



# Covid-19 & Restarting Skydiving in the UK – an Interim Briefing – May 2020

## Table of Contents

**Introduction..... 1**

**What others have been doing ..... 2**

**Situation and Biology ..... 2**

**What is needed for full emergence from lockdown without any restrictions ..... 3**

**Progressive or Restricted emergence from lockdown ..... 4**

**Mitigating Actions at DropZones ..... 4**

*Personal Protective Equipment (PPE)..... 5*

*Full-face helmets..... 6*

*Surface Disinfection and Cleaning..... 6*

*Temperature checks & Questionnaires ..... 6*

*Contact Tracing Apps..... 7*

**Organisational Changes before Reopening ..... 7**

**Conclusion ..... 9**

**Appendix 1 - SOURCES OF OFFICIAL INFORMATION AND ADVICE ABOUT COVID-19 ..... 10**

## Introduction

This document is intended to be read AFTER you have familiarised yourself with the advice published by the NHS and Government. The sources you should have read are listed in Appendix 1 at the end of this document. **You should apply that advice but remain aware that it can change with time.** The document “Covid-19 – Discussion of DZ Factors” was published 2 months ago on the British Skydiving website, before the exponential increase in levels of infection. It is no longer a valid analysis.

The level of infection in the UK is continuing to change, as is the level of knowledge about the virus. This document is being prepared on 6<sup>th</sup> May 2020 and may already be out of date by the time you are reading it. If any opinion in this document appears to conflict with official advice from the NHS or the Government, then you should follow the official advice.

What follows is a discussion about risk areas, how you might choose to mitigate them and how mitigating them could sometimes cause other potential problems. Arguments have been shortened and much nuanced detail omitted. Much of what follows about Covid-19 (C-19) at the drop zone may be only opinion, without firm evidence to back it. It should be used to promote discussion between DZOs and their staff as to what may be practical and desirable. There are probably no “zero risk” options. This document is a discussion and not an instruction.

## What others have been doing

It has been interesting to see what other national skydiving bodies (NSBs) have been doing in an effort to restart skydiving during the C-19 pandemic. Some have focused purely on how to restart a tandem operation, presumably because this is the main cash generator that helps a business survive. Others have focused on a student-free, licensed skydiver restart, presumably because they recognise the risks of close contact that is inevitable in training and supervising students.

Every country will have different national laws or regulations governing what is permissible. Each country will be at a different stage of the pandemic and will be using different methods to assess what is happening. Even when a country accurately measures what is happening, not all governments will share that information openly. Geographical, social, healthcare, ethnic and climatic differences between countries are just some of the factors that affect how quickly the virus spreads, how lethal it can be and how difficult or easy it may be to contain. With Britain having a population density of 720 people per square mile and Australia 8 people per square mile, you can imagine that there may be differences in transmission rates between countries.

It will be very tempting to look at proposals from other countries' NSBs and just think “let's do that here”. That temptation should be resisted. There is nothing wrong with looking at what other people are doing, but it will be important to consider whether their suggestions are well founded. Are they evidence based or simply window dressing or eye candy which calm customer and staff concerns but offer only limited protective effect? Unfortunately, there is only limited evidence on the effectiveness of some protective measures.

One clear lesson from the recent northern European experience is that one has to start with any new official regulations and carefully design your restart around the regulations. It is pointless to design an extensive and detailed restart policy without ensuring that it fits with whatever national and regional regulators actually allow. For that reason, I would not intend to look at a final detailed plan for the UK until we have seen a clear written policy from the Government (and possibly from the CAA too). We may also have to contend with the different regulations already emerging in each of England, Wales, Scotland and Northern Ireland. The Government has been very reluctant to reveal exact details of their long-term strategy for emergence from lockdown. They are wise to avoid a rigid plan. Their advisors are well aware that any final strategy will have to be based on how numerous different factors evolve over several weeks or months. Whatever the final exit strategy looks like, it is difficult to see how skydiving can restart until the 2 metre social distancing requirement is revoked, linked to a generous time allowance for closer exposure or is allowed to be ignored if certain other conditions are fulfilled.

## Situation and Biology

With a population of about 66 million in the UK, just over 1.3 million individuals have been tested for C-19, about a sixth of these (219,000) have tested positive and 32,000 have been recorded as dying with C-19 as at least a partial cause. Approximately 1 person in every 2000 of our population has died so far. Nobody knows what proportion of the remaining 65 million may have already had a mild infection with no testing and how many are still unexposed and thus available to become infected themselves, to pass on infection and add to the body count. Following a national lockdown, the number of admissions to, and deaths within, hospital have flattened out and may be beginning to fall slowly, but in some parts of the community outside hospital this has yet to be achieved.

