BRITISH PARACHUTE ASSOCIATION
SAFETY AND TRAINING COMMITTEE MEETING
BPA OFFICES, 5 WHARF WAY, GLEN PARVA, LEICESTER
THURSDAY 8TH AUGUST 2002

Present:	John Hitchen	-	Chairman
	Pat Walters	-	Tilstock
	Mike Rust	-	NLPC
	Dane Kenny	-	Pilgrims
	Dave Wood	-	RAFSPA
	Steve Jelf	-	Silver Stars
	Karen Farr	-	Skydive Strathallan
	David Hickling	-	BPS, Langar
	Paul Hollow	-	Target Skysports
	Paul Applegate	-	Riggers Committee

Apologies: Tony Knight, Ian Cashman, Allan Wilkinson, Ian Rosenvinge, Dave Emerson, Nick Johnston, Pete Sizer, Ronnie O' Brien, Phil Cavanagh.

In Attendance:	Tony Butler	-	Technical Officer
	Trudy Kemp	-	Assistant to NCSO/TO

Observers: Tony Goodman, John Page, Richard Wheatley, Andy Paddock, John Harding, Kim Newton, John Curtis, Dave Lewis, Sue Ball, Adrian Ball.

ITEM

1. MINUTES OF THE STC MEETING OF THE 6TH JUNE 2002

The Committee was advised that two areas of Item 3 (Riggers) were recorded incorrectly in the Minutes:

1. Paragraph 3 of Item 3 (page 3), third line stated; " He stated that the container…." This should have stated; " He stated that the **canopy**…"
2. Paragraph 4 of Item 3 (page 3), third line stated; " …inspected by an independent Advanced Rigger…" This should have stated; " **evaluated by Kim Newton and an Advanced Instructor who is AFF rated**…"

It was proposed by Dane Kenny and seconded by Dave Wood that the Minutes of the STC meeting of the 6th June 2002, with the above amendments be accepted as a true record.

Carried Unanimously

2. MATTERS ARISING FROM THE STC MEETING OF THE 6TH JUNE

Page 1, Item 2 – (Matters Arising – RAPS Panel of Inquiry/Working Group) Dave Hickling gave the meeting details regarding the progress of the ' Panel/Working Group' and stated that trials were still continuing with regard to dispatching and

different types of exits, but his Centre had been unable to do very much over the last few weeks as the Centre's Static Line aircraft, being used for the trials, had been away for its C of A.

Page 4, (Item 4(v) – (Incident/Injury Reports) At the last STC meeting the Technical Officer had agreed to draft a Tandem Malfunction report form for STC's consideration. Following some input from STC members, a draft was circulated with the agenda. It was suggested that Clubs use this report form for the rest of the year and if it was felt worthwhile, books could be produced for mandatory use and distributed to Clubs.

It was proposed by Dane Kenny and seconded by Mike Rust that the above Tandem Malfunction report as presented be approved for use.

Carried Unanimously

3 MINUTES AND MATTERS ARISING FROM THE RIGGERS' SUB COMMITTEE MEETING OF THE 6TH JUNE 2002

Page 3, Item 8 – AOB (iii) – Tandem Types. At the previous meeting John Harding had raised some concern regarding the classification of the "Atom" Tandem System as a "Vector" type. The root of his concern was in the differing emergency drills required between the two systems and he believed, following discussion with Tandem Instructors that the differences were so great as to warrant a separate classification for the Atom system. The Riggers Committee had felt that John Harding had pointed out a potential problem, which they felt that STC may wish to look at.

The Chairman asked for some input from those present. He also stated that he would be raising this issue on the next Tandem Instructor course and he would also be speaking to instructors on next weeks Instructor course at Langar.

There being no further matters arising from the previous meeting, it was proposed by Paul Applegate and seconded by Pat Walters that the Minutes of the Riggers Sub-Committee Meeting of the 6th June 2002 be approved.

