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Safety & Training Committee

Minutes of the meeting held on

Thursday 06 June 2024 at 17:00 on Microsoft Teams

Present:	Jeff Montgomery	-	Chair STC/Head of Safety & Competitions
	Iain Anderson	-	Skydive St Andrews
	Kieran Brady	-	Skydive Strathallan
	Alex Busby-Hicks	-	Skydive Tilstock
	Paul Dorward	-	Skyhigh Skydiving
	James France	-	RAF Weston on the Green
	Chris Good	-	Army AT Air Wing (N)
	Reg Green	-	Go Skydive/Pilgrims
	Nick Hynes	-	Black Knights
	Rudy McClenaghan	-	Skydive Ireland
	Russ Mellish	-	Army Parachute Association
	Andy Montriou	-	Cornish PC
	Sara Orton	-	Skydive GB
	Andy Pointer	-	Sibson Skydivers
	Pete Sizer	-	Chair Riggers' Subcommittee / Headcorn
	Gary Small	-	Skydive Chatteris
	Jason Thompson	-	Beccles Skydivers
Apologies for Absence:	Paul Floyd	-	Cyprus Parachute Centre
	Chris McCann	-	Skydive Hibaldstow
	Mike Carruthers	-	Skydive North West
In attendance:	Mary Barratt	-	Chair British Skydiving
	Tony Crilly	-	Council
	Kevin Dynan	-	STO
	Robert Gibson	-	Chief Executive Officer
	Dr Jake Hard	-	Medical Adviser
	Trudy Kemp	-	Assistant to Head of Safety/Secretary
	Ryan Mancey	-	STO
Observers:	Dylan Bartle, Dr John Carter, Bryn Chaffe, Jeremy Denning, Neal Fitzpatrick, Martin Harris, Mike Patchett, Mike Rust, Chris Sears, Reece Tudor-Owen.		

ITEM **MINUTE**

26/24 **WELCOME**

26.1 The Chair welcomed all members and guests to the 3rd STC Meeting of 2024. He gave the meeting details of the procedures for wishing to speak, voting etc, and stated that the meeting would be recorded to assist with preparation of the minutes, after which the recording would be deleted.

26.2 The Chair stated that British Skydiving has a very strong link to the military, going back to 1961 when BPA was first formed. In acknowledging the tributes which have been paid today across all our four nations, on the 80th Anniversary of the D Day Landings, which took place in Normandy on 6 June 1944 and to recognise the sacrifice of those men and women who gave their lives for the freedom we enjoy today. The Chair asked Chief Instructors to join him in a

minute's silence, to honour those brave men and women who made the ultimate sacrifice for their countries.

27/24 **DECLARATIONS OF ANY CONFLICTS OF INTEREST**

The Chair asked that any voting member with a personal, financial or material interest in business on the agenda should declare that interest at the appropriate item.

28/24 **MINUTES OF THE STC MEETING OF 11 APRIL 2024**

It was proposed by Pete Sizer, seconded by Russ Mellish that the Minutes of the STC meeting of 11 April 2024 be accepted.

Carried Unanimously

29/24 **MATTERS ARISING FROM THE STC MEETING OF 11 APRIL 2024**

29.1 **Page 2. Item 17.1 – Matters Arising – (Removal of the TBI Rating)** The Chair reported that due to a number of pressing matters that the safety team have been involved recently, the TI manual was still in the process of being formatted. It would then be made available to CIs for further consultation and comment.

Action: Chair STC, STOs

29.2 **Page 2. Item 17.2 – Matters Arising – (DSA Working Group).** Kevin Dynan (STO) reported on the recent Coroner's Inquest that had taken place in relation to the fatal accident of Rachel Fisk. At the end of the Inquest which lasted three days, and based on the evidence presented, the jury returned a conclusion of `accident'.

Kevin Dynan reported that the Coroner had noted two key points:

- One of the actions that the RAF were planning to take in the future was to conduct trials into the interaction of the 'burble' and camera wings. The Coroner is planning to write to the RAF to encourage them to report back to the Coroner on their findings with those trials.

- The Coroner is also planning to write to the CAA to encourage them to liaise with the FAA to clarify the differences with the TSOs and the technical standards that are used in rigging.

Action: Chair STC

29.3 **Page 4. Item 17.3 – Matters Arising – (Suspension of the TI rating).** Kevin Dynan reported that he has liaised with the TI concerned on numerous occasions, and haven't confirmed their availability to an interview panel.

The Chair stated that if there is no further communication from the TI concerned, it is likely that they would have to attend another TI Course to regain their rating.

Action: Chair STC

29.4 **Page 4, Item 17.4 – Matters Arising – (STC Review).** The CEO provided a summary of where we are currently with the STC review.

He stated that a methodology had been created to explore future options of STC and gave several examples:

- Governance structures within STC and its leadership
- How STC interacts with Riggers and other SIGS within STC
- Meeting frequency and average meeting attendance
- Decision making process and aligning the relevant expertise required within STC as it covers a large spectrum of technical matters including the Operations Manual, flying, medical and rigging etc.
- Improve the overall efficiency of STC

The CEO stated that STC is an important group, and shouldn't lose sight of the good work that STC currently undertakes, its credibility and its power of making high quality decisions.

As part of the consultation process, we will shortly be putting out a survey to all stake holders who come under the remit of STC. This will be a comprehensive review, analysing data from research. This approach will take time to complete and the findings reported back to CIs by late summer, early autumn.

Action: CEO, Chair STC, STOs

29.5 **Page 4, Item 17.5 – Rigging Matters – (Extension of the reserve repack cycle).** The Chair reported that this item will be a main agenda item for consideration by the Riggers' Subcommittee once a meeting is scheduled and any feedback will be reported to STC for consideration.

Action: Riggers' Chair

29.6 **Page 6, Item 18.1.1 – Rigging Matters – (Recommendations to Consider from the Reserve Packing Tool Incident)**. The recommendations put forward as a result of this incident will be considered by the Riggers' Subcommittee and any feedback will be reported to STC.

Action: Riggers' Chair

29.7 **Page 7, Item 18.1.3 – Rigging Matters – (Recommendations to Consider from Javelin Container Canopy Compatibility Incident)**. The recommendations put forward as a result of this incident will be considered by the Riggers' Subcommittee and any feedback will be reported to STC.

Action: Riggers' Chair

30/24 RIGGING MATTERS

Since the last STC Meeting in April, there has been one Rigging related incident report received. Details of which had been included in the STC SharePoint folder for this meeting.

