ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Civil Aviation Authority, Legal Department, Aviation House, Beehive Ring Road, Crawley, West Sussex, RH6 0YR** **2. European Aviation Safety Agency, Konrad-Adenauer-Ufer 3, 50668, Cologne, Germany** **3. [redacted], Head of International Aviation and Maritime Strategy, Department for Transport, Great Minster House, 33 Horseferry Road, London, SW1P 4DR [redacted]** **4. [redacted] of c/o Stewarts Law, 5 New Square, London, EC4A 3BF**
1	**CORONER** I am Jonathan Mark Layton, assistant coroner, for the coroner area of Carmarthenshire & Pembrokeshire
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 22 February 2017 I commenced an investigation into the death of Richard Mohamed Fekry Osman who was born on the 9 November 1975. The investigation concluded at the end of the inquest on 2 May 2025. The conclusion of the inquest was as follows: ***Richard Osman was a passenger onboard commercial flight MS804 travelling from Paris to Cairo which crashed into the Mediterranean Sea on 19 May 2016 following a fire onboard caused by an ignition source of unknown origin most likely associated with the first officer's oxygen supply system, which either resulted from or was fed by an oxygen leak.*** The cause of death was 1(a) air incident
4	**CIRCUMSTANCES OF THE DEATH** Richard Osman was a geologist on a business trip on flight MS804 which departed Paris bound for Cairo on 18 May 2016. In the early hours of 19 May 2016, as the aircraft was flying over the Eastern Mediterranean Sea, a fire broke out on the flight deck rendering the flight deck environment uninhabitable and causing the aircraft to be uncontrollable resulting in a crash. There were no survivors.

5	**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 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: (1) That a full review of cockpit fire/smoke procedures be undertaken to include, but not limited to: - the recognition of an oxygen fire (identifiable by a characteristic noise comparable to that of a blowtorch) and the immediate cutting off this oxygen supply. - the installation or carrying of protective equipment to deal with any cockpit fires. - a review of the effectiveness of Halon fire extinguishers to deal with onboard fires. - a review of regulations (if required) to prevent the use of cigarettes in the cockpit and related flammable items and materials. - the additional risk analyses to take into account the hypothesis of an overpressure in the oxygen distribution system. (2) That a drafting committee be convened to consider amending Annex 13 of the Convention on International Civil Aviation signed at Chicago on 7 December 1944 to provide: (a) a right for states entitled to participate in an investigation to have access to evidence to enable those participating states to release a statement in accordance with Chapter 6.6.1 in circumstances where they have been excluded from an investigation by the State of Occurrence; (b) a right of states entitled to participate in an investigation to take over conduct of an investigation in circumstances where a State of Occurrence does not produce a Final Report within a reasonable timeframe and does not produce interim statements indicating the progress of the investigation and safety issues raised within a reasonable timeframe and has not otherwise consented to the delegation of the investigation in accordance with Chapter 5.1.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you /your organization has 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 28 July 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 widow of the deceased. 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 other 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. She 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.
9	**Dated.. 5th June 2025** **Mark Layton Assistant Coroner**