Carried Unanimously

Paul Applegate then gave the meeting a resume of the Riggers' meeting held that evening and stated that the Committee had discussed and approved a number of equipment modifications:

a. To fit a Paratec Twin 402 Tandem Reserve into a Relative Workshop Vector II Tandem Container. This had been approved at the last meeting, but no drawings were supplied. The paperwork for this modification had now been received, which had been previously circulated with the Agenda.

b. Rebuild of a Tandem Vector container by Point Zero – Now called PZ Option, containing a Paratec 372 main canopy and Vector II Tandem reserve. This was approved at last meeting, but not given a name, or details of canopies.

c. To incorporate a Next Harness Container System secondary drogue release handle onto a Tandem Vector Harness Container System, for general use.

d. To install a BOC 'throwaway' pilot chute system onto a Telesis AFF container.

It was proposed by Paul Applegate and seconded by Pat Walters that the above equipment modifications be accepted.

Carried Unanimously

Paul Applegate also advised the Committee that a Panel of Inquiry Report involving a rigger had been circulated with the agenda to CCIs and Advanced Riggers. This involved a number of packing/rigging problems/incidents, which had been reported to the Riggers' Committee. Paul stated that the Report and its Conclusions and Recommendations was accepted by the Riggers Committee that evening. This Report also required acceptance by STC:

The Conclusions and Recommendations of the Panel were as follows:

CONCLUSIONS

The Panel accept that the Rigger concerned felt that he was under pressure to complete tasks he was given in what he believed to be an inadequate time frame. However, the Panel felt that after having approached his CCI with his concerns regarding what he believed to be an excessive workload, he could have approached the Chairman of the Riggers' Sub-Committee and not carried out his work in what proved to be an unacceptable manner.

RECOMMENDATIONS

The Recommendations of the Panel are that the Rigger concerned Advanced Packer and Parachute Rigger ratings be suspended for 12 months, from the date that the Riggers Sub-Committee originally suspended them (11th April 2002). That prior to having them re-instated; an Advanced Rigger evaluates him in order that his packing and rigging is re-assessed and that it is considered to be up to the accepted standard. The Panel also recommends that he be sent a letter from the Chairman of the Riggers' Sub-Committee reminding him of his responsibilities.

It was proposed by Paul Applegate and seconded by Dave Wood that the Panel of Inquiry Report including its Conclusions and Recommendations be accepted.

Carried Unanimously

4. FATAL ACCIDENTS

The Chairman advised the Committee that unfortunately there were three fatality reports to be considered at this meeting.

A. Phillip Cheasley

The Chairman reported that some details of this fatality were discussed at the last STC meeting. Since then the Board of Inquiry report had been completed and a resume sent out with the agenda.

At approximately 15.00 hours on Saturday 1st June 2002, Phillip Cheasley boarded a LET 410 operated by the Hinton Skydiving Centre, in order to

make a three-way FS jump with two other parachutists. Also on board were fourteen other parachutists.

The aircraft climbed to approximately 12,000 ft AGL and then 'ran in' at approximately 170-180° from north, over the top of the DZ control point and over the PLA.

Once the aircraft was over the exit point, the first three parachutists, including Phillip, left the aircraft followed shortly after, at various intervals, by the remaining parachutists.

The majority of Phillip's free fall descent went without incident, though only he and one of the other parachutists linked together in freefall. At approximately 4,000ft AGL Phillip separated from the other parachutist in order to 'track' away to deploy his parachute. At this time a glider was observed to be in close proximity to the three parachutists. Shortly after, at between 3,000 – 4,000ft AGL the glider was seen to collide with Phillip.

The wing from the glider was observed to detach from the fuselage and the glider was then seen to spiral towards the ground. The pilot of the glider was not seen to exit the aircraft. Phillip's reserve parachute was observed to deploy at approximately 700ft AGL. Once the parachute had deployed, no movement was seen from the jumper. Phillip was then observed to land under the parachute on the northern perimeter track of the airfield.

