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BHPA Incident Report: GBR-2018-7547

INCIDENT

Aircraft Type:	Paraglider: Gin Atlas Size L (serial number BC05-Q610049ZP); Gin Verso harness equipped with emergency parachute, Lazer EN 966 full face helmet.
Certification:	Paraglider certification: EN-B.
Location:	St Geniez, (near Sisteron) France.
Date and Time:	26th July 2018, 12:50 UTC.
Type of Flight:	Local / ridge soaring flight.
Persons Involved:	Pilot A
Injuries:	Cause of death listed as internal injuries.
Nature of Damage:	Minor damage to the glider.
Pilot's Rating/Licence:	BHPA Paragliding Club Pilot (Hill) rating, attained August 2015.
Pilot's Age:	48
Pilot's Experience:	Approximately 10 hours (since attaining CP rating), recorded in Pilot A's log book.
Information Source:	Statements from Pilots B and D, Pilot A's logbook and on-board electronic media from Pilots A and B.

1.0 Synopsis.

Pilot A was making a paragliding soaring flight on a hill site in south eastern France. Above the top of the ridge, Pilot A's paraglider was seen to experience a large asymmetric deflation. This led immediately to an accelerating left-hand rotation and rapid descent, before Pilot A impacted the top of the ridge. He was attended to by fellow pilots, passers-by, and the emergency services, but died from injuries sustained in the impact.

2.0 History of the flight.

Pilot A arrived at the paragliding site known as St. Geniez around 10:30am (local time), accompanied by Pilots B and C; two BHPA Senior Instructors (Pilots D and E); and two pilots under training. Pilots A, B and C launched at 12:25pm (local time) in conditions described as being light anabatic. Pilot A gained height above take-off and soared the ridge with Pilot B. Pilot C was able to thermal away from the hill.

Twenty-five minutes into the flight, Pilot A's paraglider was approximately 300 feet above the top of the ridge when it experienced a large asymmetric deflation on the left-hand side. The wing re-inflated and dived into a rapidly accelerating spiral turn to the left. The wing turned through one and three-quarter turns before Pilot A impacted the grass plateau above the rock face, approximately 300 metres west along the ridge from the take-off area.

3.0 Focus.

Based on the information available, the Investigation considered the flying area and local flying conditions, Pilot A's experience and currency, his equipment, and the part of Pilot A's flight immediately prior to his impact with the ground.

3.1 The flying area and local conditions.

The flying site of St. Geniez is a southerly facing ridge above the village of St. Geniez in the Alpes de Haute Provence region of France. The site has a height difference of approximately 750 feet from take-off to the landing area, and is used for recreational paragliding and training. The hill consists of a rocky escarpment that faces in a southerly direction, and a grass top area forming an intermediate plateau. The hillside behind climbs up to the peak known as "Trainon".

The conditions described in the witness statements illustrate benign morning conditions with a light southerly breeze, building in thermic activity as the day progressed. None of the witnesses noted the conditions as being turbulent. From the evidence, the conditions appeared appropriate for paragliding.

3.1 Pilot A's experience and currency.

In 2015, Pilot A completed his Club Pilot training with a BHPA school based in France. His log book had not been completed up-to-date, however it records that he flew in Spain and in the Alpes de Haute Provence region of France in 2016 and 2017. From the logbook and electronic media provided, Pilot A had acquired 8.5 hours experience since gaining his Club Pilot qualification. His total airtime noted in Pilot D's statement was 25 hours.

Immediately prior to the incident day, Pilot A had completed a post Club Pilot thermalling course under the guidance of Pilots D and E. The Investigation determined that Pilot A was suitably current to undertake the planned flight on the incident day.

3.2 Pilot A's equipment.

The Gin Atlas used by Pilot A is an EN-B class paraglider described by the manufacturer as being suitable for the "less experienced pilot". It was not possible to determine whether Pilot A was within the certified weight range, as Pilot A's total weight in flight was unknown.

The wing was examined by a paraglider service centre which undertook a general condition inspection, and measured Pilot A's wing against the manufacturer's line length specification. The wing was reported to be in good condition, apart from three missing suspension lines and minor damage that may have occurred in the impact or subsequent recovery of the equipment from the mountainside.

The suspension lines present were found to be within manufacturer's specification. The service centre reported that the control lines and stabilo lines were slightly shortened. Although shortening of control lines may affect a glider's recovery behaviour, the Investigation did not consider the extent of shortening in this instance to be a contributory factor.

The Investigation considered the type of wing and harness used by Pilot A not to be contributory factors in the incident.

After the incident, a static deployment test of Pilot A's emergency parachute inner bag from its outer container was performed. The Investigation determined that within the limits of this static deployment test, the emergency parachute deployment system functioned correctly.

3.4 The incident.

The Investigation considered the portion of the flight immediately prior to the impact.

Pilot A was flying above the ridge top in a westerly direction when his wing experienced an asymmetric deflation on the left-hand side, affecting the majority of the span of the wing. The wing was seen to rapidly re-inflate and assume a nose-down attitude, and to spiral dive in a tightening left-hand turn through 630 degrees before impacting the ground. It is evident that the wind was blowing directly onto the ridge prior to the incident. From the evidence, there was no indication of strong thermic activity before the incident, although this cannot be ruled out as causing the collapse.

4.0 Findings

The Investigation determined from the available evidence that Pilot A experienced a large asymmetric collapse of his paraglider from which he was unable to recover before impacting the ground and sustaining fatal injuries.

5.0 Recommendations.

The BHPA shall remind its members through Skywings magazine that if a wing collapse occurs at 300ft (or less) above the ground and it causes a rapid rotation or a high rate of descent, or if descending through 300ft above the ground in an uncontrollable rotation, the pilot should immediately deploy their emergency parachute without any hesitation.