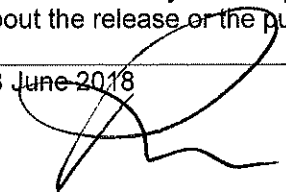


REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Baroness Sugg, Parliamentary Under Secretary of State for Transport, Department for Transport.</p>
1	<p>CORONER</p> <p>I am Peter Nieto Assistant Coroner for the Coroner area of Derby and Derbyshire.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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. https://www.legislation.gov.uk/ukpga/2009/25/contents http://www.legislation.gov.uk/uksi/2013/1629/contents/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 13 May 2017 I commenced an investigation into the death of Mr Bryan Allsop (dob: 1 June 1937; dod: 28 May 2017). The investigation concluded at the end of the inquest (with jury) on 6 June 2018. The conclusion of the inquest was: -</p> <ul style="list-style-type: none">- Medical cause of death: - 1a Head and chest injuries.- Summary of circumstances: - Mr Allsop died on 28 May 2017 as a result of a crash of the light aircraft which he was piloting. The severe injuries he sustained resulted in death very soon after the crash and the crash occurred within a short time of take-off from his local airstrip at Coal Aston in North Derbyshire.- The jury's conclusion at inquest was that the death was an accident, but that a number of factors had been contributory.
	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Allsop had been conducting some short flights on the morning of 28 May 2017, principally to test a device to prompt and remind with regards to deployment of the landing gear. On the third take-off his plane failed to reach full power or to attain sufficient altitude and in the course of turning back to the landing strip he lost control of the aircraft and crashed into a nearby field. The jury found there to be four significant contributory factors to the crash, which acted in combination: -</p> <ul style="list-style-type: none">- The aircraft's fuel vapour return line was configured so that fuel vapour was routed back to the engine rather than the fuel reserve tank to dissipate.- Mr Allsop was using E5 Mogas but his plane had not had the necessary checks and authorisation for this type of fuel.

	<ul style="list-style-type: none"> - The warm weather conditions on the day, the series of short flights and the aircraft engine running in between flights whilst not airborne, combined to make the engine more susceptible to vapour production. - On the third flight the engine did not reach full power and the aircraft could not gain sufficient altitude making Mr Allsop's attempted turn back to the airstrip likely to end in a crash.
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed a matter 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.</p> <p>The MATTER OF CONCERN is as follows. –</p> <p>The inquest heard that Mr Allsop's air crash occurred in the context of him attempting to turn back to the airstrip to land but insufficient altitude and lack of engine power made a crash whilst turning highly likely.</p> <p>The court heard evidence that neither the pilot training leading to issue of a pilot's license (for light aircraft) nor the biennial pilot license revalidation have mandatory requirements for instruction and testing in partial loss of engine power scenarios. This is the case for both EASA and non-EASA licences. The court also heard evidence that a significant number of aircraft crashes and near crashes occur in the context of partial loss of engine power scenarios. Reference was made to Australian research and also awareness of the issue at the AAIB and the LAA. The court was informed that pilot licenses require instruction and testing in full loss of engine power scenarios but that a partial loss of engine power, particularly at low altitude, presents distinct and very difficult challenges to pilots.</p> <p>My specific concern relates to there being no mandatory requirement for instruction and testing in partial loss of engine power scenarios in relation to light aircraft pilots' licences. If this is also the case for more powerful classes of aircraft for license purposes this would also be a concern.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your department have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, which is by 13 August 2018. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: -</p> <ol style="list-style-type: none"> 1. [REDACTED] 2. Mr Stephen Slater, CEO, Light Aircraft Association. 3. [REDACTED] Principal Inspector, Air Accidents Investigation Branch. <p>I am also under a duty to send the Chief Coroner a copy of your response.</p>

	<p>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.</p>
9	<p>18 June 2018</p>  <p>Peter Nieto Assistant Coroner</p>