A BPA Board of Inquiry was convened, consisting of John Hitchen (NCSO), Tony Butler (TO) and Steve Apps (IE). The Board Report, the Conclusions and Recommendations required acceptance by STC:

CONCLUSIONS

The Conclusions of the Board are the majority of Phillip's free fall descent went without incident. At approximately 4,000ft AGL he separated from the other parachutist, in order to 'track' away to deploy his parachute. Shortly after, at approximately 3,000 – 4,000ft, the collision occurred.

Even though there were systems in place that were intended to prevent this type of accident, it is the Board's belief that the glider penetrated the agreed exclusion zone, that was intended for parachuting activities only, narrowly missing the other parachutist in free fall and then colliding with Phillip, who was also in free fall. This resulted in the glider wing detaching from the fuselage. The Board believe that Philip was almost certainly fatally injured as a result of the collision.

The DZ Controller attempted to abort the drop, by ground to aircraft radio. The crew of the aircraft did not hear the call, but the Board believe that when the call was made the parachutists had already left the aircraft.

RECOMMENDATIONS

The Recommendations of the Board are:

a). That in the light of this accident, all Clubs re-asses their non-confliction procedures and satisfy themselves that they are adequate, and where other activities take place at the same site, formal, agreed procedures are in place.

b). That the Hinton Skydiving Centre liaises with the other airfield users to instigate a more formal procedure for parachuting activity notification, so that there is no doubt other airfield users are fully aware of the ' cone of parachuting operation' in use whenever parachuting is taking place.

Note: *The Hinton Skydiving Centre has now instigated a more formal system of parachuting activity notification, which includes a ' buffer' zone around the proposed parachuting activity area. They are also negotiating a revised letter of agreement with the Gliding Club.*

The above recommendations relate only to parachuting activities. It is for other organisations to make recommendations concerning their own activities.

It was proposed by Dane Kenny and seconded by Mike Rust that the Board of Inquiry Report and its Conclusions and Recommendations be accepted.

The Board also recommends that in this instance, it is it' s opinion that it would serve little purpose to instigate a Panel of Inquiry following this Board of Inquiry, as any peripheral aspects were dealt with at the time and shortly after by the ' Board' .

It is therefore recommended to STC and Council that a Panel of Inquiry is not instigated.

The above recommendation was proposed by Karen Farr and seconded by Mike Rust and voted on as follows:

For: 6 Against: 1 Abstentions: 1

Carried

David Hickling stated that although he had voted against the above proposal and he did not wish to go against the recommendations, he felt that a Panel of Inquiry should be formed as was normal policy following a Board of Inquiry. He believed that to depart from our standard procedure was unusual and felt that the formality of following normal procedure in this instance would be better for the Association.

B. Rachel Gray

There was another tragic accident at Hinton, this one in July, where the BPA member Rachel Gray was critically injured performing a low turn, on the 14th July. She died from her injuries on the 21st July.

Circulated to those present was a Board of Inquiry Report resume, including the Conclusions and Recommendations of the Board, which consisted of the NCSO & Technical Officer. This report needs to be formally accepted by STC.

At approximately 11:20 hrs on Sunday 14th July 2002, Rachel Louise Gray boarded a LET 410 along with sixteen other parachutists, which was to be the 4th parachuting lift of the day for that aircraft.

The aircraft climbed to approximately 12,000ft AGL. A 'jump run' was made over the centre of the PLA. Once the aircraft was at the correct EP approximately half the parachutists on board exited. The aircraft then completed a second circuit and 'ran in' over the PLA again. Once over the correct EP the remainder of the parachutists exited, with Rachel being the first to leave.

She was carrying out a solo jump. Her canopy was seen to deploy at the correct altitude, (between 2-3000ft AGL), and was seen to be flying correctly.

At approximately 100ft AGL Rachel's canopy, which was flying in a northerly direction, was observed to make a radical left turn, impacting with the ground before the turn was completed.

CONCLUSIONS

The Conclusions of the Board are that Rachel made an uneventful free fall decent. Deployed her main parachute at the correct altitude, and remained in a suitable area above the intended landing area. At a very low altitude, approximately 100ft AGL, she initiated a radical left turn, having been facing in a northerly direction, in order to face south for landing. She then struck the ground at high speed before fully completing the turn.

