

Safety Investigation Brief

Fatal Parachute Accident Parakai

Summary of occurrence

On the afternoon of 15 March 2019 the parachutist conducted his first jump of the day, departing from Parakai Aerodrome and exiting the aircraft at 13000 feet.

The parachutist was witnessed by staff members at the local skydiving organisation on his approach to the landing area initiating a hard left turn, with subsequent acceleration, at approximately 100 feet above the landing area. This manoeuvre oriented his canopy downwind, and delayed the recovery of the parachute to level flight. The parachutist struck the ground at speed in an approximate 45° angle of descent.

Review of video of the accident revealed the parachutist did not flare¹ the parachute to slow for landing, prior to striking the ground, nor did he adopt the emergency landing position².

The parachutist was attended to by first aiders and then airlifted to Auckland City Hospital, where he died the following day.

A review of the parachutist's records indicated he was current, and correctly qualified for the parachute jump, with no record of any previous parachute handling incidents.

It was not possible to determine why the parachutist elected to conduct high energy manoeuvres late in the approach sequence, or why he made no attempt to flare the parachute to reduce speed prior to striking the ground.

¹ Flaring the parachute is achieved by pulling down on the steering toggles, and results in the parachute slowing down, and reducing the rate of descent.

² A body position designed to spread the impact of a hard landing over several less critical areas of the body.

Administrative information

| | | |
|---------------------------------|--------------------------------------|------------|
| Aircraft manufacturer and model | Icarus Safire 3 129 | |
| Engine manufacturer and model | N/A | |
| Serial Number | N53335 | |
| Location of incident | Parakai Aerodrome | |
| Date and time of incident | 15 March 2019, approximately 1430hrs | |
| Flight rules applying | Private | |
| | Visual (VFR) | |
| Occurrence number | 19/1815 | |
| Injuries | Crew | One, fatal |
| | Passengers | Nil |
| | Others | Nil |

Pilot information

| | | |
|--------------------------------|--|-----|
| Age and gender | Male 27 years | |
| Pilot licences | NZPIA C Licence C2797 | |
| Pilot ratings | NZPIA High Altitude Course 5D Wingsuit Course | |
| Parachuting experience (Jumps) | With parachute type | 9 |
| | In last 30 days | 23 |
| | In last 90 days | 63 |
| | Total recorded jumps | 268 |

Meteorological information and flight plan

| | | |
|-----------------------------|-----------------------------------|--|
| Conditions at incident site | Wind (knots) | 070° at approximately 12-15 knots |
| | Visibility | Greater than 10km |
| | Cloud (descriptor) | Few – Scattered – Broken – Overcast |
| | Pressure (hPa) | Not known |
| | Temperature (°C) | Not known |
| Departure point | Parakai | |
| Destination | Parakai | |
| Location | S 36° 39' 01.25" E 174° 25' 52.9" | |

About the CAA

New Zealand's legislative mandate to investigate an accident or incident are prescribed in the Transport Accident Investigation Commission Act 1990 (the TAIC Act) and Civil Aviation Act 1990 (the CAA Act).

Following notification of an accident or incident, TAIC may conduct an investigation. CAA may also investigate subject to Section 72B(2)(d) of the CAA Act which prescribes the following:

72B Functions of Authority

(2) The Authority has the following functions:

(d) To investigate and review civil aviation accidents and incidents in its capacity as the responsible safety and security authority, subject to the limitations set out in [section 14\(3\)](#) of the [Transport Accident Investigation Commission Act 1990](#)

The purpose of a CAA safety investigation is to determine the circumstances and identify contributory factors of an accident or incident with the purpose of minimising or reducing the risk to an acceptable level of a similar occurrence arising in the future. The safety investigation does not seek to ascribe responsibility to any person but to establish the contributory factors of the accident or incident based on the balance of probability.

A CAA safety investigation seeks to provide the Director of the CAA with the information required to assess which, if any, risk-based regulatory intervention tools may be required to attain CAA safety objectives.

About this safety investigation brief

The purpose of this brief is to identify to the aviation community:

- what happened
- factors contributing to the accident
- any relevant safety messages.

Civil Aviation Authority of New Zealand
Level 15, Asteron Centre
55 Featherston Street
Wellington 6011

OR

PO Box 3555, Wellington 6140, NEW ZEALAND

Tel: +64-4-560 9400 Fax: +64-4-569 2024

www.caa.govt.nz