



# Aviation Investigation Final Report

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<b>Location:</b>	Brooklyn, Iowa	<b>Accident Number:</b>	CEN13LA500
<b>Date &amp; Time:</b>	August 16, 2013, 17:30 Local	<b>Registration:</b>	N2070K
<b>Aircraft:</b>	Cessna 206	<b>Aircraft Damage:</b>	Minor
<b>Defining Event:</b>	Miscellaneous/other	<b>Injuries:</b>	1 Fatal, 1 None
<b>Flight Conducted Under:</b>	Part 91: General aviation - Positioning		

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## Analysis

Before departure for the positioning flight, the pilot was told that an observer/passenger would be joining him for the flight. The airplane, which was typically used in skydiving operations, had its right cabin door removed, and a fabric roll-up jump door had been installed; it was not closed during the flight. The pilot reported that the passenger sat behind him on the right side of the airplane and that he heard him attach his seatbelt. During the flight, the passenger moved forward in the cabin, which resulted in the passenger's reserve parachute inadvertently deploying and the passenger being pulled through the open jump door. The passenger hit the doorframe, and the parachute became entangled with the empennage, which resulted in a loss of airplane control and a subsequent aerodynamic stall. The parachute eventually separated from the empennage, and the pilot was able to regain control of the airplane and land it without further incident. A postaccident examination revealed that the passenger had inadvertently attached his seatbelt to the handle that released the reserve parachute. Therefore, the reserve parachute deployed when the passenger moved. The pilot did not conduct a safety briefing before the flight; however, the improper routing of the seatbelt may not have been identified even if he had conducted a safety briefing. Additionally, if the jump door had been closed, it is likely that the passenger would not have been pulled out of the airplane.

## Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be:

The improper routing of the seatbelt, which resulted in the inadvertent deployment of the reserve parachute, and the open jump door, which allowed the passenger to be pulled from the airplane.

## Findings

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<b>Personnel issues</b>	Use of equip/system - Passenger
<b>Aircraft</b>	Passenger compartment equip - Incorrect use/operation
<b>Personnel issues</b>	Use of equip/system - Pilot

## Factual Information

### History of Flight

<b>Enroute-climb to cruise</b>	Miscellaneous/other (Defining event)
<b>Enroute-climb to cruise</b>	Aerodynamic stall/spin
<b>Uncontrolled descent</b>	Attempted remediation/recovery
<b>Landing</b>	Miscellaneous/other

On August 16, 2013, about 1730 central daylight time, a Cessna 206 airplane, N2070K, was damaged inflight near Brooklyn, Iowa. The commercial pilot was not injured; however, the passenger was fatally injured. The airplane was registered to Brooklyn Air Inc., and operated by Skydive Iowa Inc., under the provisions of 14 Code of Federal Regulations Part 91 as positioning flight. Visual meteorological conditions prevailed for the flight, which operated without a flight plan. The flight originated from Skydive Iowa Airport (091A), Brooklyn, Iowa, and was en route to Grinnell Regional Airport (KGGI), Grinnell, Iowa.

According to the pilot, the purpose of the flight was to position the airplane to Grinnell, Iowa, so that maintenance could be conducted. After starting the airplane engine and preparing to taxi, the pilot was notified by the company tandem master that a passenger would be joining him for the flight to Grinnell as an observer. Both the pilot and passenger were wearing parachutes, as required by the company policy. The airplane was used in skydive operations and the right-side, cabin door had been removed.

The pilot reported that the passenger boarded the airplane, took a seat on the right side of the airplane, behind the pilot, and fastened his seatbelt. He stated that he did not inspect the seatbelt and had heard the "click" of the seatbelt as it was latched. No passenger briefing was provided by the pilot. Shortly after departure, the passenger elected to move from his position behind the pilot to a position in the front of the airplane, beside the pilot. As the passenger was moving, the reserve parachute, in the passenger's parachute-pack, deployed and the passenger was pulled from the airplane.

The pilot stated that as the passenger exited the airplane, he heard a loud "bang". At the same time, the parachute became entangled in the empennage. The airplane pitched up approximately 50 degrees, banked 80 degrees to the right, and stalled. Eventually, the parachute separated from the empennage and the pilot was able to recover the airplane between 600 and 700 feet above ground level (agl). The pilot observed the parachute open, and about 100 feet agl, the parachute made a sharp right turn. The pilot assumed that the passenger was controlling the parachute.

According to one witness on the ground, he observed the canopy of the parachute circle several times before the parachute seemed to go straight down. Another witness commented that the parachute was very low and very fast. A witness responded to the location where the parachute came down and found the passenger unconscious and without a pulse. According to the Iowa Department of Public Health, who conducted the autopsy, the passenger died from multiple blunt force injuries.

The pilot continued to KGGI and landed without further incident. A post-accident examination of the airplane revealed minor damage to the fuselage at the door frame and skin damage to the horizontal stabilizer. Blood was found on the door frame of the airplane where the passenger egressed. Further examination revealed that the "D" ring, or handle that released the reserve parachute, was buckled into the seatbelt.

A review of the airplane operating limitations, "Limitations for the Operation of an Aircraft with a Door Removed" – stated that "when operations other than intentional parachute jumping and skydiving are conducted, a suitable guardrail or equivalent safety device must be provided for the doorway."

The pilot reported that a "roll-up door" was installed on the airplane but was not in use at the time of the accident flight because of the warm temperatures and because one of the devices used to fasten the corner of the door to the airframe was broken, preventing them from properly securing the door.

Despite multiple attempts, the pilot refused to provide the required Pilot Operator Aircraft Accident/Incident Report, National Transportation Safety Board Form 6120.1/2.