There had been very little wind at the time of the accident and all parachutists on board the aircraft had been instructed, prior to take off, by the CCI to land facing in a southerly direction.

Prior to the accident Rachel had completed only three jumps during 2002. These had all been within the previous six weeks. With 432 jumps, she was an experienced parachutist. However, the Board believes that this lack of currency, together with the low wind speed, may have contributed to Rachel making the incorrect decision to turn so low to the ground.

RECOMMENDATIONS

The Recommendation of the Board is that the subsequent Panel of Inquiry, which follows a Board of Inquiry and is set up to investigate any peripheral aspects to the fatality, also considers the following:

Is there anything further that can be done by the BPA and Clubs to educate parachutists of the dangers of low turns?

The Chairman stated that a Panel of Inquiry would be convened to look in to this aspect and he asked for ideas and input from those present of ways of educating people about the consequences of low hook turns.

It was proposed by Mike Rust and seconded by Dave Wood that the Board of Inquiry Report and its Conclusions and Recommendations be accepted.

Carried Unanimously

C. Oliver Reynolds

This fatal accident took place on the first day of the FS Nationals at Hibaldstow, on the 27th July, where the BPA member Oliver Reynolds was critically injured performing a low turn. He died from his injuries later the same day.

Circulated to those present was a Board of Inquiry Report resume, including the Conclusions of the Board, which consisted of the Technical Officer and BPA Examiner Ian Cashman. This report needs to be formally accepted by STC.

At approximately 06.45 hrs on Saturday 27th July 2002, Oliver Reynolds boarded an SMG-92 aircraft along with nine other parachutists, which was to be the first lift of the day for that aircraft.

This lift was the start of the first 'round' of the British National Championships in FS and Oliver was a member of a 4-way team taking part.

The aircraft climbed to 10,500ft AGL. A 'jump run' was made over the centre of the PLA. When the aircraft was over the 'exit point', Oliver, along with his four fellow team members exited in order to carry out their planned FS jump. The remaining parachutists exited shortly after.

The free fall part of the descent went without incident, during which a number of FS manoeuvres were completed. At approximately 4,000ft AGL the parachutists separated and deployed their parachutes between 2 - 3,000ft AGL.

All parachutes deployed normally and Oliver's parachute appeared to be flying correctly. At approximately 200ft AGL his parachute was observed to be flying over the landing area designated for Experienced Parachutists, approximately 100 metres from the parachute centre buildings and control point. At a very low altitude Oliver's parachute was seen to make a radical turn, either left or right, (there was some confliction between witnesses as to the direction of turn). The parachute completed approximately 180° of the turn, at which point he impacted with the ground.

CONCLUSIONS

The Conclusions of the Board are that Oliver made an uneventful free fall descent, deployed his main parachute at the correct altitude, remained in a suitable area in order to land in the intended landing area. At a very low altitude he initiated a radical turn in order to face into wind for landing, though there was very little wind and a satisfactory landing could have been achieved facing in any direction. He then struck the ground at high speed before fully completing the turn.

The Board do not know why Oliver made such a radical turn so close to the ground and can only conclude that he was not aware of how low he was prior to initiating the turn, or that he may have felt he could have executed the turn successfully.

It was proposed by Paul Hollow and seconded by David Hickling that the Board of Inquiry Report and its Conclusions and Recommendations accepted.

Carried Unanimously

The Board also feel that in it's opinion it would serve little purpose to instigate a further Panel of Inquiry following this Board of Inquiry, as the Panel to be formed following the previous fatality can also take into account this fatal accident.

It is therefore recommended to STC and Council that a Panel of Inquiry is not instigated.

The above recommendation was proposed by David Hickling and seconded by Pat Walters.