The report concerned a Record of Inspection (ROI) Form (F112) that appeared to have been amended and re-used. The paperwork had been amended with tippex, covering the name, number of the previous and date of next inspection and added their details to the ROI, in effect, re-using the previous document.

British Skydiving staff contacted the Advanced Packer (AP) concerned, to bring the error to their attention, and the AP, provided an explanation of how it happened.

The equipment was packed in the USA, by a British Skydiving AP, who also held an FAA Rigger qualification. The rig was being repacked as it did not have a seal on it, as per the current FAA regulations. The owner requested the AP to produce a British Skydiving ROI, however, the AP did not have their ROI book with them and made the amendments as per the request of the owner, with the agreement, that the AP would send a new ROI in the post once they returned to the UK. The following day, the equipment owner, experienced a cut away, and got the reserve re-packed by different FAA rigger, who did not look at the ROI, just the data card, therefore, the ROI remained with the equipment without having been replaced by the previous packer, as there was no need to re-issue a new ROI on return to the UK.

The Chair reported that no action has been taken on behalf of British Skydiving, and the AP concerned was deeply apologetic for any misunderstanding.

31/24 INCIDENT/INJURY REPORTS – RESUMÉ

A resumé of incident and injury reports had been included in the SharePoint folder for this meeting.

The Committee were given details of a number of additional incident and injury reports received since the Agenda had been published, details of which will be included in the full Incident Resumé (Appendix 1).

Kevin Dynan (STO) provided further details relating to a number of the additional incidents:

The first incident involved a B Licence skydiver with 194 jumps cutaway after what they thought was initially a pilot chute hesitation. The jumper was tracking away from a 7-way FS jump. They were initially about to pull but noticed that another jumper was close after tracking in a similar direction. They extended their track slightly and deployed without washing off the speed. The main did not deploy as expected so the jumper conducted their reserve drills. The reserve deployed but the main pilot chute was entangled with the reserve lines. The jumper cleared the pilot chute but noticed that the main deployment bag was still trailing behind them. The main risers had released but remained attached to the RSL which had not released and was still attached at the Velcro. The jumper landed without incident. They were jumping a Scorpion 190 main canopy and Paratec Next container. Images taken after landing of the equipment have been included in the resumé.

The second incident involving a Wingsuit jumper with 504 descents experienced a similar incident following a wingsuit jump. The wingsuiter had a bag lock on deployment, but after cutting the main canopy away, one riser remained attached from the RSL. They were jumping an SWS container and Skipper 150.

Kevin Dynan stated that he had personally not heard of this type of incident occurring before and that he would be following this up with Paratec.

One of the additional reports had included a Tandem instructor with 963 Tandem descents who experienced two malfunctions a couple of weeks apart. The first malfunction was caused by a steering toggle that was entangled with the slider after opening. The instructor made several attempts to clear the entanglement but was unable to do so. The instructor believes this may have been caused by a brake fire on opening. The second malfunction was caused by a streaming canopy. After an uneventful Tandem skydive, the instructor deployed the main canopy only for it to stream for several seconds longer than expected. The Instructor attempted to assist the deployment by pulling on the rear risers but when that did not clear the streamer, they carried out their full reserve drills. The canopy was an A2-350. The instructor had packed neither of the two canopies involved in the two incidents. Both canopies were packed by different packers.

Kevin Dynan stated that in discussion with other members of the safety team, streamers are not unusual on older A2 canopies. However, the canopy involved in these incidents only had approx. 600 jumps.

The CI of the PTO concerned reported that it was possible that the drogue may not have been calibrated properly, which may have potentially resulted in a slower opening. The PTO are currently investigating this process together with the size of sliders for the A2, as this may also have a significant impact on this particular incident. He will keep the STOs updated. The CI concerned stated that the canopy in question is now back online and has been jumped numerous times since this incident without further problems.

Kevin Dynan asked if anyone else was experiencing similar issues to please report them to HQ, so that we can monitor the situation.

Kevin Dynan reported that we have received quite a few incident reports in a short space of time,

It was felt by those present that not a lot of jumping had taken place recently due to the bad weather, which may have resulted in some jumpers suffering a lack of currency, and that due to this may have had an impact on the increase of incidents.

Kevin Dynan reported that he had conducted a comparative analysis into the amount of incident reports that we had received to date compared to the same period last year. He stated that the figures are only really relevant if we have the exact number of jumps that have been undertaken at PTOs at this point in the year.

He asked whether PTOs thought there was any value in reporting the number of jumps they are conducting on a more regular basis which he believed may help to identify trends etc.

There did not appear to be much appetite for this from those CIs present, but it was felt that there may be some value in looking at the currency of the individual jumper concerned rather than reporting the overall jump numbers more regularly.

Kevin Dynan provided an update regarding an B Licensed skydiver who sustained serious spinal and pelvis injuries whilst practicing high performance landing manoeuvres. He reported that the skydiver concerned had to undergo an operation and currently remains in a spinal unit.

32/24 **SKYDIVING FATALITY – INTERIM REPORT RESUMÉ**

An interim resumé report following the recent fatal accident at Sky-High Skydiving had been included in the STC SharePoint folder for this meeting.

The Chair reported on the tragic death of a British Skydiving member whilst filming a Tandem skydive at Sky-High Skydiving on 27 April. British Skydiving extended their deepest condolences to their family, friends, and colleagues.

Immediately after British Skydiving were informed of the accident, both the HOSTC and one STO went to Sky-High Skydiving and instigated a Board of Inquiry, which is ongoing. The Board consists of the HOSTC, the two STOs and the Chair of the Riggers' Subcommittee as a co-opted member.

Statements from the staff and GoPro footage taken by the Videographer indicate that after an uneventful freefall and Tandem deployment, the Videographer initiated the deployment of their main canopy. As the canopy deployed, it was observed that the left-hand brake had fired immediately, causing the canopy to spin during the opening, and induce diving line twists.

The Videographer attempted to clear the twists for approximately 11 seconds whilst the canopy is in a diving rotation. The Videographer's hands leave the risers and disappear from view for a further 17 seconds (it is presumed because they are attempting to cutaway). The Videographer then resumes attempts to clear the twists for a short period of time before the reserve pilot chute is seen to deploy and fully inflate but not extract the reserve canopy. Shortly after the reserve pilot chute deploys, the Videographer's hands are again lost from view. Eleven seconds after the reserve pilot chute is deployed, the Videographer impacts the roof of a warehouse building.

The AAD was a Cypres-2 which was turned on before use. The AAD did not fire during the canopy descent. The AAD has been sent to Airtec for analysis and the Board are expecting Airtec's analysis to be returned in June.

