Mrs D Hocking
Assistant Coroner for Leicester (City and South)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mr Andrew Haines, Chief Executive, Civil Aviation Authority.**
1	**CORONER** I am Mrs D Hocking, Assistant Coroner for Leicester (City and South)
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 05/12/2016 I commenced an investigation into the death of John Christopher Armstrong, aged 70. The investigation concluded at the end of the inquest on 03 January 2018. The conclusion of the jury was Accidental Death. The jury's Box 3 read as follows:- "Mr Armstrong, a 70 year old healthy male and an experienced glider pilot conducted a flight in a glider from Husbands Bosworth Airfield on 4th December 2016. The weather conditions were good, with visibility reasonable but reduced when flying towards the low sun. During the flight Mr Armstrong conducted a 270 degree turn, then approximately 28 seconds later was involved in a mid-air collision with a Cessna aircraft that was on a training navigation flight. The collision occurred at approximately 12.30pm. Although the Cessna took suitable evasive action, the collision resulted in the wing of the Cessna hitting the left wing of the glider, severely damaging it and causing the glider to nosedive to the ground at approximately 12.30pm. There was no evidence of evasive action from Mr Armstrong's glider. Air ambulance was shortly dispatched and arrived at 12.49pm. Unfortunately Mr Armstrong suffered severe injuries as a result of the impact with the ground and was pronounced dead at the scene, at Laughton Road, Laughton, Leicestershire on 4th December 2016. From the evidence provided neither aircraft saw one another on enough time to avoid the collision." The cause of death was: - "Head, spine and chest injuries."
4	**CIRCUMSTANCES OF THE DEATH** As above from the jury's conclusion. The Air Accident Investigation Board conducted an investigation and concluded that "The accident occurred because the pilots did not see each other's aircraft in sufficient time to take effective avoiding action. Collision avoidance was by lookout and visual detection, which has limitations and the low sun would have reduced the likelihood of the pilot of G-CLJK (the glider) seeing G-CSFC (the Cessna) in time. G-CLJK was fitted with FLARM but G-CSFC was not fitted with such a system. Therefore, there was no electronic means to increase the ability to detect other aircraft in the vicinity to allow for effective collision avoidance. The CAA have since issued CAP 1391 and are part of CWG which promotes the installation of EC (Electronic Conspicuity) devices in aircraft"
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.

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	The **MATTERS OF CONCERN** are as follows. – (1) A 'see and avoid' principle of avoiding collisions is subject to limitations of the human eye and may be a significant problem in certain weather conditions (as in this case, a low sun): 2) There is no effective way of one aircraft ascertaining another aircraft's position in flight or have any warning of an impending collision. Some aircraft have alarms and/or anti-collision devices but (a) they are not necessarily compatible with other systems that are used and (b) they are not mandatory; (2) There was no Air Traffic control over Husbands Bosworth airfield even though there is a gliding club at the airfield and therefore, one would assume, a higher usage of airspace and likelihood of a collision. There were seven aircraft in the vicinity at the time of the accident (including the two aircraft involved in the accident) but no-one controlling the position of the aircraft.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 09 March 2018. 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] (Wife) [redacted] (Brother in Law) [redacted] (AAIB) [redacted] (Lawyer representing Go Fly Oxford) [redacted] (Aviva Insurance) [redacted] (Solicitor representing Insurers of Coventry Gliding Club) 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	Dated 12th January 2018 Signature Assistant Coroner for Leicester (City and South)