Carried Unanimously

5. INCIDENT/INJURY REPORTS RESUME

i) There had been 41 Student injury reports received since the last meeting. 29 male and 12 female. Four of them occurred during ground training, (2 during a warm-up session, 1 during exit training & 1 Student walked into an aircraft in a hangar). 2 of the injuries happened during exits (1 dislocated a wrist – catching the static line & 1 caught the edge of the door).1 Student lost consciousness under canopy and landed striking the side of a building (sustaining bruising to the chest and legs) and 1 Student fell over returning from the PLA. The remaining 33 were all landing injuries. One was on round canopies and 32 were on ram-air canopies.

ii) There had been 14 injury reports received for Intermediate or Experienced Parachutists. 10 male and 4 female. These reports included injuries to two parachutists who collided under canopy – a 4-way FS jump where one of the team collided with the cameraman on deployment. One sustained two broken ribs and the other a collapsed lung.

iii) Since the last meeting there had been 15 Student Parachutist Malfunctions/Deployment Problems reported. 13 male and 2 female. All were on ram-air canopies.

iv) There had been 39 reports of Malfunction/Deployment Problems to Intermediate or Experienced Parachutists since the last meeting. 37 male and 2 female.

v) There had been 21 Tandem Injury or Incident reports received since the last meeting. 6 were injury reports, 5 of them were minor and one was a dislocated ankle. 14 were malfunctions/deployment problems and one was a Tandem bumping into another Tandem on landing – no injuries.

vi) There had only been 1 report received of an AAD firing since the last meeting and involved an FXC firing at approximately 7,000ft whilst a Category Student was carrying out a freefall exercise.

vii) There had been four reports received where jumpers have had to jettison Skysurfing boards.

viii) There had been 7 ' off landing' reports received, 4 on displays, and 3 at clubs.

ix) Two reports had been received of parachutists losing helmets.

x) There had been 7 reports received of display misfires, 2 malfunctions & 3 of jumper hitting things on landing (a fence, a park bench & a marquee) and one where a jumpers canopy landed on a member of the public. Also one jumper injury.

xi) There had been 3 reports involving aircraft. One where 2 AADs fired whilst an aircraft was descending, the door was closed and this caused no problems. Another involved a reserve cable catching on the door of an aircraft on exit, deploying the reserve. The third involved the control column on a Cessna jamming. The jumpers exited and the pilot was able to land the aircraft without further incident.

xii) The BPA received a letter from the RAF regarding a military free fall programme from the Skyvan at South Cerney, where a 4-way group was launching a ' piece' from the tailgate. One got caught on the door support hook and was hung up. He was eventually pulled back in the aircraft. The letter was to remind jumpers using this type of aircraft, that the hooks must be retracted before jumping.

xiii) The final incident involved two instructors who were dispatching Students from a Cessna Caravan. One instructor was dispatching and the other was assisting to retrieve the static line bags. A number of bags were unhooked before all the static line Students were dispatched, (contravening the requirements of the Operations Manual). Both instructors have been disciplined by the Commandant of the centre.

The Chairman stated that both the instructors had been severely reprimanded by the APA for their actions and had both been put on a probationary period as APA instructors until 15th December 2002 during which time all aspects of their instruction would be closely monitored. Failure to complete the probationary period to the full satisfaction of the APR CCI or the expedition CCI could jeopardise their BPA instructor ratings.

The Chairman asked those present if they were satisfied with the action taken by the APA' s Safety & Training Committee concerning the two Instructors concerned or did they feel that further action should be taken.

Dane Kenny was also able to provide some background information on this matter and he proposed, seconded by Karen Farr that a letter was sent from the Chairman of STC to both Instructors reminding them of their responsibilities as Instructors and also to remind them of the consequences of what may happen if static lines are unhooked.

Carried Unanimously

6. SUGGESTED CHANGES TO THE BPA OPERATIONS MANUAL

A number of suggested changes to the BPA Operations Manual went out with the agenda. The Technical Officer presented the suggested changes.

A). A number of people have suggested that it might be a good idea to refer to risk assessment in the BPA Operations Manual. This might be done in a safety statement as an introduction to the Operations Manual.