Investigations are ongoing. Until the Board completes its full report, the following reminders should be considered for all jumpers:

Emergency Procedures: *Skydivers should be reminded to practice their emergency procedures with particular emphasis on 'peeling' the cutaway pad off of the retaining Velcro before punching it down. Also, on the importance of not delaying the cutaway procedure for too long, whilst attempting to kick out of diving line twists.*

Packing: *All packers are to be reminded of the importance of ensuring the steering toggles are stowed in the correct manner. Depending on the riser design, the eyelet in the steering line must be pulled below the guide ring, inserting the tab of the toggle all the way through the eyelet of the steering line. The tab of the toggle should end up secured in the in the toggle keeper at the top of the guide ring, depending on the design of the riser.*

Equipment: *Attention should be paid to the condition of the equipment, as toggle keepers may sustain wear and tear over time, allowing sufficiently stowed toggles to release prematurely. Attention should also be paid to the excess line keepers, often situated on the reverse side of the rear riser, to ensure the excess remains secured during deployment, and not trailing prior to taking control of the canopy.*

Jumpers should also consider installing hard housings within the cutaway cable channels of their risers, should they not have these fitted. Jumpers should contact their PTO Rigger & manufacturer of their container for details of any hard housing design and installing instructions.

The Chair reported that the Board would complete their findings in due course, which may include further recommendations if appropriate. A more detailed resumé would be circulated to Chief Instructors shortly.

33/24 PROPOSED RELOCATION TO A NEW DZ – SKYDIVING LONDON

A proposal from Dylan Bartle had been included in the STC SharePoint folder for this meeting regarding the relocation of Skydiving London to RAF Weston on the Green.

Full details of the request together with aerial maps of the location had been included in the STC SharePoint folder for this meeting.

The DZ intends carrying out all types of Parachuting, including solo AFF & Category system students, Tandem and other Licensed jumping.

Both Martin Harris (DZ Operator) and Dylan Bartle (Chief Instructor) were present at the meeting.

Following consideration, it was proposed by Andy Montriou, seconded by Russ Mellish that the above request be accepted.

For: 15 Against: 1 Abstentions: 1 (Chris Good)

Carried

The Chair reported that the above was also subject to the acceptance of the PTO Affiliation application by Council.

34/24 ACCEPTANCE OF STC & RIGGERS' SUBCOMMITTEE TERMS OF REFERENCE AND STC PROPOSAL PAPER

34.1 STC Terms of Reference (Form 160)

A draft of the STC Terms of Reference had been included in the STC SharePoint folder for this meeting.

The Chair reported that subsequent to the review of the Riggers' Subcommittee Terms of Reference, this in turn had led to a number of amendments within the Terms of Reference for STC.

The Chair clarified a number of points raised by CIs regarding the amended Terms. He stated that there had been some technical issues with regard to some CIs being unable to access the STC SharePoint folder. In most cases the issues had been resolved with the assistance of British Skydiving staff and our IT company. Anyone else experiencing problems was asked to contact the STC Secretary.

Following consideration, it was proposed by Pete Sizer, seconded by Rudy McClenaghan that the STC Terms of Reference be accepted.

For: 15 Against: 1 (Gary Small) Abstentions: 0

Carried

34.2 Riggers' Subcommittee Terms of Reference (Form 194)

A draft of the Riggers' Subcommittee Terms of Reference (Form 194) had been included in the STC SharePoint folder for this meeting.

The Chair reported that the Riggers' Subcommittee Terms of Reference had already been accepted by Riggers' following an E-vote in early April.

Following consideration, it was proposed by Pete Sizer, seconded by Reg Green that the Riggers' Subcommittee Terms of Reference be accepted.

Carried Unanimously

34.3 STC Proposal Paper (Form 354)

A draft of the STC Proposal paper had been included in the STC SharePoint folder for this meeting.

Following consideration, it was proposed by Gary Small, seconded by Russ Mellish that the STC Proposal Paper be accepted.

Carried Unanimously

The Chair stated that Form 354 would be published in due course and that any future proposals to STC should be submitted on this form.

35/24 PERMISSIONS

35.1 Request from Red Devils Army Parachute Display Team

A request had been received from Stephen Handley, Team Leader of the Red Devils Army Parachute Display Team to carry out a display into an arena which falls outside the usual British Skydiving requirements.

Full details of the request together with aerial maps of the location had been included in the STC SharePoint folder for this meeting.

The proposed display this year is to be held at the National Memorial Arboretum in Staffordshire on 6 July 2024. The display landing arena has a total area of 10,500 square metres (more than the 5000-square metre BS requirement). However, the width of the arena varies as it has an irregular shape. It is 25-30 metres on the whole but in parts it widens to 50 metres. Therefore, they did not have 50 metres of width for the whole arena as laid down in the British Skydiving Operations Manual.

This arena was cleared previously by STC in 2022 and 2023 for the Red Devils.

Because the arena curves around roughly in a circular shape, landing into wind will be possible regardless of the wind direction. Therefore, the caveats proposed by the Team Leader are as follows:

1. The exact landing area will be dictated by the weather conditions on the day, and we will land directly into wind i.e. the cross will be moved to favour an into wind landing.

2. No landing of any canopy formations in the arena.

3. Each parachutist must have completed a minimum of 700 jumps to take part in this display.

4. Each parachutist must have completed a minimum of 30 parachute displays and deemed competent by the team leader.

5. The organiser must ensure that the whole area (outlined on the image) is available for us to land on.

6. All jumpers must wear a floatation device (PLP).

7. All participants will be current full time team members and will have completed a full display season.

Following consideration, it was proposed by Chris Good, seconded by Paul Dorward that the above request be accepted.

Carried Unanimously

35.2 Request from – GoSkydive

A request from Reg Green had been included in the STC SharePoint folder for this meeting.

Reg Green had requested an exemption from Section 9, 1.3.2. (Chief Pilot Requirements) of the Operations Manual as it pertains to a Mr Reece Tudor Owen, with the caveat that he cannot conduct British Skydiving Pilot Proficiency Checks.

The Drop Zone seeks to appoint a non-flying Chief Pilot whose role is predominantly the oversight of flying operations and compliance. Mr Tudor-Owen is an ideal candidate for this position, with a credible flying background, previous experience as a Chief Pilot and a substantial amount of parachute flying. Unfortunately, he no longer holds a medical due to a medical condition. However, his condition does not in any way impact his ability to perform administrative tasks, mentor pilots or oversee the conduct of flying operations.

