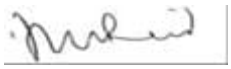
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Civil Aviation Authority, Aviation House, Beehive Ring Road, Crawley, West Sussex, RH6 0YR.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 30 June 2023 I commenced an investigation and opened an inquest into the death of Peter GREGORY. The investigation concluded at the end of the inquest on 1 August 2024 The conclusion of the inquest was that Mr. Gregory *"died as the result of an accident".*
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mr. Gregory come by his death?", I recorded as follows: *"On the morning of 25.6.23 a hot air balloon being flown by Peter Gregory, an experienced balloon pilot, suffered a sudden parachute stall in the course of a rapid ascent during a competition race. The parachute stall caused the envelope of Mr. Gregory's balloon to collapse, and the balloon to descend rapidly to the ground in a field at Ombersley Court, Ombersley. Mr. Gregory suffered fatal injuries in the resulting impact, and was confirmed deceased at the scene a short time later that day."*
5	**<u>CORONER'S CONCERNS</u>** 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 inquest heard evidence from an investigator at the Air Accidents Investigation Branch (AAIB) that Mr. Gregory's balloon was home-built, based on a design produced by a friend and fellow balloon pilot, and that the balloon's design (in particular, the location of the balloon parachute's centralising lines, which determine its height within the balloon envelope) may have played a part in the parachute stall which led to the balloon's sudden and fatal descent. The inquest also heard that the AAIB has recommended that the Civil Aviation Authority (CAA) publishes guidance on the design, testing and inspection of amateur-built balloons to reduce the risk of accidents due to unsafe conditions such as parachute stall, but that it is up

	to the CAA whether or not to regulate the design and construction of amateur/home-built balloons; 2) The inquest also heard evidence that the CAA currently neither regulates, nor publishes guidance for the safe oversight of competition balloon flying in the UK. Whilst there is guidance published by the British Balloon and Airship Club (BBAC), the BBAC is a sporting body and not a regulator, and therefore does not have the power, for example, to ground a balloon which does not conform to its published guidance.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the Civil Aviation Authority, have the power to take such action, by carrying out a review of the regulation of balloon flying in the UK, considering in particular whether there should be regulation of the design, construction, inspection and testing of amateur or home-built balloons, and of competition balloon flying in the UK.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **27 September 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: (a) [redacted], Mr. Gregory's parents; (b) 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	**2 August 2024**  **David REID** **HM Senior Coroner for Worcestershire**