	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive of the UK Civil Aviation Authority**
1	**CORONER** I am David Manknell, Assistant Coroner, for the coroner area of London Inner South
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 29 October 2019 an inquest was opened into the deaths of Jonathan Neal Goldstein, Hannah Louise Goldstein and Saskia Lucia Goldstein. The inquest was concluded on 5 December 2023. The conclusion of the inquest was a narrative conclusion that each person deceased was either the pilot of or passenger in: *"a light aircraft on 25 August 2019 that was crossing the Swiss Alps in the region of the Simplon Pass. During the flight, the pilot lost control of the aircraft, which stalled at low altitude and collided with the ground. This was due to a lack of anticipation in the management of the flight climb. A lack of training and experience in mountain flying contributed to the accident."*
4	**CIRCUMSTANCES OF THE DEATH** The deceased (a father, mother and their 6 month old child) were in a light aircraft being flown by the father, Jonathan Goldstein, from North Weald to Perugia, via Troyes and Lausanne. Jonathan Goldstein held a PPL(A) licence but did not have (and was not required to have) any specific training in mountain flying. The accident was investigated by the Swiss Transportation Safety Investigation Board ("STSIB")(Report 2383), who found that Jonathan "*was lacking appropriate training in mountain flying*", and that "*a lack of training and experience in mountain flying contributed to the accident.*"
5	**CORONER'S CONCERNS** During the course of the investigation and inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – In their report, the STSIB found that: At 1.10: *"Flight training for PPL(A) obtention in Switzerland* *The training syllabus for the PPL(A) according to EASA does not foresee any training dedicated to mountain flying. However, this flight technique requires the acquisition of a specific know-how which, for example in Switzerland, is generally acquired in two distinct navigation sections of the PPL(A) syllabus carried out at different stages of progression and includes at least two mountain flights. These two mountain navigation flights are performed with the help of visual references and part of the training is to plan*

	two flights that cross the Alps in different directions. These two exercises, generally, include basic mountain navigation, crossing alpine passes at recommended minimum safe altitudes, as indicated on the ICAO 1:500 000 map, calculation of the point of climb and descent and dealing with specific phenomena encountered in the alpine environment." At 3.1.2 (Conclusions: pilot) *"The pilot was lacking appropriate training in mountain flying ."* At 3.2 (Causes) *"A lack of training and experience in mountain flying contributed to the accident."* The STSIB also included "Safety Advice" in the report, which they targeted at 'general aviation operators' that: *"General aviation operators in Europe should emphasise the dangers of navigating through mountain passes and adapt flight tactics according to the predefined flight plan. For mountain flights, many recommendations on safety measures such as flight tactics, flight plan and equipment can be found in the VFR manual under rules of the air and air traffic services (RAC) 4-5-2, 4-5-3."* In light of the issues raised by the STSIB, I am concerned that there is a lack of appropriate training and/ or guidance in the UK in respect of mountain flying for holders of PPL(A) licences. In my opinion, the CAA should take action to ensure that holders of PPL(A) licences have appropriate training and knowledge if undertaking flying in mountainous areas, and that they are made aware of and have access to appropriate guidance. Specifically, I am concerned that: 1) There is no compulsory specific mountain flying training element to either the theoretical or practical parts of PPL training, and once qualified, there is no restriction on the right of pilots with PPL(A) licences to conduct mountain flying without having had such training; 2) Nor, in the absence of any formal requirement, does the CAA request or require flying schools to provide specific mountain flying advice for PPL(A) candidates; and 3) Despite the safety advice given by the STSIB, guidance has not been given in the UK by any organisation to currently qualified pilots, highlighting the specific risks of navigating through mountain passes, and offering either guidance, or the location where guidance can be found.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 30 January 2024. 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: [redacted], and the Air Accidents Investigation Branch. 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	**5 December 2023**