### Pilot Information

<b>Certificate:</b>	Commercial	<b>Age:</b>	27
<b>Airplane Rating(s):</b>	Single-engine land; Multi-engine land	<b>Seat Occupied:</b>	Left
<b>Other Aircraft Rating(s):</b>	None	<b>Restraint Used:</b>	3-point
<b>Instrument Rating(s):</b>	Airplane	<b>Second Pilot Present:</b>	No
<b>Instructor Rating(s):</b>	None	<b>Toxicology Performed:</b>	No
<b>Medical Certification:</b>	Class 2 With waivers/limitations	<b>Last FAA Medical Exam:</b>	February 25, 2013
<b>Occupational Pilot:</b>	Yes	<b>Last Flight Review or Equivalent:</b>	
<b>Flight Time:</b>	320 hours (Total, all aircraft), 1 hours (Total, this make and model)		

## Aircraft and Owner/Operator Information

<b>Aircraft Make:</b>	Cessna	<b>Registration:</b>	N2070K
<b>Model/Series:</b>	206	<b>Aircraft Category:</b>	Airplane
<b>Year of Manufacture:</b>	1964	<b>Amateur Built:</b>	
<b>Airworthiness Certificate:</b>	Normal	<b>Serial Number:</b>	206-0196
<b>Landing Gear Type:</b>	Tricycle	<b>Seats:</b>	
<b>Date/Type of Last Inspection:</b>	August 1, 2013 Annual	<b>Certified Max Gross Wt.:</b>	
<b>Time Since Last Inspection:</b>		<b>Engines:</b>	1 Reciprocating
<b>Airframe Total Time:</b>		<b>Engine Manufacturer:</b>	CONT MOTOR
<b>ELT:</b>		<b>Engine Model/Series:</b>	IO-520
<b>Registered Owner:</b>	Brooklyn Air Inc.	<b>Rated Power:</b>	285 Horsepower
<b>Operator:</b>	Sky Dive Iowa Inc	<b>Operating Certificate(s) Held:</b>	None

## Meteorological Information and Flight Plan

<b>Conditions at Accident Site:</b>	Visual (VMC)	<b>Condition of Light:</b>	Day
<b>Observation Facility, Elevation:</b>	KGGI, 1008 ft msl	<b>Distance from Accident Site:</b>	15 Nautical Miles
<b>Observation Time:</b>	17:35 Local	<b>Direction from Accident Site:</b>	270°
<b>Lowest Cloud Condition:</b>	8000 ft AGL	<b>Visibility</b>	10 miles
<b>Lowest Ceiling:</b>	Broken / 8000 ft AGL	<b>Visibility (RVR):</b>	
<b>Wind Speed/Gusts:</b>	3 knots / None	<b>Turbulence Type Forecast/Actual:</b>	/ None
<b>Wind Direction:</b>	130°	<b>Turbulence Severity Forecast/Actual:</b>	/ N/A
<b>Altimeter Setting:</b>	30.18 inches Hg	<b>Temperature/Dew Point:</b>	25°C / 10°C
<b>Precipitation and Obscuration:</b>	No Obscuration; No Precipitation		
<b>Departure Point:</b>	Brooklyn, IA (09IA)	<b>Type of Flight Plan Filed:</b>	None
<b>Destination:</b>	Grinnell, IA (KGGI)	<b>Type of Clearance:</b>	None
<b>Departure Time:</b>	17:15 Local	<b>Type of Airspace:</b>	Unknown

## Wreckage and Impact Information

<b>Crew Injuries:</b>	1 None	<b>Aircraft Damage:</b>	Minor
<b>Passenger Injuries:</b>	1 Fatal	<b>Aircraft Fire:</b>	None
<b>Ground Injuries:</b>	N/A	<b>Aircraft Explosion:</b>	None
<b>Total Injuries:</b>	1 Fatal, 1 None	<b>Latitude, Longitude:</b>	41.745555,-92.409164(est)

## Administrative Information

<b>Investigator In Charge (IIC):</b>	Rodi, Jennifer
<b>Additional Participating Persons:</b>	Harrison McNaughton; FAA Flight Standards District Office; IA
<b>Original Publish Date:</b>	August 7, 2014
<b>Last Revision Date:</b>	
<b>Investigation Class:</b>	<a href="#">Class</a>
<b>Note:</b>	
<b>Investigation Docket:</b>	<a href="https://data.ntsb.gov/Docket?ProjectID=87837">https://data.ntsb.gov/Docket?ProjectID=87837</a>

The National Transportation Safety Board (NTSB) is an independent federal agency charged by Congress with investigating every civil aviation accident in the United States and significant events in other modes of transportation—railroad, transit, highway, marine, pipeline, and commercial space. We determine the probable causes of the accidents and events we investigate, and issue safety recommendations aimed at preventing future occurrences. In addition, we conduct transportation safety research studies and offer information and other assistance to family members and survivors for each accident or event we investigate. We also serve as the appellate authority for enforcement actions involving aviation and mariner certificates issued by the Federal Aviation Administration (FAA) and US Coast Guard, and we adjudicate appeals of civil penalty actions taken by the FAA.

The NTSB does not assign fault or blame for an accident or incident; rather, as specified by NTSB regulation, “accident/incident investigations are fact-finding proceedings with no formal issues and no adverse parties ... and are not conducted for the purpose of determining the rights or liabilities of any person” (Title 49 *Code of Federal Regulations* section 831.4). Assignment of fault or legal liability is not relevant to the NTSB’s statutory mission to improve transportation safety by investigating accidents and incidents and issuing safety recommendations. In addition, statutory language prohibits the admission into evidence or use of any part of an NTSB report related to an accident in a civil action for damages resulting from a matter mentioned in the report (Title 49 *United States Code* section 1154(b)). A factual report that may be admissible under 49 *United States Code* section 1154(b) is available [here](#).