## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Chief Executive**<br>**Civil Aviation Authority**<br>**CAA House**<br>**45-59 Kingsway**<br>**London**<br>**WC2B 6TE** |
| 1 | **CORONER**<br><br>I am JACQUELINE LAKE, Senior Coroner, for the coroner area of NORFOLK |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 14 March 2014 I commenced an investigation into the deaths of:<br>Carl Alan Dickerson, Age: 36 years The investigation concluded at the end of the inquest on 15 January 2016. The conclusion of the inquest was medical cause of death: 1a) Head and Chest injuries and short-form conclusion: Accidental Death<br><br>Edward Enda Haughey – Lord Ballyedmond, Age: 70 years, The investigation concluded at the end of the inquest on 15 January 2016. The conclusion of the inquest was medical cause of death: 1a) Head injuries and short-form conclusion: Accidental Death.<br><br>Lee Christopher Hoyle, Age: 45 years. The investigation concluded at the end of the inquest on 15 January 2016. The conclusion of the inquest was medical cause of death: 1a) Head and Chest injuries and short-form conclusion: Accidental Death.<br><br>Declan Joseph Small, Age: 42 years. The investigation concluded at the end of the inquest on 15 January 2016. The conclusion of the inquest was medical cause of death: 1a) Head and Chest injuries and short-form conclusion: Accidental Death. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On 13 March 2014 all four men were on board an Augusta Westland AW139 helicopter, G-LBAL. It was dark and foggy. Shortly after take-off the helicopter impacted with the ground near Gillingham, Norfolk. All four men died as a result of their injuries. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) On the 13 March 2013 at the time of take-off, it was dark and there was fog. Visibility was therefore limited. There are Regulations in place which would have prevented a take-off in these conditions had this been a departure from a licensed aerodrome and had this been a commercial venture. |

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| | (2) Because this was a departure from a non-commercial venture and take-off was from an unlicensed aerodrome, those Regulations do not apply.<br>(3) It is understood there was an accident in the 1990s in similar circumstances and operating under private category rules, as a result of which the Irish Air Accident Investigation Unit (AAIU) published a report and noted that "*The flight used a navigation approach procedure that would not meet the standards required by the UK Authorities for public transport operations. However, this was not illegal because the flight was operated under private category rules.*"<br>(4) The AAIU made recommendations including that "*The UK CAA should consider the establishment of a special category for the operation of corporate aviation*". It is understand this recommendation was accepted but no special category was established. Guidance was provided but not regulation.<br>(5) New European aviation legislation affecting the non-commercial operation of aircraft will come into effect in the UK from 25 August 2016 which will introduce new regulations for the management and operation of this type of aircraft.<br>(6) It is understood the CAA has decided a broader and deeper review of Instrument Flight Rules outside controlled airspace in general is necessary and that a project plan is being developed to address the issues, develop recommendations and suggested courses of action. There is liaison with the European Aviation Safety Agency "in taking forward any such changes".<br>(7) It is of concern that despite the previous accident in the 1990s and this accident, a departure from a non-commercial venture and an unlicensed aerodrome is not covered by the equivalent regulation as a departure from commercial and licensed premises. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 March 2016. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>**Family:**<br>[redacted]<br><br><u>Legal:</u><br>Stewart Law LLP<br>JWK Solicitors<br>Slater Gordon (UK) LLP<br>Clyde & Co<br>Holman Fenwick Willan LLP<br><br>I have also sent a copy to the AAIB who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response. |

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| | The Chief Coroner may publish either or both in a complete or redacted or summary form.<br><br>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 February 2016**<br><br>.....<br>**Jacqueline Lake LL.M**<br>**Senior Coroner for Norfolk Area** |