A number of prospective first-time jumpers and group organisers, such as a college activity group leader, have already asked to see a risk assessment. The nearest to this that we have is the Operations Manual, though a Working Group has been formed to look into the subject of Safety Management System (SMS) and risk assessments. At the moment, the Operations Manual makes no reference to risk assessment. Addition of the suggested introduction below would remedy this. It is therefore put

forward for STC's consideration.

BPA OPERATIONS MANUAL, SECTION 1 (CONDUCT AND CONTROL OF SPORT PARACHUTING), New Paragraph 1 (Introduction), to read:

1. INTRODUCTION

The British Parachute Association (BPA) is the governing body of sport parachuting in the United Kingdom. The BPA is committed to maintaining the highest standards of safety in the sport. The BPA's approach to safety is established as good practice in the sport.

Since its foundation in 1962, the BPA has carefully analysed accidents and injuries in sport parachuting. This long experience has enabled the BPA to build up a detailed knowledge of the risks in the sport. As risks have been identified and assessed, measures to manage and control the risks have been put in place. These control measures are documented in this Operations Manual. The BPA Operations Manual may therefore be thought of as the outcome of a cumulative and continuing assessment of the risks inherent to, and associated with, sport parachuting. As techniques of risk assessment become more widely used across many fields of human endeavour, the BPA has an ongoing commitment to develop and promote the role of proactive risk assessment in the sport.

The BPA authorises only qualified individuals as competent persons to conduct parachuting activities at BPA Affiliated Clubs, Schools, Centres, Associations or Organisations (Clubs) or in BPA Registered Display Teams. Such activities are conducted in accordance with the procedures set out in this Operations Manual. The training and qualification of persons as competent, and the content of the BPA Operations Manual, are regulated by the BPA Council through its Safety and Training Committee, assisted by competent technical staff employed by the BPA.

The BPA has in place a well-established procedure for the sharing and promulgation of safety information and the reporting and collection of information and data for analysis and action. This enables improvements to be made to control measures, as necessary, on a continuing basis. As with any action sport, sport parachuting can never be entirely risk-free. Participants in the sport must therefore voluntarily accept an element of risk. By its regulation of the sport in accordance with this Operations Manual, and by actively promoting a positive safety culture, the BPA ***assists parachute clubs and display teams to*** manage risk in sport parachuting to ***an acceptable level***.

Note: The above 'bold italics' were minor suggested changes by the Technical Officer following input he had received.

It was proposed by Mike Rust and seconded by Dave Wood that the above suggested changes to the BPA Operations Manual be accepted.

Carried Unanimously

B). It has been pointed out that in the current Operations Manual, Categories 2, 4 & 5 require that the Student should ' count' throughout, but Category 3 does not include this, which is not the intention. It is therefore suggested that:

SECTION 2 (DESIGNATION AND CLASSIFICATION OF PARACHUTISTS, Paragraph 4 (The Category System), sub-para 4.3, be changed to read:

4.3. Category 3

Has demonstrated the ability to perform three consecutive stable Dummy Ripcord Pulls (DRPs), counting and maintaining a positive arch throughout.

It was proposed by Dane Kenny and seconded by Pat Walters that the above suggested change to the BPA Operations Manual be accepted.

Carried Unanimously

C). There has been some confusion regarding the Tandem Instructor currency/rating renewal requirements. If a Tandem Instructor has not completed 20 Tandem descents in the previous 12 months, he/she has to complete refresher training. If a Tandem Instructor has not completed the required jumps in the previous two years, he/she has to be re-evaluated. Some instructors believe that if after 12 months they only have to be refreshed (if they do not complete 20 jumps) and then may be refreshed again twelve months later, if again they do not complete 20 jumps. The intention was that in this scenario the instructor should be re-evaluated. Therefore it is suggested that:

SECTION 4 (INSTRUCTORS), Paragraph 5.7 (Tandem Instructor Rating Renewal), sub-para 5.7.3. change to read:

5.7.3. Subsequent failure to reach the required number of Tandem descents in the next 12 months, will require the instructor to present him/herself for re-evaluation on a TI course. The course Instructor Examiners will decide on the number of descents required.

