport jumping.

Need we go further.

In addition to violating P.C.A. safety regulations and local club rules, the deceased showed extremely bad judgment in canopy manipulation. In the undersigned's opinion, based upon all pertinent information obtained and a personal knowledge of the area, proper canopy manipulation would have landed the deceased on or near the target even though many safety regulations were ignored.

For the Record: The Midwest Sky Diving Club ridgedly enforces all P.C.A. regulations and stresses common sense. This is a case of a jumper ignoring both without knowledge of other club members and tragic results occurred.

God willing, I shall never have to write another such report."

"DANGER FOR DANGER'S SAKE IS SENSELESS."

....Victor Hugo

Sincerely,

PARACHUTE CLUB OF AMERICA

Parachutist

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