SGGQ420P NPTRS Query System 10/31/20 AFS620DB Detail Format 12:40 ------ For Official Use Only-----SECTION I - Rec Id : WP15201301108 Insp Code : WJR Record 1 of 1 Phone : 408-291-7681 : ROBINSON, WILBERT J InspName Activity # : 3712 Far : 105 NPG : Callup Date : Start Date : 8/9/2012 Planned : N Closed Date : 10/12/2012 Results : C : C Status OTNA Office : Designator : Arcft Reg # : Affil DSGN : Depart Point : OAR Arriv Point : Complaint # : Flight Occurence # : MMS Incident # : IWP152013001 Sim/Dev ID : Insp Unit : UNT2 Insp Type : ASI EIR # : Accident # : Last DO Update : 10/23/2012 Process Date: 10/23/2012 Down Office Related Record ID : Orig Insp Non-Cert Act Name/Company : Foreign #: N Airman #/Name:

Examiner #/Name: Appl. #/Name: #/Name: RI

Exam Kind 8430-13 # : Pass/Fail : Num Misc : Misc Tracking : : Local Use : Regn Use Natl Use : Act Time : Travel Time : Trav Cost : 0.00

Geographic : N Foreign : N Triggers :

SECTION II - PERSONNEL

Record ID:WP15201301108

Personnel Name: GERADO PLORES

Position : PARACHUTIS Base: OAR Remark

SECTION IV - COMMENTS

Record ID:WP15201301108

CMNT CODE: G899I

On August 08, 2012, a parachutist, Gerado Flores, Main Chute appeared to have deployed prematurely, while he was on his back, as he performed what appeared to be a barrel roll. He then lost consciousness as he descended to the ground. This incident occurred at a drop zone at the Marina Muni Airport in Marina, CA. Mr. Flores wore a GO-Pro video camera in his left hand under his glove. Video footage revealed the following: |

11 Video Footage |] 11

Mr. Flores exit from the aircraft was uneventful. Approximately 16 seconds into the descent after exciting the aircraft, Mr. Flores executed a barrel roll maneuver that put him on his back. At that instance, the hand deploy pilot chute prematurely deployed out of its pouch which appeared to cause the

For Official Use Only----unintentional deployment of the main parachute at approximately 13,000 feet. The deployment appeared to be successful with Mr. Flores commenting, on video, everything is ok. However, upon further review of the video footage, the Inspector noted a few anomalies that were revealed during the viewing: 11 Immediately after deployment, Mr. Flores appeared to have control of the right hand red steering toggle (handle) but did not have control of the left. It was dangling behind him in the wind as he descended to the ground. || Suspension lines that attached between the riser and main parachute were noted broken and dangling in the wind. | | 11 11 The Slider appeared pinched on one side and not fully expanded. | | Parachute Examination | | On August 14, 2012, an examination was performed by Inspector Robinson, San Jose FSDO and Allen Silver, FAA Master Rigger and Designated Parachute Rigger Examiner (DPRE), #2130616, on an Eclipse Student Parachute assembly. The inspection of the parachute was performed at Mr. Silver s parachute loft, Silver Parachute Sales & Services, in Hayward, CA. | | Container - We began the inspection with the TSO d harness and container. The container showed signs of wear and tear that appeared beyond serviceable limits. The material on the flap of the reserve container was worn on numerous parts of the cover. | 11 The main parachute closing flap velcro was completely worn. The Inspector tested and pulled the velcro flap apart with less than one inch pound of pressure which is beyond acceptable industry standards in accordance industry recognized manual, The Parachute Manual Volume II, Chapter 4, Paragraph 4.158. | 11 Reserve Parachute The reserve parachute ripcord was not safety tied or sealed in accordance with 65.133 and consideration given to removing the parachute from service and repacked. || П Harness The shoulder/back harness that connects to the main parachute showed signs of wear and tear that appeared beyond serviceable limits. Suspension Lines - Upon viewing the video the inspector noticed at least two lines that were broken. In addition, upon closer investigation, the Inspector noted that the lines were tied (knotted) in place on cells 4 and 5. This could only have occurred while in the possession of an individual on the ground prior to any packing of the main parachute. These lines should have been replaced prior to allowing this parachute to be placed in service. Slider - The discrepancies from the suspension lines on the left side of the main parachute appeared to have prevented the slider from deploying all the way down and flat into its proper position. || 11 Training | |

SGGQ420P 10/31/2012 NPTRS Query System 12:40 Detail Format AFS620DB ----- For Official Use Only-----11 Mr. Flores has logged 30 jumps, the equivalent of approximately 30 minutes of free-fall time. His training records revealed that he had been trained on performing the maneuver executed during this particular jump.] | Conclusion: | | 11 The hand deploy pilot chute premature deployment was a contributing factor to the deployment of the main parachute. Evidence of the pilot chute being properly placed and secured in the pilot chute s storage pouch was inconclusive. || 11 The main parachute closing flap velcro appear to be unserviceable due to it being worn beyond acceptable industry standards in accordance the industry recognized manual, The Parachute Manual Volume II, Chapter 4, Paragraph 4.158. The Velcro is a critical part of the proper opening sequence and should have been replaced on this certified harness/container prior to it being placed in service. | | 11 The Slider discrepancy caused a braking action applied to the main parachute which placed the parachute in slow turn to left configuration all the way down to the drop zone. Although not a contributing factor, the Reserve Parachute was properly packed but the ripcord was not properly sealed in accordance with Title 14 Code of Federal Regulation (CFR) Part 65.133. A parachutist inspection of the

equipment prior to jumping may have caught this discrepancy.