His Majesty's Senior Coroner for The County of Devon, Plymouth and Torbay
Philip Spinney

13 December 2024
Case ref: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Secretary of State for Transport, Great Minster House, 33 Horseferry Road, London, SW1P 4DR

Secretary of State for Health, 39 Victoria Street, London, SW1H 0EU

CORONER

1 I am Ian Michael Arrow for The County of Devon, Plymouth and Torbay

CORONER'S LEGAL POWERS

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

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http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 15 March 2022 I commenced an investigation into the death of Jean LANGAN. The investigation concluded at the end of the inquest. The conclusion of the inquest was

Accident

3 1a Head Injury

1b

1c

II

CIRCUMSTANCES OF THE DEATH

On 4th March 2022 Jean Langan attended Derriford Hospital with her niece for an Appointment. As they were returning to their car which was parked in an unrestricted public car park, Car Park,B, a landing helicopter's downwash caused Jean to fall backwards and strike her head on the ground. She suffered a serious head injury which caused her to lose consciousness. Jean was taken into Hospital for treatment but sadly died shortly after. At the time of her fall Jean was not restricted from the area.

The circumstances are particularly set out in the AAIB report 2/2023 Aircraft G-MCGY 4 March

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.

Helicopters should land safely at Hospital Helicopter Landing sites without endangering those on the ground in the vicinity of the landing site.

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The **MATTERS OF CONCERN** are as follows.

There was identified the need for a real time data base of Hospital Helicopter Landing sites to ensure the safe landing of helicopters.

There was identified a need to ascertain the contact details of the relevant manager of each Helicoptor landing site at all Hospital Trusts which receive helicopters.

More particularly set out by the representative for the Air Service Operator by letter of the 6th of December 2024 reciting a request of 22 November 2024.

ACTION SHOULD BE TAKEN

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

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th of February 2025. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons. The Family, Plymouth University Hospital Trust, Bristows, The CAA,

8 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 13 December 2024

Signature 

I M ARROW Coroner Appointed by Chief Coroner to hear the Inquest

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