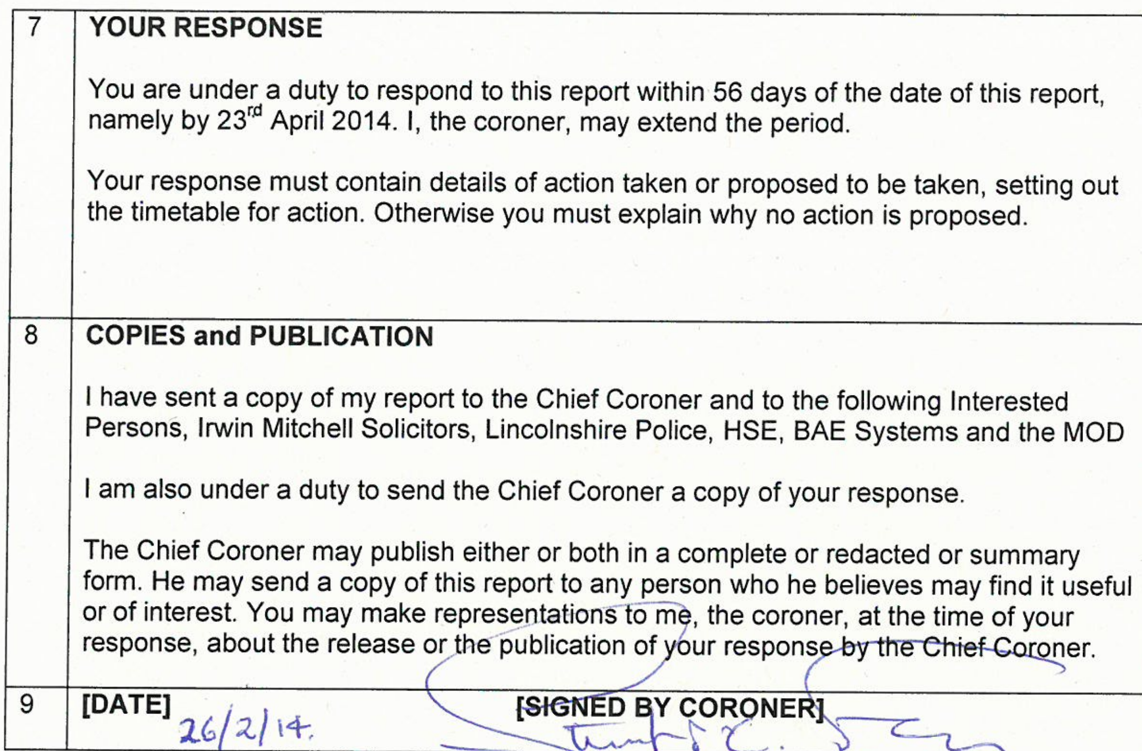
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Managing Director** **Martin-Baker** **Lower Road** **Higher Denham** **Br Uxbridge** **Middlesex** **UB9 5AJ**
1	**CORONER** I am S P G Fisher, senior coroner, for the coroner area of Central Lincolnshire
2	**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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 22nd November 2011 I commenced an investigation into the death of Sean James Cunningham, age 35. The investigation concluded at the end of the inquest on 29th January 2014. The conclusion of the inquest was a narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** On the 11th November 2011, the deceased ejected from an aircraft. His parachute failed to deploy and he suffered fatal injuries as a result of a fall to the ground.
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 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. – Martin Baker (the manufacturers of the ejection seat) continue to manufacture, and the MOD continue to operate aircraft incorporating ejection seats in respect of which there continues to be a significant risk of the strapping-in process impacting negatively on the safe operation of the ejection seat, principally in consequence of strap misrouting. This risk continues despite pilot instruction, training and specific warning to seek to ensure that it does not occur. My concern is that no design solution, to a well-established problem in this regard, has yet been found. It is not clear to me at the end of this inquiry as to whether Martin Baker Aircraft have a sufficiently comprehensive, robust and auditable system in place that will ensure that in the event of a need for a safety warning or a safety critical alteration to maintenance procedures being issued in the future, it will be sent to and received by all end users of the applicable seat or seats within an appropriate timescale. My concern relates the companies process for the urgent dissemination of safety critical information in this respect.
6	**ACTION SHOULD BE TAKEN**



7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd April 2014. 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, Irwin Mitchell Solicitors, Lincolnshire Police, HSE, BAE Systems and the MOD 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	**[DATE]** 26/2/14. **[SIGNED BY CORONER]**