Once someone is infected with C-19, it may be a number of days before they begin to feel unwell. They may typically start to feel achy and tired, with a sore throat or dry cough. They may develop a raised temperature (fever) and may go on to become short of breath. There are numerous complications that can occur after that. Worryingly, an infected person can start to shed virus particles and be infectious to other people before they have noticed any symptoms or raised temperature themselves. Not all people with C-19 develop the typical symptoms. Symptoms can be mild or vague and may resemble other problems such as hayfever, a cold, asthma, a tummy upset or chilblains. Mild or vague symptoms will not worry an affected individual, but that person can still be infectious to other people.

The C-19 virus is found in tears, respiratory tract secretions (snot, spit, phlegm), blood, urine and faeces. It is thought that the two main routes of transmission are airborne and surface contact. There has also been speculation about faeco-oral transmission. Airborne transmission can be visible spray and droplets during coughing, sneezing, talking and also by invisible aerosol present even during normal respiration (but produced in much greater amounts during effort or shouting). Droplets may go directly into the face or eyes of others when they are nearby, may contaminate hands or may contaminate shared surfaces. Aerosol may travel further with air circulation but the further it travels, the lower the concentration of virus particles and the lower the risk of infection. Surface transmission happens when an infected person touches infected secretions on their own face (or facemask) and then touches handles, rails, equipment, food, utensils or cash that may be touched by other people. Faeco-oral transmission (eating someone else's poop) may occur if an infected person fails to wash their hands properly after going to the toilet. The virus has been shown to survive for 3 days on inert surfaces such as plastic or steel and lesser times on a range of other surfaces. The virus is tiny, with a diameter of about 100 nanometres (about one 10,000<sup>th</sup> of a millimetre or 4 millionths of an inch) and so large numbers can be present in even a small area of contamination. The virus is inactivated by soapy water, alcohol hand gel, some other skin disinfectants and a range of chemical products intended only for object disinfection such as bleach solutions and peroxide solutions. Many of these products are poisonous or can cause skin burns – read the label!

## What is needed for full emergence from lockdown without any restrictions

As things look at present, unfortunately, I think we will need at least one of four things before fully normal and unrestricted skydiving operations can resume:

1. *Antibody Testing and Certificate of Immunity.* An antibody test would demonstrate that a person has had the C-19 infection and now has immunity. This would allow the Government to issue a certificate of immunity – the certificate holder would be able to abandon social distancing without being a major risk to anyone. So far, no one has produced an antibody test which has been demonstrated to be chemically reliable and adequately predictive of long-term immunity. When one does become available, there will be a delay before large scale testing is available (takes time to industrialise a process). Chile has already introduced a Test Passport but has been heavily criticized for using unproven technology. If or when it does come, initial testing will be focused on critical workers, then key workers, public service workers and other groups according to the latest government policies. It is unlikely that skydiving instructors (let alone Joe Skydiver) will be high on the priority list.

2. *Vaccination and Certificate of Vaccination.* People with evidence of vaccination with an effective vaccine would be able to abandon social distancing without being a significant risk to others or to themselves. Even when a vaccine is developed, it will take considerable time to show a high level of effectiveness in the general population and even longer to assess its safety, duration of action and level of side effects. Once this is done it will take significant additional time to ramp up mass production. Initial supplies will be prioritized to critical and key workers and population groups at most risk. Skydiving instructors will probably be low on the priority list. No one knows what the time scale will be, but 6-24 months would not be an unreasonable guess.

3. *Herd Immunity.* Eventually, such a large proportion of the population will have had Covid19 that there may be few opportunities for the virus to spread to new unexposed victims. No one knows how long this will take to happen because we don't yet have tests to identify the proportion of the population who have had the disease, either without symptoms or mildly, and recovered. It is possible that it will take a number of waves of infection,

with recurrent lockdowns, before herd immunity is established. You can imagine that herd immunity might take a year or two to happen if there are recurrent lockdowns (or would occur faster without lockdowns and potentially involve collapse of the health and emergency services and a huge excess mortality).

