REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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THIS REPORT IS BEING SENT TO:

The Department of Transport, Great Minster House, 33 Horseferry Road, London SW1P 4DR

1 CORONER

I am Michel Dudley Oakley Senior Coroner for the area of North Yorkshire East

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INVESTIGATION and INQUEST

On the 4th May 2016 I commenced an investigation in to the deaths of Ajvir Singh Sandhu aged 25 and Cameron James Forster aged 21. The investigation was concluded at the end of the Inquest on the 5 December 2016. The conclusion of the inquest in the case of both persons was accidental.

4 CIRCUMSTANCES OF THE DEATH

Both the deceased persons were Flying Officers training with the Royal Air Force at RAF Linton Upon Ouse. On the 30 April 2016 whilst off duty the first deceased Mr Sandhu hired a Slingsby T67 Firefly aeroplane from Full Sutton Flying Centre at York. Mr Sandhu had previously hired the same plane back in January.

Both Mr Sandhu and Mr Forster then flew out of Full Sutton Flying Centre and whilst performing aerobatics and getting the aircraft into a spin above Castle Howard near to Whitwell Hill Malton the light aircraft which they were flying crashed into a field and both occupants were killed.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows. -

1. The two lead investigators from the AAIB stated that neither occupant was wearing a parachute and that parachutes were not supplied but had they done so and abandoned the aircraft at a safe height that would have offered both of them the possibility of survival. The AAIB referred me to leaflet number 90 issued by the CAA relating to static line parachutes and I would advise that further consideration should be given to whether those leaflets should be revised and/or that regulations are introduced making

mandatory the provision of parachutes with static lines for aircraft of this nature.

- 2 That there should be a review taking place of whether regulations should be introduced to make spin recovery training mandatory on specific types of light aircraft before a person can fly that light aircraft and carry out aerobatics.
- 3. Evidence was given from the AAIB that whilst it was clear that Mr Sandhu had had spin recovery training within the Royal Air Force that spin recovery training had taken place on two different aircraft and not the Slingsby Firefly. Concern has been expressed within the Inquest that in an aircraft well understood to have areas requiring specific handling techniques it should be established that the persons who fly them are trained and proficient in those areas and have the ability to recover the aircraft from an uncontrolled condition.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that your department have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd February 2017 I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely and to of the AAIB

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9 8th December 2016 Michael D Oakley