Reg Green's request had also provided full details of Mr Tudor-Owen's flying experience to date. Unfortunately, as Mr Tudor-Owen does not hold a medical, he cannot fulfil the currency requirement of the Chief Pilot role (See Operations Manual, Section 9, Para 1.3 below) nor can he conduct British Skydiving Pilot Proficiency Checks. To become current and perform Proficiency Checks, one must do so by flying as PIC. Flying as PIC cannot be achieved by conventional means. Nor is it pertinent to many aspects of the intended appointment. Even though his role will be an entirely ground based, Reg Green states that he considers it to be prudent to have Mr Tudor-Owen re-familiarise himself with parachute flying, to better act as a CP. Reg Green proposes that this can be achieved by means of an SET instructor, who is also British Skydiving current, to fly with Mr Tudor Owen for a nominated amount of parachute sorties. British Skydiving Pilot Proficiency Checks can be conducted by any Pilot Examiner or Chief Pilot, and these will be conducted by other suitably qualified pilots flying for GoSkydive (See Operations Manual, Section 9, Para 1.1.7 below).

"British Skydiving Operations Manual, Section 9 Flying.
1.3. Chief Pilot (CP). 1.3.1 CIs will appoint a Chief Pilot who will be responsible to them for the PTO's flying operations. The name of the CP should be notified to British Skydiving in writing at least seven days in advance of the appointment (Form 108H – British Skydiving Chief Pilot Application). 1.3.2 To become a British Skydiving Chief Pilot (CP) the applicant must meet the following minimum requirements: a. Be a current British Skydiving Authorised Pilot. b. Have a recommendation of a CI and a Pilot Examiner (Form 108H). c. Have been a British Skydiving Authorised Pilot for at least 1 year. d. Have a minimum of 100 hours' skydiver flying. e. Have successfully completed CP written examination, administered by an STO or the HoSTC."

"British Skydiving Operations Manual, Section 9 Flying.
1.1.7. Proficiency checks. All Pilots must complete a proficiency check at least every twelve months. This must be conducted by a CP or PE and signed off on Form 108E. This form is to be retained in a Pilot's personal file, which is to be kept and maintained by the CP."

Both Reg Green and Reece Tudor-Owen were present at the meeting to answer any questions relating to this request.

Following consideration, it was proposed by Jason Thompson, seconded by Rudy McClenaghan that the above request be accepted.

For: 13 Against: 0 Abstentions: 3 (Reg Green, Alex Busby-Hicks, Gary Small)

Carried

35.3 Request from Andy Pointer – Sibson Skydivers

A request from Andy Pointer had been included in the STC SharePoint folder for this meeting for Gerry Cepelak to regain his TI rating after a long lay-off.

Andy Pointer stated that Gerry Cepelak has a total of 699 Tandems, the last of which was in November 2014. He anticipates Gerry completing a full TI course due to the length of time since the last Tandem but are asking to skip the TBI course.

Prior to attending the TI course, Andy Pointer will refresh the MOI lecture with Gerry as well as run through some teaching practices. He will also familiarise him with current safeguarding procedures and the code of practice and code of conduct, as these were not part of the TBI Course at the time that Gerry Cepelak originally gained his rating. Andy Pointer had also stated that Gerry Cepelak has held a CSI rating in the past and that he holds a current British Skydiving Parachute Rigger rating.

Andy Pointer had asked STC to consider granting Gerry Cepelak an exemption from completing the TBI course and allow him to apply directly for a TI course, which will take place in 2024.

Following consideration, it was proposed by Gary Small, seconded by Russ Mellish that the above request be accepted.

For: 15 Against: 0 Abstentions: 1 (Andy Pointer)

Carried

35.4 Request from Andy Montriou – Cornish PC

A request from Andy Montriou had been received for a change to a number of the restrictions that were put in place 4 years ago for AFF at Perranporth.

Full details of the request including aerial maps had been included in the STC SharePoint folder for this meeting. Andy had given the reasoning behind the proposals and was also present at the meeting to provide further details.

The Chair also provided some background information to those present and reported that Ryan Mancey (STO) had conducted a PTO audit at CPC recently and he was therefore aware of the current operational set up at the PTO. The proposed changes to the existing conditions at CPC were as follows:

Existing Conditions are in black. (Proposals in red)

1. AFF students will be taught water drills as part of Canopy Control lesson.

Change to:

1 AFF Students will be taught water drills as part of Hazardous landings.

2. Students will be taught to carry out a cross wind/ downwind landing as an avoidance manoeuvre to avoid overshooting towards water.

No change

3. Students will be taught procedures for landing on or near cliff as part of abnormal/ hazardous landings.

No change

4. Students will undergo extensive water drills in suspended harness during training.

Change to:

4. Students will undergo water drills in suspended harness during training.

5. If a student has undergone no refresher training in the previous 21 days, they will receive Full Refresher training on canopy control and water drills.

No change

6. After ground school, all students must carry out a Tandem skydive as a familiarisation exercise for canopy control.

No change

7. Student skydiving operations will run on specific days and never alongside Tandem skydiving program. (Other than AFF student Tandem prior to level one).

Remove requirement

8. Prior to skydiving operations authorised personnel will Activate with Swanwick, RNAS Culdrose and Newquay airport.

No change

9. A WDI will be thrown, before student skydiving. Should there be a significant change in the wind strength or direction and after a prolonged period of time (60mins) since previous flight, another WDI must be thrown.

Remove requirement

10. All skydivers are required to wear a manually operated, self-inflating life belt. fitted with an easily accessible operating handle for the student.

No change

11. Students will wear a radio until they have a minimum of 10 jumps following obtaining A Licence (28jumps).

No change

12. DZ control and student talk down will be carried out in the middle of the PLA.

Remove requirement

13. DZ controller will always carry a mobile phone and have access to the safety brief for entry into the water.

No change

14. A nominated DZ assistant with radio and phone will be positioned between the perimeter track and the cliffs during student skydiving.

Remove requirement

15. When the spot winds indicate any wind from 190'-100' resulting in offshore winds blowing towards the quadrant of 280' – 010', no student skydiving is permitted.

Change wording to:

15. Student jumping will not take place during offshore wind conditions (190'-100').

16. When the spot winds indicate winds from 280'-010' onshore, the plane will fly offset crosswind Run ins, no further the 0.5 mile from centre of PLA on coastal side.

Remove requirement

17. No students are to be released outside of the cut off points, either short or long of the main runway or more than 0.5 miles offset from the centre of PLA towards the coast.

Remove requirement

18. Only one student per pass (levels 1-8).

Proposed to Change:

18. It is proposed to change this to two students per pass. Obviously special consideration will be given to the conditions at that time, the experience and currency of the students concerned, - for example two students who have both jumped that day in similar conditions and not two Level one students.

