REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. British Parachute Association, 5 Wharf Way, Glenparva, Leicester LE2 9TF

1 CORONER

I am Andrew Tweddle Senior Coroner, for the Coroner area of County Durham and Darlington

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. (see attached sheet)

3 INVESTIGATION and INQUEST

On 15th September 2016 I commenced an investigation into the death of Pamela Gower aged 49 years. The investigation concluded at the end of the inquest on 13th December 2016. The conclusion of the inquest was misadventure.

4 CIRCUMSTANCES OF THE DEATH

The deceased suffered from Achondroplasia (dwarfism). She was a keen parachutist. She used a custom designed parachute harness. She had undertaken parachute training in Spain and the UK. On 10th September 2016 she was to undertake a level 6 parachute jump. She had satisfied her instructor that she was properly prepared to make this jump. She initially refused to jump from the aircraft. After a period back on the ground she returned to the drop zone and jumped out of the aircraft with her instructor. She attempted a barrel roll manoeuvre as part of the instability training element of this level. She did not recover from this and went into a high speed spin. Her stature made it more difficult for her to recover. In spite of attempts to deploy her parachute she was unable to do so and lost consciousness during her descent. Her reserve parachute deployed correctly. She sustained fatal injuries upon impact with 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. -

1. The BPA board of enquiry raised a question as to whether the deceased was progressed beyond her abilities, taking into account the time periods between her later jumps. Evidence from the Chief Instructor and owner of the parachute club in question was that the training given to the deceased met all Parachute Association rules and moreover exceeded them. He did not believe that there was any difficulty caused in this case arising from the time periods between her jumps nor that the deceased was progressed beyond her abilities. Notwithstanding this evidence, the BPA Chief Operating Officer remained of the view that the question raised in the report was still a valid one and one which was being actively considered by the BPA. In the circumstances, I have no doubt that the threshold for this report is being met and I am under an obligation to make this report.

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 9th February 2017. 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.

The Air Law Firm

I have also sent it to

who may find it useful or of interest.

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.

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Dated 15. X11-16

Signed.

A.TWEDDLE, H. M. Coroner County Durham and Darlington