4. *Identification of a medication which massively reduces the complications and death rate of Covid19, without frequent or unacceptable side effects.* There isn't one at present. There will be quite a few which slightly reduce the risks and quite a few with unacceptable side effects. There may be overoptimistic claims by some drug companies or by their investors. Even if a good drug is invented/identified, it may be over a year later before it can be adequately assessed and put into large scale production.

## Progressive or Restricted emergence from lockdown

A more likely scenario is that the lockdown will be eased in stages and that a range of requirements may be imposed to allow greater travel and mixing. The Government has published five "conditions" which must be fulfilled (and maintained) in order for it to start easing the lockdown. The conditions are sufficiently vaguely worded to allow differing interpretation by expert advisers. However, most would agree that 3 of the 5 are probably achieved at present and 2 of the 5 are a fair way from being met. No one knows when they will all be met.

Once the conditions are met, the government is unlikely to let everyone out to do whatever they want. It is probable that certain population groups and certain activities will be allowed more freedom to travel and mix, provided that they comply with specific requirements. It will take 6-8 weeks for the effects of this relaxation to become apparent and for the Government to decide whether the lockdown needs to be fully or partially reimposed, their restrictions can remain unchanged or they are able to authorise a further limited relaxation. There may be a number of iterations of this process before we are back to normal. Although the Government has remained keen throughout to allow individuals a regular opportunity to exercise in social isolation, it is conceivable that close contact activities with a low exercise component may not be seen as a priority for early release from restriction.

As part of their plans to relax elements of the lockdown, the UK Government is hoping to both monitor and control further spread by a combination of increased levels of testing, use of a mobile phone app to mark contact with an infected individual and increased conventional contact tracing. All of these would be linked to requirements for isolation by those infected and by those identified as their contacts. Although this sounds hopeful for the future, at present none of these three elements have been developed to the point of being fully tested and available at full scale for deployment at national level within the UK. No one knows when the elements will eventually all be ready, nor how effective they will actually be in controlling any resurgence of C-19.

## Mitigating Actions at Drop Zones

There are some actions that can be taken which may reduce the risk of a C-19 carrier being admitted to a DZ or the risk of C-19 being passed on at a DZ. When a serious infectious disease is present in a population in tiny numbers and it is felt that it is well controlled by use of a combination of contact tracing, isolation and public health measures, there is such a tiny risk at the DZ that it is not felt worth implementing any special measures at all. Such is the case with Meningococcal Meningitis and Tuberculosis which are always present in the UK. Similarly, no special measures were required at DZs when we had a few cases of Ebola in the UK. When a disease is becoming more widespread, then the risk at the DZ is greater but can often be kept to an acceptable level by both administrative and behavioural changes at the DZ. The higher the incidence of disease in the population, the more extreme the changes will need to be at the DZ in order to keep risk at an acceptable level. Eventually, no mitigating actions can keep the risk at an acceptable level and DZ activity has to stop. As a pandemic appears to come under control, a time will come when it is possible to reverse the process of mitigation and lockdown. It is very reasonable to ask if there are mitigation measures we can take to allow an earlier restart of skydiving. I will mention some of the more commonly suggested options below. Nearly

everyone (public, planners, governments) was surprised by the speed at which we went from no precautions at all to a full lockdown. Unfortunately, going in the opposite direction is likely to be very much slower.

### *Personal Protective Equipment (PPE)*

If your only concern is avoiding infection transmission, it should be fairly obvious that you should stay where you can't breathe other people's aerosol and do not have to touch things that other people have touched (stay at home). If you have to go out, try to stay as far away from other people as possible, the greater the distance the better. Avoid close face to face contact. If you have to be close to someone else, try to be there for the shortest time possible. If you have to touch other surfaces while out, carry and use a hand disinfectant before and after each surface contact and wash your hands thoroughly immediately on return home. In terms of personal protection, there is nothing that comes even close to the effectiveness of DISTANCE.

If you need to be closer to other people or to touch shared surfaces, you might be considering using other methods such as a face mask or rubber/plastic gloves. You may be aware that there are various gut feelings about the benefits or disadvantages of masks and gloves in preventing C-19 transmission but there is no convincing evidence specific to C-19. There have been studies in the past looking at bacterial transmission rates with gloves and looking at small particle filtering with a range of mask types – these studies do not inspire great confidence. Much PPE in fact offers only very limited risk reduction but engenders a feeling of being protected in the user. This may result in the user spending too long in proximity to others.