19. Max 2 consolidation students per pass.

Proposed to change:

19. Existing condition states "Max 2 consolidation students per pass" It is proposed to remove this restriction in order that the CI can use his/her judgement and knowledge of the conditions, experience and skill level and currency of the individuals involved.

20. The aircraft will not land before the student skydivers are on the ground.

No change

21. If skydivers were to land in the water, all skydiving will be suspended. DZ Control or DZ assistant will call emergency services, coastguard, RNLI lifeboat (St Agnes) search and rescue helicopter is based at Newquay airport.

No change

22. Visiting instructors must be briefed by CI.

No change

23. Pilots must be briefed by Chief Pilot.

No change

24. Ground school AFF lesson plans specific for Perranporth have been produced, detailing all the necessary training for abnormal / hazardous landings.

No change

Following consideration, it was proposed by Gary Small, seconded by Rudy McClenaghan that that the above changes to the operational restrictions at CPC be accepted.

For: 14 Against: 0 Abstentions: 2 (Andy Montriou, Alex Busby-Hicks)

Carried

Andy Montriou agreed to submit their updated SOPs once these had been amended, and thanked CIs for their time in considering this request.

Action: Andy Montriou

36/24 INSTRUCTOR COURSE REPORTS

The following Instructor Course Reports had been included in the STC SharePoint folder for this meeting:

36.1 Sky-High Skydiving, March 2024

The Association wished to thank Sky-High Skydiving for hosting the Tandem and AFF Instructor Courses from 18 – 22 March. The remaining TI candidates had now completed their training. The Course Report had been included in the STC SharePoint folder for this meeting and was for information only.

36.2 Skydive Langar, April 2024

The Association wished to thank Skydive Langar for hosting the Tandem, AFF and Pre-Advanced Instructor Courses from 15 – 19 April 2024. The Course Report had been included in the STC SharePoint folder for this meeting and was for information only.

36.3 Skydive Strathallan, May 2024

The Association wished to thank Skydive Strathallan for hosting the Category System, Tandem, AFF, Basic, Advanced and Category System Instructor Courses from 13 – 22 May 2024. The Course Report had been included in the STC SharePoint folder for this meeting and was for information only.

37/24 A.O.B

There were no items under AOB for consideration.

38/24 DATE OF NEXT MEETING

Thursday 1 August 2024 at 5pm
Virtually by Microsoft Teams

The meeting closed at 18:34 (duration: 01:34)

Attached:

- **STC Actions Table**
- **Appendix A - Injury/Incident Reports Resumé**

Distribution: Chair British Skydiving, Council, CIs, CAA, Editor – Skydive the Mag, File

Accepted by STC: 1 August 2024
Published: 2 August 2024

ACTIONS FROM STC MEETING OF 6 JUNE 2024			
Item	**Action Required**	**Action Owner**	**Agreed Completion Date**
29.1	Review of TBI Rating	Chair STC, supported by STOs	Ongoing
29.2	DSA Recommendations	Chair STC	Ongoing
29.4	STC Review	CEO, Chair STC, supported by STOs	Ongoing
29.5	Consultation re Extending the Reserve Repack Period	Chair Riggers' Subcommittee	Ongoing
29.6	Recommendations from Reserve Packing Tool Incident	STC, Riggers' Subcommittees	August 2024
29.7	Recommendations from Javelin Container Canopy Compatibility Incident	STC, Riggers' Subcommittees	August 2024
35.4	Andy Montriou to submit updated PTO SOPs	Andy Montriou	August 2024

APPENDIX 1 - Injury/Incident Reports - Resumé

The following Injury/Incident Reports had been received since the last meeting:

a. There have been two Student injury reports received since the last STC meeting.

A first jump static line student fractured their left ankle after a late flare and failing to adopt the PLF position before landing. The student reportedly did not respond to commands on the radio under canopy or on final approach. At approx. 15ft the student was observed to be looking at the altimeter on their left wrist and not ahead in the direction of landing. The student did not flare when instructed or adopt a PLF position.

Another static line student on their first jump broke their leg after a slightly high flare. The student fell forwards on to their knees on landing which is what is thought to have caused the injury.

b. There have been six Licensed skydiver injury reports received including a fatality listed as a main agenda item.

A Licensed skydiver injured themselves whilst practicing high performance landing manoeuvres. A C Licence skydiver with around 600 jumps initiated a 270 degree turn but as they attempted to transition from rear risers to toggles, they dropped the right toggle. The skydiver then attempted to flare the canopy using the rear risers, stalling the canopy about 5ft from the ground. The skydiver sustained injuries to the pelvis and spine and was taken to hospital by air ambulance.

An A Licence skydiver sprained an ankle when they tripped on the step of a DZ vehicle returning from the PLA following a jump.

A C Licence skydiver with 250 jumps dislocated their ankle and bruised their leg when conducting a pre-declared downwind landing. The skydiver flared too high and landed hard on one leg. The skydiver was jumping with a 10 kt tailwind and jumping a Sabre1 170.

A skydiver experienced a seizure on the ground when dirt diving for a multi aircraft formation jump. The skydiver had reportedly had a seizure two years ago but was in possession on a declaration of fitness signed by a doctor. The jumper was grounded, and Chief Instructors notified.

A B Licence skydiver injured their arm and ribs following a low turn on final approach and collision with the landing direction arrow in the PLA.

c. One report has been received of Student Malfunction or Deployment problems.

A first jump static line student experienced an entanglement on exit. The student had pitched head down on exit causing their legs to come up and be entangled with the lines. The entanglement caused the canopy to develop a turn, but the student was able to clear the entanglement, take control of the canopy and landed without further incident.

d. There have been 25 malfunction/deployment problem reports received for Licensed skydivers.

Four malfunction reports have been received of brake fires that develop into diving and spinning canopies with line twists. This includes the fatal incident detailed as a main agenda item. The skydivers had 2,900 jumps, 1,600 jumps, 2650 jumps and 540 jumps. Two were filming Tandem descents, one was a tracking jump and one a solo FS jump. The canopies were an Odyssey 120, Odyssey 130, Comp Velocity 96 and sabre 2 170. The brake fire on the Comp Velocity was caused by the steering line snapping. The lines were reportedly due to be replaced.

Four further reports were received of canopies opening with line twists that started to dive and spin causing them to be cutaway. The skydivers had 3,500 jumps, 770 jumps, 1,991 jumps and 2,400 jumps. They were jumping a Comp Velocity 75, Sabre2 120, Comp Velocity 96 and a Crossfire 3 119.

