IN THE CORONERS COURT
OF VICTORIA
AT WANGARATTA

Court Reference: 3878 / 2010

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, SUSAN JANE ARMOUR, Coroner having investigated the death of RODERICK PETER OLDFIELD

without holding an inquest:

find that the identity of the deceased was RODERICK PETER OLDFIELD

born on 23 July 1957

and the death occurred on 7 October 2010

at Emily Spurr, approximately 500 metres north of the Mystic Hill Launch Site, Mystic Lane, Bright, Victoria, 3741

from:

1 (a) MULTIPLE INJURIES FALL FROM HEIGHT (PARAGLIDER)

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**[1]:

1. Mr Roderick Peter Oldfield was a 53 year old Park Ranger who resided with his partner, Ms Janice Pardy, in Porepunkah, Victoria at the time of his death. He was a Paraglider Intermediate Pilot with 1300 hours flying time, including 100 hours during the previous renewal year, having joined the Hang Gliding Federation of Australia ("HGFA") in 1997. He was described by fellow pilots and by his partner as a very safety conscious pilot who was meticulous in regards to the maintenance of his equipment.

[1] The circumstances of Mr Oldfield's death were the subject of an investigation by Leading Senior Constable Anthony Finlaw (29125) of Victoria Police who prepared an Inquest Brief for the Coroner. I have drawn from this investigation in making my factual findings.

2. On 7 October 2010 Mr Oldfield travelled to the Mystic Hill launch site, a popular and purpose-built launch pad used by hang-glider and paraglider pilots which was situated above the town ship of Bright in Victoria. The weather was fine and the wind was blowing around 6 to 8 knots. Mr Oldfield was at Mystic Hill in the company of three other paraglider pilots, Roger Adams, John Chapman and Nick Fenwick. All pilots prepared themselves and their gliders for take-off with John Chapman launching first at about 12.50pm, followed by Mr Oldfield a few minutes later. Mr Fenwick, who was still on the launchpad, observed Mr Oldfield dangling from his harness immediately after he launched and before he disappeared out of sight. He immediately telephoned Garrit Verway, another paraglider pilot en route to Mystic Hill, to ask him to keep an eye on Mr Oldfield. Around 1.00pm Mr Chapman, who had noticed Mr Oldfield flying along Emily Spurr towards the landing paddock, saw him separate from his paraglider and fall about 200 feet into the pine plantations below. Mr Verway was directed into the area where Mr Oldfield was seen to go down and subsequently located him on an old access track. He removed Mr Oldfield's helmet to check for a pulse and signs of life but found none. Police and paramedics attended the scene after which it was confirmed that Mr Oldfield was deceased and he was subsequently transported to Bright Hospital.

3. Victoria Police immediately commenced an investigation into the death of Mr Oldfield. They located a tree with several broken branches which they believed Mr Oldfield had struck prior to hitting the ground and located his paraglider about 50 metres south from where he came to rest. His helmet, on examination, was found to have sustained extensive damage.

4. The Civil Aviation Safety Authority was notified of the incident as was the State Coroners Office. Police were assisted at the scene by Detective Senior Constable Adam Nienkemper of Victoria Police, a paragliding instructor, who was in Bright at the time of the incident instructing a paragliding course[2].

5. Police spoke to Mr Oldfield's partner, Ms Janice Pardy, who indicated that prior to Mr Oldfield's death he was very happy and was looking forward to a holiday they were both planning. He had a good night's sleep the previous night and they had breakfasted outdoors

[2] Detective Senior Constable Neinkemper was also a senior safety officer at two paragliding clubs and had previously provided technical assistance, on behalf of the Hang Gliding Federation of Australia, in Coronial investigations in relation to three other paragliding fatalities in Victoria and Tasmania in 2001, 2003 and 2004.

before she had gone for a run and he had gone paragliding. Whilst running down Mystic Hill she had seen him hanging out of his harness but lost sight of him a short while later.

6. Detective S/C Neinkemper, who had known Mr Oldfield for about ten years through the paragliding community and believed him to be an experienced and competent pilot, inspected the paraglider on 8 October 2010. He did not find any faults with the paraglider but did note that the leg straps were not closed. Detective S/C Neinkemper concluded that the accident was the result of pilot error and that Mr Oldfield had fastened only the apron and flight deck of the pod and not fastened the leg straps prior to take-off. This error had gone undetected because the design of this particular harness[3] meant that Mr Oldfield's flight deck covered the area where the leg straps attached to the harness.