Everyone already wears gloves on their hands all the time – those gloves are called skin. Wearing an additional layer of latex gives no protection against transmission unless the gloves are changed whenever you touch your face/mask and after each contact with other objects or people. Gloves will need to be changed without you touching their external surface and will all need to be disposed of appropriately. You will get through numerous gloves every day. A simple and very effective alternative is to wash your hands or use alcohol-based hand disinfectant between contacts and with face touches. Some studies have suggested that contamination rates go up when gloves are used because they make some users overconfident and careless, almost believing that there is some hidden magical or scientific quality in the glove that protects them. In other words, gloves can become “gesture protection” rather than actual protection. I have seen a suggestion that packers may use a new set of gloves with each rig that they pack. While that sounds a nice idea, I suspect that thin clinical gloves are unlikely to survive the traumas of even a single pack job. Regular hand disinfection between pack jobs is more likely to succeed.

In 2008, a study examined the comparative effectiveness of simple fabric facemasks, water resistant surgical masks (WRSM) and properly fitted N95 or FFP3 filtering masks, using an aerosol of fine particles about 3 microns in size (only 3/1000<sup>ths</sup> of a mm, but still 30 times bigger than a C-19 virus particle). The first two types of mask stop large visible fluid particles but are not sealed to the face and leak invisible aerosol. Simple fabric masks gave some reduction in particle count but were classed as giving poor overall protection. WRSMs gave rather greater reduction in particle count but were still classed as very poor. Only fitted filtering masks gave anywhere near adequate protection with 95-99% reduction in particle count. Even the best masks were unable to give complete protection. For my own benefit, I have tried a rough estimate of how mask use compares with distance in terms of protection. This was “back of an envelope” stuff without experimental confirmation or peer review. It appears that if you are 1 metre from another person and put on a simple fabric mask, it may give similar protection to simply stepping back half a metre more. A WRSM may give protection equivalent to stepping back about a metre (i.e. to the recommended 2 metre spacing). An N95 or FFP3 mask may give protection equivalent to stepping 5-10 metres away. At present neither WRSMs nor N95/FFP3 masks are likely to be available for general use because there are still shortages within the NHS. The simple fabric masks not only give quite limited protection but also rapidly become moist with exhaled breath, may generate their own spray from dampness and are a focal point for contamination of hands by frequent touching and adjustment. It is still possible that Government ministers will mandate masks for close contact in certain situations in the future (e.g. public transport and shops) but they are hesitating before advising the use of WRSMs for fear of making shortages in health and social care even worse. If masks are used while jumping without a full-face helmet they are at high risk of being displaced during, or destroyed by, freefall. Masks worn under a full-face helmet are much less likely to be displaced, but if displaced and interfering with vision when a visor is occasionally left unlatched on exit, it may be much harder to reposition them. The thought of a student parachutist attempting to deal with a displaced or damaged mask at a critical phase of a parachute jump is rather unsettling.



The eye is a potential portal of entry for virus particles, particularly when close to others. Glasses are not generally regarded as adequate protection, but goggles or visors may help. Even in warm indoor environments, they can mist up. Every time they are lifted to defog, there can be a face touch and exposure.

### *Full-face helmets*

While there is not a shred of experimental evidence that skydivers' full-face helmets reduce the risk of transmission of Covid-19, there is little doubt that they can reduce the number of big bits of snot, spittle and tears landing on the face, nose, lips or eyes of a tandem instructor. Whether they make any difference to breathing in aerosol from the student, or from other skydivers while in the aircraft, is another matter. They have no air filtration system. It is not clear whether larger snot particles or invisible respiratory aerosol are the most important routes for C-19 transmission. Full-face helmets would be regarded as a potentially contaminated surface and the outside of the instructor's helmet would need to be washed regularly. I think that full-face helmets for students would be impractical. You would need a new one for every student. Even if you got your student to wear a fluid resistant soft mask under the helmet to stop contact of lips/nose with the liner, the inside of the helmet would still be contaminated by respiratory aerosol. Full-face helmets for students would carry direct risks too – reduced ability to communicate, more prone to panic with claustrophobia or visor misting, unable to pinch nose to clear painful ears/sinuses, more at risk of choking on their own vomit in the few students who do throw up in the air. If an anxious tandem student was panicking and needing help releasing or opening or removing a full-face helmet, the tandem instructor may be distracted from his primary tasks (canopy control, avoiding other canopies, grasping secondary toggles, preparing student for landing, appropriate flare). Distraction from primary tasks means greater risk of an incident or injury for both of the tandem pair. At present, use of full-face helmets for any student would be in conflict with Section 6 of the Ops Manual:

