HGFA Airwaves
18th of June, 2012

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SAFETY ISSUE

CORONERS COURT FINDING

All HGFA members as individuals and some as Club Officials should address themselves to the following.

Mr Roderick Peter Oldfield a much loved, liked, admired and respected man and a Paraglider Pilot died in a paragliding accident on 7 October 2010.

On the 27 March 2012 the Victorian Coroner issued a finding into the death of Rod Oldfield and issued recommendations. (Link to full report below.)

Its statements included the following.

"The HGFA should distribute this finding into the death of Mr Oldfield to all associated paragliding clubs to encourage awareness of the importance of having safety management systems (reference to IRIS - Incident Reporting Information System) of this kind, and to encourage clubs and pilots to utilise fully the IRIS system for improvements in the ongoing safety of the sport."

REPORT ACCIDENTS AND INCIDENTS ON IRIS, THOSE INVOLVING YOURSELF AND ALSO THOSE OF OTHERS. MULTIPLE REPORTS ARE NOT A PROBLEM, THE PRESENT CHRONIC NON-REPORTING IS.

It is most important that the HGFA Community of pilots are informed of the risks that exist in the pursuit of out particular flying activities and in aviation in general.

In the interest of pilot awareness of specific risks in our activities and recommendations that contribute to their individual safety a summary of elements of the Coroner's report are provided below.

Roderick Peter Oldfield died on 7 October 2010 at Emily Spur, 500 metres north of the

Mystic Hill Launch Site, Mystic Lane, Bright, Victoria, 3741 from "Multiple Injuries Fall from Height (Paraglider)".

He was described by fellow pilots and by his partner as a very safety conscious pilot who was meticulous in regards to the maintenance of his equipment.

Detective S/C Neinkemper, who had known the Mr Oldfield for about ten years through the paragliding community and believed him to be an experienced and competent pilot, inspected the paraglider on 8 October 2010. He did not find any faults with the paraglider but did note the leg straps were not closed. Detective S/C Neinkemper concluded that the accident was the result of pilot error and that Mr Oldfield had fastened only the apron and flight deck of the pod and not fastened the leg straps prior to take-off. This error had gone undetected because the design of this particular harness meant that Mr Oldfield's flight deck covered the area where the leg straps attached to the harness.

The Coroner's Prevention Unit (CPU) concluded that whilst it is difficult to establish the number of deaths that occur because paragliders fail to secure their harness, there is sufficient information to suggest that it is a well recognised problem in the paragliding community.

In many of the previous paragliding incidents identified by the CPU where harnesses were not properly secured, the incident occurred following an interrupted pre-flight check, or following a take-off which had failed and was then repeated.

Harness safety education should aim to ensure that pilots understand that when there has been an interruption to the pre-flight check, or there has been an aborted take-off, they are at significant risk of overlooking a critical safety step and that, in such circumstances, pilots should ensure that they repeat the pre-flight checks again from the beginning.

Recommendations

1. That the HGFA encourage all Australian paragliding clubs to ensure that safety education is regularly provided to all paragliding pilots. This education should enforce the importance of pre-flight check, and include recovery techniques for unsecured harnesses. It should also ensure paraglider pilots are aware that they are most at risk of a critical safety error in the circumstances of an interrupted pre-flight process, or failed take-off, and that they should diligently repeat their pre-flight checks from the beginning in these circumstances.

2. That the HGFA actively engage with all paragliding harness manufacturers who provide harness for the Australian market, to encourage the development of appropriate safety designs directed to reduce the incidence of unsecured harness straps, and to provide appropriate feedback and analysis of safety innovations already in the market.

http://www.coronerscourt.vic.gov.au/resources/3bb9d8d8-06af-417d-8e64-e60ae3203434/roderickpeteroldfield_.pdf

Fly Safely - LIVE in four dimensions
John Twomey, Operations Manager, HGFA

For technical information, visit: http://www.dhv.de/web/en/safety/articles-statistics/pod-harness-test/

R.I.P. R.P.O.

About 'Airwaves'

Airwaves is intended to communicate pertinent notices in-between the printed magazine editions.

If anyone has any suggestions or comments about 'Airwaves' then please send them through to: secretary@hgfa.asn.au.

Regards,

Sun Nickerson
HGFA Secretary

Feedback

Questions and or feedback regarding HGFA Operations or Management are welcome! Please feel free to email the HGFA Committee (committee@hgfa.asn.au).

Sincerely,

The HGFA

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