Four reports were also received of canopies with tension knots, or the slider tangled with the lines. A B Licence skydiver with 175 descents released the brakes after opening only for one of the toggles to become entangled with the excess brake line locking it on full drive. A C Licence skydiver with 8,500 jumps cutaway after their removable slider stuck in the lines. They suspected this was caused by tension knots. They were jumping a Valkyrie Hybrid 79. A D Licence skydiver with 4,547 descents

cutaway from a Crossfire 119 canopy that began spinning violently after opening. The jumper suspected this was caused by tension knots. A C Licence skydiver with 250 descents jumping a Sabre 150 also experienced a spinning canopy after opening. On checking the canopy after deployment, the skydiver noticed that the canopy was inflated but the slider was caught in the lines. All the above cutaway and deployed their reserve canopies.

A C Licence skydiver with 354 descents experienced a pilot chute in tow malfunction following an FS jump. This was reported caused by a lazy throw of the pilot chute and the bridle forming a knot around the pilot chute.

Two reports have been received of lines snapping. A C Licence skydiver with 308 jumps experienced a brake line snapping after opening. The brake lines reportedly only had about 30 jumps after replacement. The jumper elected to perform their Emergency Procedures. An A Licence skydiver with 40 jumps experienced two lines snapping on opening of the Navigator 240 they were jumping. The canopy began an uncommanded turn which the jumper corrected with slight toggle input. The jumper noticed some deformity of the canopy but elected to land it. The jumper flared as normal and landed a little hard on to soft ground without injury.

Two malfunction / deployment problems reports were received from CF jumpers. A CF jumper with 478 jumps cutaway when a teammate's foot became entangled in their canopy. They elected to cutaway to assist in clearing the entanglement. A CF jumper with 360 jumps experienced a pilot chute in tow. They did a 3 second delay from 12,000ft and threw their pilot chute. As the canopy had not deployed within 7 seconds, the jumper completed their reserve procedures. As the reserve canopy opened, the main pilot chute became entangled with the reserve slider. The jumper cleared the entanglement, stuffing the main pilot chute down their jumper. After landing safely, the jumper noticed that the pin had snagged the bridle – see attached image.

Two reports have been received of malfunctions caused by step through / harness rotations. A B Licence skydiver with 173 descents and B Licensed skydiver with 106 descents. Both had packed their main canopies themselves.

Two reports have been received of jumpers unable to deploy their main pilot chutes. A B Licence skydiver with 127 jumps and 16 jumps on the parachute system experienced a stiff pull. They made two attempts and then pulled their reserve. On the ground, the pilot chute was easily pulled out of the BOC pouch and the stiff pull could not be replicated. A B Licence skydiver with 69 descents and two jumps on the parachute system made two attempts to get stable and pull before electing to pull the reserve handle. The jumper may have rushed the pull or been restricted in reaching the pull by their new freefly suit which was tightly fitted. The jumper is to undertake further ground training before jumping again focussing on practice pulls.

One report was received of an A Licence skydiver with 43 descents that couldn't release a toggle after practicing rear riser turns. They completed the exercise before releasing the toggles at which point they could release only the one toggle and the canopy began a diving turn. The jumper cutaway and deployed their reserve canopy.

A B Licence skydiver with 88 descents cutaway from a canopy that appeared malformed, bowing in the middle. The Chief Instructor suspected a pilot chute over the nose and discussed the identification and actions following with the jumper concerned.

e. Two Tandem injury reports have been received.

A report has been received of a student that incurred minor bruising to their elbow, possibly after contact with some hardware on their harness. Their Tandem instructor has 27,000 descents and 5,000 Tandems.

A report has been received of an injury to a Tandem instructor on landing. The instructor has over 19,000 Tandem descents and injured their knee slightly on a sliding landing on to soft grass.

f. There have been seven Tandem malfunction/deployment problem reports received.

Two reports have been received of Tandem canopies that experienced malfunctions caused by tension knots. A TX2 and Sigma 340. The Tandem instructors have 1,100 and 338 Tandem descents. Both were unable to clear the knots and so cutaway and deployed the reserve.

Two reports have been received of out of sequence deployments. One of these reports was received from a candidate on a Tandem course. The candidate was completing a drogueless exercise with a container and forgot to set the drogue after completing the in-air exercises. The candidate pulled both drogue releases before deploying the reserve. The second report was received from a Tandem instructor with 277 Tandem descents. On exit, the Tandem instructor lost sight of the cameraflyer. The instructor deliberately delayed throwing the drogue to avoid a potential entanglement. The instructor became fixated in locating the camera flyer and lost altitude awareness. On receiving an alert from their audible altimeter, the instructor started their deployment sequence before throwing the drogue, pulling both drogue release handles before deploying their reserve.

One report has been received of a Tandem instructor with 11 Tandem descents that cutaway from a pack rotation. The canopy was not packed by the instructor.

One report has been received of a Tandem instructor with 442 descents that experienced spinning, diving twists after the Sigma2 340 main canopy deployed. They were unable to clear the twists and completed their emergency procedures.

One report has been received from a Tandem instructor with 15,000 Tandems that was unable to deploy the drogue. The instructor made several attempts to deploy the drogue after exit before electing to deploy their reserve. On inspection of the new Next Century container, it was suspected that some of the drogue material had been caught in the drogue bridle cover as the instructor tried to throw the drogue.

g. One report has been received concerning AADs.

An A Licence skydiver with 38 descents jumping club equipment experienced a pilot chute in tow caused by a misrouted bridle that was not picked up on the flightline check. They pulled their reserve at the same time as the AAD fired. They also landed off the DZ.

h. 21 'off-landing' reports have been received. Three were students, including one Tandem pair. The other 18 were experienced skydivers.

The two students were AFF L4 and L7, both became disorientated on opening, the Tandem instructor had 3,480 Tandem descents and landed off after a deep spot.

Sixteen of the experienced skydivers landing off were part of two groups. A 13-Way wingsuit group and a 10-way CF stack.

The wingsuit group had significantly extended the spot and flew too far upwind making it difficult for most of the group to make it back to the PLA. Nine members of the group landed off. The jumpers in the group that landed off had between 570 and 1484 descents in total, and between 100 and 584 wingsuit descents.

Seven members of a 10-way CF stack landed off when the stack was flown too far downwind by the stack pilot. Three landed on the PLA but seven jumpers landed one mile north of the PLA.

The remaining experienced skydiver to land off was a D Licence freefly jumper that did not make it back from a deep spot.

