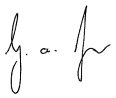
Coroner Service
West Sussex, Brighton & Hove

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 British Airline Pilots' Association (BALPA)** **2 Civil Aviation Authority (CAA)**
1	**CORONER** I am Gareth JONES, Assistant Coroner for the coroner area of West Sussex, Brighton and Hove
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 21 July 2023 I commenced an investigation into the death of John Peter MCLOUGHLIN aged 44. The investigation concluded at the end of the inquest on 06 March 2025. The conclusion of the inquest was that: John Peter McLoughlin was a Pilot employed by West Atlantic UK. He was on a training course which he found stressful and highly pressurised. He had a fear of failing the course. He was staying at a Hotel in Brighton. On the 19th of July 2023, he hung himself in the bathroom [redacted]. There was no third party involvement. The room was closed and he was alone. He had removed his wedding ring. He was not under the influence of drink or drugs and there was no evidence of mental illness. [redacted]. This caused his death. I find that he did this act which ended his life and did so with the intention of ending his life.
4	**CIRCUMSTANCES OF THE DEATH** John Peter McLoughlin was a Pilot employed by West Atlantic UK. He was on a training course which he found stressful and highly pressurised. He had a fear of failing the course. He was staying at a Hotel in Brighton. On the 19th of July 2023, he hung himself in the bathroom [redacted]. There was no third party involvement. The room was closed and he was alone. He had removed his wedding ring. He was not under the influence of drink or drugs and there was no evidence of mental illness. [redacted]. This caused his death. I find that he did this act which ended his life and did so with the intention of ending his life.
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) John was an experienced Pilot. He was on a training course run by Quadrant which he found stressful and with which he struggled. On the course, mental health issues were discussed. The support offered was through Peer Support who allow pilots to talk to

	another pilot who is a trained mental health first aider, but they are not medically trained. Although HM Coroner is of the view that there is great merit in talking through difficulties with those in the same industry, I have concerns that Peer Support is not adequate support for those who are suffering severe mental health difficulties and suicidal thoughts. It appears that there is not enough support in the industry as a whole for pilots whose problems escalate beyond the usual stresses and pressures of the job.
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 May 01, 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I have also sent it to [redacted] 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: 06/03/2025  Gareth JONES Assistant Coroner for West Sussex, Brighton and Hove