

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used after an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 (RPAS)

1 CORONER

I am Angela BROCKLEHURST, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area

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 16 August 2022 I commenced an investigation into the death of Shaun CROSSFIELD aged 54. The investigation concluded at the end of the inquest on 16 March 2023. The conclusion of the inquest was that:

Upon the 9th August 2022, Shaun Crossfield began a flight upon a Paramotor in a field situated at New Church Farm Tong Lane Bradford.

Mr Crossfield, whilst in flight suffered the impact of air turbulence, which caused the canopy of his Paramotor to partially collapse, adversely affecting his ability to maintain a normal flight pattern.

Due to further damage to the control mechanisms of the Paramotor, it became uncontrollable, descending into a downward spiral which could not be reversed; resulting in a catastrophic impact with the ground, with an immediate fatal consequence to Mr Crossfield.

The Ambulance Service was called to the scene where an attending Paramedic certified the death of Mr Crossfield at 19:19 hours that day

4 CIRCUMSTANCES OF THE DEATH

Shaun is a 54yr old man who lives in Gomersal, Cleckheaton with his father.

Shaun is described by his family as an avid flyer of Paramotors. He has been engaged in this activity for around 4-5years at the time of his death.

On the 9th of August Shaun has set off from home to head out flying that evening with two friends. At around 19:00hrs Shaun got into difficulties, for reasons not yet known, whereupon he and his Para-Motor then plummeted to the ground.

He was declared dead by paramedics at 19:19hrs.

5 CORONER'S CONCERNS

During the course of the investigation my inquiries 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:

(brief summary of matters of concern)

The Deceased prior to commencing his flight had repaired both propeller blades on his aircraft himself, which had previously been damaged, and during his flight the left hand control line came into contact with an uneven repaired section of the propeller.

The propeller was turning under power at that time causing the line to be entrapped and partially severed.

The tension upon the control line instigated a rapid and dynamic turn leading to a spiral dive from which the deceased was unable to recover before impacting upon the ground.

It appears to be the case that no regulatory authority is available to control the quality or airworthyness of the class BGD Luna 2 Paraglider flown by the deceased.

The absence of such quality control and licensing for use and registration of such aircraft does provide the opportunity for future deaths to occur.

Had a mandatory inspection and certification of fitness been carried out and imposed by qualified inspectors, in all likelihood such a death as suffered by the deceased may not have occurred.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 March 10, 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

I have also sent it to

(Spouse) (Father-in-Law)

who may find it useful or of interest.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any person who I believe may find it useful or of interest.

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 Dated: 02/02/2024

Angela BROCKLEHURST HM Assistant Coroner for

West Yorkshire Western Coroner Area