All the above landed off the DZ without injury or further incident.

i. Five reports have been received of items coming off on exit, in free fall or on deployment.

A Tandem student's glasses/goggle came off in freefall, an AFF L1 student lost a shoe on exit, a B Licence jumper lost their G3 visor in freefall during an FS jump, and two C Licence jumpers lost GoPro cameras in freefall / deployment.

j. One report has been received of aircraft problems. A Cessna 208 Caravan clipped the refuelling platform with the right-hand elevator as it taxied after refuelling.

Additional Incident Reports

The following Incident/Injury reports had been received since the Agenda had been circulated:

a. There have been four Student injury reports received.

A static line student on their first jump injured their ankle / foot when they landed on a rock. The PLA is a field with some small, scattered areas of uncut grass and rocks. Students are warned to avoid these areas of the PLA if possible.

An AFF Consolidation student with 10 descents injured their ankle when they landed on a concrete runway. It was likely that the injury was caused by the student reaching for the ground as they were flaring.

An AFF consolidation student with 14 descents broke their nose when landing in a tree. This incident is discussed further in the off-landing reports.

An AFF Level 3 student dislocated their shoulder in freefall after a practice pull. The student was able to control the canopy and flare by using both toggles with their other hand. The student had a pre-existing shoulder injury which had been declared on their doctor's medical certificate and had also consulted the Medical Adviser prior to jumping.

b. There have been Four Licensed skydiver injury reports received.

A Licensed skydiver with around 350 jumps injured their back whilst attempting to flare the canopy on landing with the rear risers. The skydiver mistakenly gripped the front risers instead of the rears when attempting the manoeuvre, possibly distracted by an accuracy tuffet in the PLA. The jumper initially dusted themselves off following the landing but then went to hospital when the pain did not subside and was diagnosed with L2 fracture. They were jumping a Sabre2 170.

A C Licence skydiver with 250 descents sustained a broken Sacrum in an accuracy competition. The jumper was flying in deep brakes to hit the disk but did not let the canopy fly before initiating the flare. The jumper was jumping a Spectre 170 not an accuracy canopy.

A D Licence Skydiver with 335 jumps sustained a whiplash injury when they had a very hard opening on their Sabre2 190 canopy.

A C Licence jumper with 458 jumps dislocated their shoulder in a landing incident. On landing the canopy was drifting to the right which the jumper exacerbated by reaching out to break the fall. As they did so they landed on their right-hand side dislocating their shoulder.

c. Three reports have been received of Student Malfunction or Deployment problems.

A static line student on their first jump experienced what was thought to be a tension knot. As the canopy deployed following a satisfactory exit, it appeared to have slight end cell closure on one side of the canopy resulting in an un-commanded turn. The student took control of the canopy and was asked repeatedly to check their canopy over the radio. Following no further action, the student was then directed to trim the canopy using the opposite toggle. The student was able to control the canopy and landed on the PLA without further injury or incident.

An AFF Level 2 student with 2 jumps experienced a stuck toggle. After deployment, the student conducted their control checks to find the right toggle was stuck. The canopy started to turn so the student released the toggles and carried out their reserve drills.

An uncurrent A Licence skydiver with 57 descents over 20 years was conducting an AFF consol jump when they experienced a potential tension knot in the brake line or a stuck toggle. The jumper reported that when releasing the brake toggles and conducting a practice flare, one of the toggles felt like it was caught on something. As they did not feel in control of the canopy, they elected to cutaway and deploy the reserve.

d. There have been Eighteen malfunction/deployment problem reports received for licensed skydivers.

Three Licensed skydivers cutaway from line twists. A D Licence jumper with 2,200 jumps cutaway from line twists they thought may have been caused by a brake fire. They were jumping a Crossfire2 119. A C Licence jumper jumping a Crossfire2 129 opened in line twists. The twists cleared but then started to develop in the other direction and the canopy started to dive and spin. The jumper cutaway and deployed their reserve. A B Licence skydiver with 100 jumps experienced twists after opening. They attempted to clear the twist but cutaway when the canopy developed a diving rotation.

Two reports have been received of jumpers cutting away from tension knots. Both were jumping hyper performance canopies. A D Licence skydiver with 2926 descents jumping a Leia 74 and a C Licence skydiver with 8500 descents jumping a Valkyrie Hybrid 79.

Three reports have been received from Licensed skydivers that cutaway from lineovers. An A Licence skydiver with 42 jumps on a Silhouette 260, A C licence skydiver with 321 descents on a Spectre 150 and an AFF Instructor with 3052 descents on a Crossfire2 109. The AFF instructor cutaway after several unsuccessful attempts to clear the lineover.

Two reports have been received of Licensed skydivers that were unable to deploy their main pilot chutes due to stiff pulls. A B licence skydiver with 77 descents jumping with a new pilot chute and unfamiliar toggle made two attempts to deploy their pilot chute before pulling their reserve handle. The jumper thinks they may have been attempting to pull the opening of the BOC as well as the toggle. An A Licence skydiver with 47 descents made three attempts to deploy their stiff pilot chute before completing their full reserve drills. The equipment was examined on the ground and no issues were found with the pilot chute deployment. The jumper was competing at their first scrambles event and feels they may have been pulling some part of the harness.

A Licensed skydiver with 86 descents cutaway from a canopy where the slider had become entangled in the lines. After deployment, the skydiver attempted control checks, but the canopy started to dive so they elected to cutaway and deploy their reserve.

A CF Jumper with 270 descents carried out their reserve drills when their canopy started rotating after deployment. The jumper was unable to stop the rotation so cutaway. They were jumping a Triathlon 160

A D Licence skydiver with 2,811 descents had a suspension line break on opening on a Leia 66. The skydiver completed a control check and the canopy appeared to be controllable, so they landed the canopy without further incident. The lineset (Vectran 400) has only 150 jumps and so the jumper is discussing this further with the Manufacturer.

A D Licence skydiver with 335 descents also had a brake line snap on a hard opening on a Sabre2 190. The jumper landed the canopy on rear risers.

Two reports have been received of step through / pack rotations. The jumpers had 396 and 569 descents and had both packed the canopies themselves. Both were from the same PTO and received advice on packing techniques from their Chief Instructor.

A B Licence skydiver with 194 jumps cutaway after what they thought was initially a pilot chute hesitation. The jumper was tracking away from a 7-way FS jump. They were initially about to pull but noticed that another jumper was close after tracking in a similar direction. They extended their track slightly and deployed without washing off the speed. The main did not deploy as expected so the jumper conducted their reserve drills. The reserve deployed but the main pilot chute was entangled with the reserve lines. The jumper cleared the pilot chute but noticed that the main deployment bag was still trailing behind them. The main risers had released but remained attached to the RSL which had not released and was still attached at the Velcro. The jumper landed without incident. They were jumping a Scorpion 190 main canopy and Paratec Next container. Images taken after landing are shown below.

