Derby & Derbyshire Coroner's Area

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted]Chair)** **The British Hang Gliding and Paragliding Association Ltd** **8 Merus Court** **Meridian Business Park** **Leicester** **LE19 1RJ**
1	**CORONER** I am Peter Nieto, Area Coroner, for the Coroner Area of Derby & Derbyshire.
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 13 December 2018 I commenced an investigation into the death of Michael Frank Bostock (dob: 11 April 1958; dod: 12 December 2017). The investigation concluded by way of an inquest hearing on 24 March 2020 (a copy of the record of inquest is enclosed with the covering letter to this report). My findings at inquest were as follows: - - Medical cause of death: - 1a Chest injuries. 1b Paraglider crash. - My conclusion as to Michael's death was a short form conclusion of *accident*. I stated at the end of the inquest that my intention was to send this report to the British Hang Gliding and Paragliding Association (BHPA).

4	**CIRCUMSTANCES OF THE DEATH** Michael died on 12 December 2017 at Stanage Edge near Hathersage in Derbyshire as a result of his paraglider wing collapsing in strong turbulent wind which caused him to crash and hit the ground in a fast and heavy impact. He sustained serious chest injuries and died at the scene. On the evidence the wind conditions had initially been good but suddenly deteriorated and Michael had been manoeuvring to land when the wing collapse occurred. Witness evidence portrayed Michael as an experienced, competent and diligent paraglider pilot.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. One witness at the inquest, also a paraglider pilot, raised concerns about the use of unsuitable speed bar lines which may be prone to breaking in use, and on the evidence of other witnesses at the inquest there appears to me to be a lack of clarity and advice on speed bars use and set-up generally. The evidence as to how serious the immediate consequences of a broken speed bar line is in flight was unclear to me but use of speed bars appears to be almost standard and a malfunctioning or broken speed bar system would limit the in-flight options of pilots, with feasibly serious consequences for some. 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. I emphasise that I did not find that Michael had been using his speed bar at the time of his wing collapse. The **MATTERS OF CONCERN** are as follows: - 1. There does not appear to be clear guidance as to specifications for speed bar lines. Advice appears to be necessary to paraglider pilots for them to ensure that a line of the appropriate standard and specification is used to connect the speed bar to the paraglider risers. The BHPA is in a position to provide advice to pilots and to liaise with leading paraglider manufacturers. 2. Existing BHPA guidance to pilots for pre-flight checks does not appear to include inspection of speed bar lines and associated elements of the paraglider. Speed bar inspection could be included with the general and standard pre-flight inspection. 3. Paraglider pilots are of different sizes and weights and on the evidence presented to me speed bar systems should be configured and set-up to take account of such differences. Again the BHPA is placed to consider providing advice to pilots. It appears to me that paragliding is a surprisingly unregulated activity, given the risks, and in this context it is crucial that the BHPA as the

	governing body for the activity considers the need for further guidance to pilots on the concerns which I have raised.
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 **26 May 2020**. 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 : 1. [redacted] (Michael's wife). 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	**31 March 2020** **Mr Peter Nieto** **HM Area Coroner** **Derby & Derbyshire Coroner's Area**