[Sec 6 – Equipment](#)

#### [2. EQUIPMENT USED BY STUDENT SKYDIVERS](#)

[All equipment, other than main parachutes used by Student Skydivers must be acceptable to British Skydiving \(via Riggers' Subcommittee and STC\) – \( Presumably this will also apply to any use of masks by SPs\)](#)

#### [3. PERSONAL CLOTHING AND EQUIPMENT](#)

##### [3.1. Helmets](#)

[3.1.1. Student and British Skydiving 'A' Licence skydivers must wear a suitably sturdy open faced, hard protective helmet without a peak.](#)

[3.1.2. Student Tandem Skydivers must wear a 'French Type' ribbed helmet.](#)

### *Surface Disinfection and Cleaning*

We have already seen quite a lot of advice about “disinfecting” parachute equipment and disinfecting common touch points in aircraft. Now is the time to be contacting kit manufacturers to establish whether they have tested and approved any materials or brands for disinfecting their products. I suspect most will say that alcohol-based products, bleach-based products and peroxide-based products are not only unproven but potentially quite damaging. Similarly, the manufacturers of jump aircraft can be contacted to obtain advice about what methods may be used to clean or disinfect parts of their aircraft. Bleaches may be corrosive to metal and fabric methods of aircraft and alcohol-based cleaners can degrade plastic components and Perspex screens. It would be a shame to be overenthusiastic about chemical cleansing of kit or aircraft and to ruin or ground an expensive piece of kit.

PTOs will need to decide if it is practical to allow hiring of club kit for the time being. It will probably be impractical to disinfect rigs after use. No one has tested various parts of a rig to see how long coronavirus can survive on different areas so no one knows how many days a rig would have to “rest” between users. In the absence of evidence to the contrary, three days would seem the absolute minimum for now.

Goggles are one of the few bits of shared kit that can easily be cleaned in soapy water, but any employee regularly cleaning them may need enhanced protection from aerosol generated by the task.

### *Temperature checks & Questionnaires*

If someone has a raised temperature, they should definitely not be at the DZ and should be regarded as infectious. How effective are temperature checks in keeping C-19 carriers off the DZ? In a recent study of seriously ill C-19 patients admitted to a US hospital only one third had a raised temperature at the time of admission. Combining a brief questionnaire about symptoms with a temperature check may exclude more early

cases, but some people who are infectious but still feeling well will still slip through this net. This area is fraught with issues of consent, confidentiality and data protection.

### Contact Tracing Apps

There are at least 5 mobile phone contact tracing apps that had been hoping to win the UK market, but at present the Government is encouraging uptake of one produced by NHSX. The apps are all still evolving and final functionality and effectiveness are not yet established. There is considerable media discussion around technical issues, data sharing and privacy – I will not attempt to discuss these issues apart from noting that C-19 has shown little respect for anyone’s privacy to date. Essentially the app assesses time and distance from other app users. If one of those other users later gets symptoms of C-19 and remembers to report it on the app, all close/prolonged contacts in the last 2 weeks will get a message about the need to self-isolate. This message may come days before any symptoms appear and thus help to limit spread. For one of the apps to become fully effective, it may need to be used by 60% of the population or 80% of smart phone users. As well as the apps, the UK Government is intending to massively expand the conventional contact tracing workforce. The Contact Tracing workers will try to interview new cases to establish where they have been and who they have been in close contact with over recent days. They will then communicate with those establishments or close contacts to advise on the need for self-isolation.

Government has stated that the app is not intended to be a passport for admission to anywhere. However, businesses trying to protect themselves from a two-week shutdown may take a different attitude. Some businesses may want to encourage customers to use the app, others will want a declaration that it has been used for two weeks with no significant contacts and others may even wish to inspect the app before allowing admission. I have no view on whether any of those responses are either desirable or legally permissible.