It was proposed by Dane Kenny and seconded by Steve Jelf that the above suggested change to the BPA Operations Manual be accepted.

Carried Unanimously

D). At the last STC meeting the Medical Section of the Operations Manual was amended to reflect the acceptance of the new ' Solo' Student medical form. However, the amendment could give the impression that after the first jump the Student would have to complete another (different) medical form. This is not the intention. It is therefore suggested that:

SECTION 11 (MEDICAL), Paragraph 1 (Medical Requirements to Parachute), sub-para 1.1.2. be changed to read:

1.1.2. **Form 114A. ' Solo' Student Parachutist Declaration of Fitness to Parachute/Doctor' s Certificate** is for Student Parachutists making a ' first' static line or AFF jump. The duly completed form is valid for the first and subsequent jumps during the period of validity of the form.

It was proposed b David Hickling and seconded by Karen Farr that the above suggested change to the BPA Operations Manual be accepted.

Carried Unanimously

7. AFF/TANDEM INSTRUCTOR COURSE - SIBSON

The Association wishes to thank the Peterborough Parachute Centre for hosting the course, with took place from the 10th – 13th June 2002. The report went out with the agenda and was for information only.

8. PERMISSIONS

i) A letter from Dennis Buchanan went out with the agenda requesting a nine month extension to the AFFBI rating of Kieron Hayes. The Committee was advised that Kieron would not complete his training with the Manchester Fire Service until November and he feels that he needs to top up his skills levels. Kieron would be doing a lot of training over the winter months to ensure that he is fully prepared prior to completing the AFF Course.

It was proposed by Dennis Buchanan (proxy) and seconded by Pat Walters that the above permission be accepted.

For: 7 (incl 1 x proxy) Against: 0 Abstentions: 2

Carried

ii) A letter from Dave Hickling was circulated to those present requesting permission for an Experienced Parachutist to continue jumping (she has made 210 jumps) on a restricted Medical Certificate.

The parachutist was present at the meeting and because of the nature of this request the Chairman gave her the option of this item being discussed " in camera", to which she agreed. Therefore all observers other than relative parties were asked to leave the room whilst this item was being discussed.

David Hickling advised those present that when she reached 40 years old in 2002, she required a Doctor's Certificate. She went to her own Doctor who at that time felt unable to complete her certificate. She stopped jumping and sought the advice of the BPA Medical Advisor who after discussions with her and David Hickling produced an amended " Declaration", which was acceptable to her own Doctor.

The Limitations suggested (by BPA Medical Advisor) for the Medical are as follows:

i. Valid only at Drop Zones where CCI has discussed with BPA Medical Advisor.
ii. Holder may not act as Jumpmaster or Instructor.
iii. Holder may not act as Display Parachutist.

David Hickling advised the Committee that the parachutist's Doctor had signed the Certificate for a period of three months and stated that this may be extended to a longer period.

Following some discussion on this matter, it was proposed by Dave Hickling and seconded by Pat Walters that the above permission be accepted.

Carried Unanimously

Observers were invited to return to the meeting.

iii) Circulated to those present was a letter from Allan Wilkinson requesting permission for a water jump to be carried out without an Advanced Instructor being present. The two jumpers taking part are very experienced parachutists (Dick Kalinski and Jm White).

It was proposed by Allan Wilkinson (proxy) and seconded by Dane Kenny that the above permission be accepted.

Carried Unanimously

iv) Circulated to those present was a letter from Dave Wood requesting a seven month extension to the CSBI rating of Mick Murphy.

It was proposed by Dave Wood and seconded by Dave Hickling that the above permission be accepted.

Carried Unanimously

9. A.O.B.

The Chairman welcomed Steve Jelf; the new CCI of the Silver Stars and he apologised for not introducing him at the start of the meeting.

Date of next Meeting:- Thursday 10th October 2002
At 7 p.m.
BPA Offices, Leicester

9th August 2002

Distribution

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