7. No autopsy was performed as the Coroner determined, after advice from the medical investigator, Dr Paul Bedford, Forensic Pathologist with the Victorian Institute of Forensic Medicine, that a reasonable cause of death could be established on the existing information. Dr Bedford performed an external examination of Mr Oldfield at the mortuary, reviewed the circumstances of his death and the post-mortem CT scan and provided a written report of his findings. Dr Bedford identified the cause of death as "multiple injuries fall from height (paraglider)".

8. Toxicological analysis of post-mortem blood samples were negative for alcohol or other commonly encountered drugs or poisons.

9. I find that Roderick Oldfield died from multiple injuries sustained when he fell from height whilst paragliding, having failed to fasten his harness leg straps prior to take off.

[3] Advance Impress Harness with cocoon attached.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act* 2008 I make the following comments connected with the death:

1. In light of the circumstances of Mr Oldfield's death, and in the interests of prevention of other deaths in similar circumstances, I asked the Coroners Prevention Unit ("CPU") [4] for a report to identify any similar incidents and to provide information on the safety aspects of "pod-style" harnesses.

2. The CPU Report concluded that whilst it is difficult to establish the number of deaths that occur because paragliders fail to secure their harness, there is sufficient information to suggest that it is a well-recognised problem in the paragliding community.

3. It is also widely acknowledged that experienced pilots may be more likely to fail to properly complete their pre-flight checks than less experienced pilots. The "human factor" is a major concern in aviation safety in general and may account for a number of adverse events. In many of the previous paragliding incidents identified by the CPU[5] where harnesses were not properly secured, the incident occurred following an interrupted pre-flight check, or followed a take-off which had failed and was then repeated.

4. Whilst design innovations aimed at minimising the probability of pilots failing to secure their harness have been developed and it is likely that further design solutions will be adopted in the industry to manage the risk, the importance of pilot diligence cannot be over-emphasised. Harness safety education should aim to ensure that pilots understand that when there has been an interruption to the pre-flight check, or there has been an aborted take off, they are at significant risk of overlooking a critical safety step and that, in such circumstances, pilots should ensure that they repeat the pre-flight checks again from the beginning.

5. The Hang Gliding Federation of Australia's commitment to ongoing safety improvement has been demonstrated by the development of their Incident Reporting Information System ("IRIS")

[4] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of the Coroner. The CPU assists the Coroner in formulating prevention recommendations and comments, and monitors and evaluates their effectiveness once published.

[5] Identified from previous reports of Australian fatalities, international media reports, safety investigation reports and from paragliding associations.

which will collect, analyse and disseminate details relating to safety issues experienced by paragliding clubs and pilots in Australia. The Hang Gliding Federation of Australia should distribute this finding into the death of Mr Oldfield to all associated paragliding clubs to encourage awareness of the importance of having safety management systems of this kind, and to encourage clubs and pilots to utilise fully the IRIS system for improvements in the ongoing safety of the sport.

7. I would like to acknowledge the invaluable assistance provided by Detective Senior Constable Neinkemper and Mr Geoffrey Wenness and Mr John Olliff of the HGFA in this investigation.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act* 2008, I make the following recommendations(s) connected with the death:

1. That the Hang Gliding Federation of Australia encourage all Australian paragliding clubs to ensure that harness safety education is regularly provided to all paragliding pilots. This education should reinforce the importance of the pre-flight check, and include recovery techniques for unsecured harnesses. It should also ensure paragliding pilots are aware that they are most at risk of a critical safety error in the circumstances of an interrupted pre-flight process, or failed take-off, and that they should diligently repeat their pre-flight checks from the beginning in these circumstances.

2. That the Hang Gliding Federation of Australia actively engage with all paragliding harness manufacturers who provide harnesses for the Australian market, to encourage the development of appropriate safety designs directed to reducing the incidence of unsecured harness straps, and to provide appropriate feedback and analysis of safety innovations already in the market.

DISTRIBUTION OF FINDING

Apart from the Senior Next of Kin of Mr Oldfield, I hereby direct the Principal Registrar of the Coroners Court of Victoria to provide a copy of this finding to the following for their information and for any action they deem appropriate:

Mr John Olliff and Mr Godfrey Wenness
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Signature:

SUSAN JANE ARMOUR
Coroner
Date: 27 March 2012