## Organisational Changes before Reopening

Organisational changes and planning required before reopening will depend partly on the specifics of Government requirements but will also be affected by the annual throughput, number of permanent staff, physical characteristics of the property, amount of centre equipment, car parking, guardable entry points, outdoor shelter areas. This section could easily run for several pages, but I will just list questions for discussion at each PTO. This list is not exhaustive (though may be seen as exhausting). There are bound to be more issues than just those listed here:

- Who will regularly check the NHS and Government web sites to ensure that the C-19 regulations have not been significantly amended?
- Will you simply open and let anyone attend, without any preparation or screening?
- Will you restart with just permanent staff and a few select instructors, coaches and a few very experienced jumpers? – this may allow you all to regain currency and to identify problem areas in the new operation.
- Do you feel your students and low experience jumpers will have adequate “head space” to focus on safe skydiving and not be overly distracted by C-19 requirements?
- Student skydivers will almost all require significant retraining after a long layoff. Do you have sufficient staff available for the retrains and will you run an appointment or booking system to control attendances and prevent needless waiting around?
- Will you restart “small” and only increase throughput once you have reduced choke points?
- Will you screen all attendees using at least one or more of Questionnaire, Temperature and App? Who will do the screening, what protection will they need, what will you record and will it comply with GDPR requirements?
- Will screening start before attendance, with students needing an appointment and experienced jumpers registering for a day’s attendance (along the lines of boogie/event registration requirements, with confirmation of approval before attendance)?
- Will you allow/require experienced jumpers to upload/email a PDF of their new British Skydiving membership rather than requiring physical check and close personal contact?

- What minimum standard will you set for kit inspection for visiting jumpers and will you allow earlier provision of electronic copies of documents to reduce paper handling by your staff at the time? What hand cleansing or covers will you require for kit checkers before inspecting a visiting jumpers kit?
- Are you up to date with any temporary extensions to medical certificate or reserve repack expiry dates that STC or Council may have approved?
- Are you up to date with any temporary changes to currency or recency requirements in the Ops Manual that STC or Council may have approved?
- Will you allow spectators to attend, particularly in the early weeks of a restart?
- If allowing spectators to attend, how will you screen or control them?
- Will you use your website and contact lists to ensure all potential users of your DZ are fully aware of any new requirements before they attend?
- Will you / Can you - use a gate guardian to control access?
- Will you use Covid Wardens to encourage/reinforce appropriate behaviour, group size limits and spacing, particularly in congested areas such as reception, manifest, toilets, video area, exit trainer, café (if you are allowed to run one)?
- If indoor shelter is now restricted, will you have or provide enough outdoor shelter from rain or sun for the expected numbers of attendees with adequate spacing, or will you expect people to wait in their cars. What will you do with attendees without their own car?
- Will you encourage tandem customers to leave quite promptly once their jump is over?
- Do you have adequate hygiene supplies for all areas?
- Do you have adequate signage and floor markings in required areas?
- Have you trained your staff in the new requirements and do they feel content with their own risk level?
- Do you have enough staff for the increased workload?
- Do you have an adequate and frequent cleaning rota/regime for all public areas and surfaces?
- Are you continuing to check Government, NHS, HSE, MOD information sources to ensure that your duty of care to staff and customers is complied with?
- Have you checked with your provider of Employers Liability Insurance that they are continuing to provide cover and that they are content with your management of C-19 risks to your staff?
- Have you checked with local emergency services to establish whether they are operating at full pre-Covid capacity or are still impaired due to excessive demand or staff absences?
- Are your First Aid providers content with their level of protective equipment and the fact that they may need to spend considerable time close to an injured person who may be generating aerosol?
- Have your First Aid providers reviewed current Covid guidance from the Resuscitation Council, particularly about aerosol generation during resuscitation and changed priorities in terms of ECM, defibrillation and respiratory support? Do you have adequate protective equipment to be able to offer resuscitation? If your first aiders no longer feel able to offer normal resuscitation, will you be informing attendees about this?
- Do you intend to allow all disciplines of skydiving from the moment of opening?
- Will you allow performance landings from a greater than 90 degrees turn at any point during C-19 restrictions?
- If you are going to allow them, will it be immediately or only after regaining a specified level of currency/recency?
- If you originally had a Boogie, Training Event or Competition in the calendar for shortly after reopening, are you planning to just go ahead with it, or review the practicalities after a few weeks of your new operation?
- If everyone in the aircraft has a mask and a fully donned, closed, full-face helmet, how well will you manage essential communication both in normal operation and in an aircraft emergency?
- Will you open in-flight doors once at a safe altitude to improve fresh air levels in the cabin or will hypothermia during the ride to altitude be regarded as more of a risk than C-19?
- Has the CAA published anything on what pilots can/must/must not do in the way of personal protection while flying?
- Will you require all payments to be electronic or contactless in order to avoid the common touchpoint of cash? Do you have adequate systems in place to cope with this?
- Will you encourage manifesting by Burble or some similar system?
- If face covering is mandated, who will provide it (you or the customer) and who will be responsible for assessing its suitability and secure fit?
- Will you continue to offer a sympathetic policy to those who regard themselves as being at risk and who wish to defer their jump without financial penalty?