A Wingsuit jumper with 504 descents experienced a similar incident following a wingsuit jump. The wingsuiter had a bag lock on deployment, but after cutting the main canopy away, one riser remained attached from the RSL. They were jumping an SWS container and Skipper 150. Picture below:

e. Three Tandem injury reports have been received.

A Tandem student broke their ankle on landing. The student was initially in a good position but put their feet down just prior to landing. The instructor has 690 Tandem descents, 43 in the last 3 months. The student had a BMI in the Obese range.

Another student received a suspected sprained or dislocated ankle on landing when they also dropped their legs on landing. The student appeared to be trying to lift their legs from the leg straps

rather than grabbing underneath their thighs as briefed and practiced under canopy. The student had previously passed a suspended harness test prior to jumping. The instructor has 5,000 Tandem descents, 99 in the last three months. The jumper was aged 66 and had a BMI in the Overweight range.

A Tandem Instructor with 70 Tandem descents injured their knee when tightening up their student prior to exit. The instructor was in an aircraft with bench seats and moved their legs back and under the bench to tighten up the lateral straps when the injury occurred.

f. There have been four Tandem malfunction/deployment problem reports received.

A Tandem instructor with 160 Tandem descents experienced a deflated drogue in tow following an eventful exit when the camera flyer had been briefly entangled with the drogue. The instructor gave a fairly poor key and was quick to throw the drogue after exit which resulted in the camera flyer leaving slightly late and become briefly entangled with the drogue. The drogue cleared the entanglement but was deflated. The Instructor waited for 8 seconds before releasing the drogue and the canopy opened uneventfully.

A Tandem instructor with 963 Tandem descents experienced two malfunctions a couple of weeks apart. The first malfunction was caused by a steering toggle that was entangled with the slider after opening. The instructor made several attempts to clear the entanglement but was unable to do so. The instructor believes this may have been caused by a brake fire on opening. The second malfunction was caused by a streaming canopy. After an uneventful Tandem skydive, the instructor deployed the main canopy only for it to stream for several seconds longer than expected. The Instructor attempted to assist the deployment by pulling on the rear risers but when that did not clear the streamer, they carried out their full reserve drills. The canopy was an A2-350. The instructor had packed neither of the two canopies involved in the two incidents. Both canopies were packed by different packers.

A Tandem instructor with 2,100 Tandem descents identified a tension knot in the left-hand brake lines after opening. They attempted unsuccessfully to clear the knot before executing their reserve drills. The canopy was a A2 370.

g. Two reports have been received concerning AADs.

Both reports refer to one incident of a double AAD fire. An AFF Level 3 student was in a good position after exit and initial freefall so was released by both instructors. After release, the student began to spin. The instructors attempted to catch the student but were unable. Both instructors chased the student. The secondary instructor repeatedly gave the student the pull signal. The student began to tumble before settling in a de-arched, back to earth position. The student attempted to complete their reserve procedures, but their AAD fired first. As the student's AAD fired, the secondary instructor deployed their main canopy, only for their AAD to also fire resulting in a two-out configuration for the instructor. Both the student and the instructor landed off without further incident or injury.

h. Twelve Off landing reports have been received.

In addition to the instructor and student that landed off mentioned above, one other off landing report has been received of a student skydiver. An AFF Consolidation student with 14 descents landed in a 40ft tree and was recovered by the fire service. The student was jumping in good conditions but for reasons unknown turned to head towards a forest. The student broke their nose when impacting with the trees but was otherwise unhurt.

Six off landing reports have been received from Licensed skydivers. Two of the reports noted that the jumpers landed off in relatively strong winds, the other misjudged the landing pattern and landed off the PLA in a ditch. Two reports were received from jumpers that landed off because they initially flew too far away from the PLA and then couldn't make it back. One of these jumpers had 21 jumps, landed next to a grain silo and part of their canopy was hung up on the silo structure. The fourth report was received of a participant in a 2 aircraft FF load. The JM of the lead aircraft abandoned the run in due to cloud at the opening point, however some of those in the trail aircraft had climbed out. One of the jumpers fell off the aircraft attempting to climb back in and landed off.

Two Tandem pairs and a camera flyer landed off on one lift. The group were caught out in changeable cloud conditions and found themselves too far downwind. The group could have possibly made it back, but all made the decision to land off rather than transit over an area of potential hazards.

One other report was received of a Tandem camera flyer with 1,600 descents that landed off after they became disorientated in a patch of cloud. When they exited the cloud, they elected to land off rather than risk flying over a built-up area back to the PLA.

i. One report has been received of an item coming off on exit, in free fall or on deployment.

A GoPro was lost by an AFF Instructor following an eventful Level 1 AFF exit.

j. One report has been received of an aircraft issue.

A Cessna 206 was climbing to altitude when the pilot noticed a decrease in available power. The aircraft ran in over the PLA at 8,000ft, the jumpers exited, and the aircraft made a reduced power descent to a nearby airport.

Comparative analysis

1st of Jan to 31st May	2023	2024	% Change
Injury reports	30	25	-17%
Malfunction / deployment problems	47	68	45%
Tandem malfunction / deployment problems	14	17	21%
Off landings	24	38	58%
Total Incidents	115	148	29%

Injuries Headlines

1st of Jan to 31st May	2023	2024	% Change
Serious injuries (Fractures / dislocations / etc)	14	16	14%
Fatalities	0	1	100%
Very serious injuries (requiring Air Ambulance)	2	1	-50%
Tandem injuries	8	5	-38%
Tandem Fractures / dislocations	4	2	-50%

Malfunction Headlines (non-Tandem)

1st of Jan to 31st May	2023	2024	% Change
AAD Fire	1	4	300%
Brake fire	7	7	0%
Line over	2	4	100%
Pack rotation / step through	2	5	150%
Tension knots	3	7	133%
Stiff / Hard / No Pull	1	7	600%
Spinning diving twists	9	13	44%
Twists - Wingsuit	4	0	-100%

Malfunction Headlines (Tandem)

1st of Jan to 31st May	2023	2024	% Change
Tension knots	6	3	-50%
Twists	1	1	0%
Uninflated Drogue in tow	1	1	0%
Out of sequence deployment	0	2	100%
Streamer	0	1	100%
Drogue failed to release on primary pull	0	2	100%