

Initial Incident Report

02 March 2011

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Drop Zone: Skydive San Marcos, Texas

Date of Skydive: Monday, 21 February 2011

Jumper: Doug Wood

Status: Not Injured

Type of Jump: Wingsuit Jump

Container: Mirage M6, SN: 1027, DOM: 07/98

AAD: Aviacom Argus, SN: 309010111615, DOM: 03/09

Reserve: Precision Raven 2, SN: 262241, DOM: 07/98

Deployment Altitude: unknown, altimeter read multiple jumps due to slow vertical speed on wingsuit, believed to be under 2000' according to numerous witnesses, jumper has a history of low pulls on previous jumps

Latest reserve repack date and details: unknown, multiple pack cards in rig, rigger unwilling to respond with copy of logbook page and date. No in-date pack card found in rig (believe fabrication of pack card and logbook entry may be attempted after comments made by jumper)

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Incident Description: Jumper exited the aircraft for a wingsuit jump. He deployed at a low altitude (according to observers), actual deployment altitude is yet undetermined. His Main canopy deployed properly and he landed safely on the drop zone landing area. After walking back several hundred yards to the packing room, he “threw”(jumpers own wording) down his gear for the packer, who then packed it for the next jump and was about to close the container when the reserve popped open. Drop Zone Manager, Eric Butts, who is also the Safety & Training Advisor and Head Rigger, was in the room and immediately recognized that the AAD had fired and that the cutter had not cut cleanly through the closing loop, thus holding the reserve closed until the rest of the threads broke on the packing floor and allowed the reserve to open. It is undetermined when or at what altitude the AAD fired.

Investigation by the drop zone staff riggers, Eric Butts and Paula Wargo Hunt determined that the closing loop (recommended in the manual to be 4.5” to 4.75”) was actually approximately 4 ½” originally and not more than 5”. Loop seemed to be dry, lacking in the recommended treatment of silicon by the manufacturer. Cut ends of the loop were found to be uneven in length. All reserve grommets were absent of any burrs or sharp edges. Cutter was located on top of pilot chute. Battery voltage was ok in unit, as determined by self test.

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Reserve seems to have been packed in concordance with the manufacturers recommendations except for the absence of silicon on the closing loop.

Manufacturer's recommended modification of the cutter location as stated in Mirage Service Bulletin in December of 2004 was completed on this container, cutter was located under the no.3 bottom flap and not on the no.1 kicker flap of the container.

Conclusion: It is our belief that the cutter of this unit, when fired, did not cut cleanly through the closing loop, thus leaving the container closed.

Co-Authors :

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