- Will you be reminding potential attendees of government advice that certain groups should still be self-isolating?

If all of this feels like too much hassle, have you considered the effect on your newly reopened business of being shut down for 2 weeks by a contact tracer?

## Conclusion

I'm sorry if this briefing isn't what you were hoping to hear. I'd rather be realistic than raise false hopes or give groundless reassurances. Even if the Government's plans go without a hitch or any resurgence of cases, it could so easily be Autumn or later before we are allowed to jump again. Of course, I may be quite wrong and it may all blow over in no time. Whatever I think, I will inevitably be constrained by formal Government and NHS advice, as indeed will we all. The devil will be in the detail of the Government's written plans, mainly concerning minimum distancing, maximum group size and specified allowable or prohibited activities. Low quality unproven "PPE" will not give enough protection to allow assurance of safety during proximity.

"Acceptable level of risk" may be viewed quite differently by Governments, NSBs, PTOs, their employed staff, self-employed staff, regular skydivers and students. Each will have a completely different agenda related to public health, reputation, sport safety, sky hunger, business survival, risk to own health, risk to health of friends and family, income, loan interest payments, etc. We should not be surprised that there are strong differences of opinion. However, whatever individual plan is adopted it must at the very least comply with the Government's requirements and should not entail abandoning established skydiving safety procedures without very good reason. The individual plan may also need to take account of any requirements added by landlords or airfield authorities where DZs are operating.

With a deep economic recession, falling job security, rising household debt and increasing unemployment, many will be reluctant to spend scarce funds on personal recreation or on sponsoring other people's jumps. Regardless of what Government allows us to do and regardless of what parachute training organizations and their instructors are willing to do to make a living, we may find that customers do not regard sitting on the lap of a stranger in a confined space as being a risk they wish to take for themselves or for their families, at least for the foreseeable future. It is quite possible that much of our customer base may have evaporated for the time being.

John Carter  
British Skydiving Medical Adviser

May 2020

## Appendix 1 - SOURCES OF OFFICIAL INFORMATION AND ADVICE ABOUT COVID-19

The advice about COVID-19 is likely to change day by day as the level of infection in the general population changes and as more well evidenced information becomes available. It is worth rechecking these pages regularly for the most up to date advice.

### **General Advice from NHS**

<https://www.nhs.uk/conditions/coronavirus-covid-19/>

<https://www.nhs.uk/conditions/coronavirus-covid-19/common-questions/>

<https://www.nhs.uk/conditions/coronavirus-covid-19/self-isolation-advice/>

### **General Advice from the Government**

<https://www.gov.uk/guidance/coronavirus-covid-19-information-for-the-public>

<https://www.gov.uk/guidance/coronavirus-covid-19-information-for-the-public#diagnosis-and-analysis>

### **Advice to Employers**

<https://www.gov.uk/government/publications/guidance-to-employers-and-businesses-about-covid-19/guidance-for-employers-and-businesses-on-covid-19>

### **Advice on Reducing Spread of Infection**

<https://www.gov.uk/government/publications/novel-coronavirus-2019-ncov-guidance-to-assist-professionals-in-advising-the-general-public/guidance-to-assist-professionals-in-advising-the-general-public>

### **Advice to transport staff**

<https://www.gov.uk/government/publications/covid-19-guidance-for-staff-in-the-transport-sector/covid-19-guidance-for-staff-in-the-transport-sector>

### **If a medically suspected or confirmed case of COVID-19 has been at your DZ**

<https://www.gov.uk/government/publications/covid-19-decontamination-in-non-healthcare-settings/covid-19-decontamination-in-non-healthcare-settings>

### **REGIONAL GUIDANCE**

It is possible that the infection may evolve differently in different parts of the country and so advice may vary not just with time but by region. Further region specific advice is available from:

Health Protection Scotland

<https://www.hps.scot.nhs.uk/a-to-z-of-topics/wuhan-novel-coronavirus/>

Public Health Wales

<https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/>

Public Health Agency in Northern Ireland

<https://www.publichealth.hscni.net/news/covid-19-coronavirus>