Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **CEO, JET2.com, P O Box 284, Leeds, LS11 1GE**
2. **CEO, Civil Aviation Authority, Aviation House, Beehive Ringroad, Crawley, West Sussex RH6 0YR**

1 CORONER

I am James E THOMPSON, Assistant Coroner for the 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.

3 INVESTIGATION and INQUEST

On Twenty-Eighth June 2018 I commenced an investigation into the death of Andrew Paul WESTLAKE aged 29. The investigation concluded at the end of the inquest on Thirtieth November 2020. The conclusion of the inquest was Narrative Conclusion - Andrew Paul Westlake died on 29th May 2018 at Ortaca Yucelen Hospital, Turkey from injuries caused by a fall from a height of 10.2 metres from the second floor of the Dalaman Airport Terminal building. He had jumped over a glass barrier guarding the drop from the second floor to the ground floor of the terminal building. This occurred whilst he was suffering some form of mental health episode and it is likely he was unaware of consequences of his act.:

The medical cause of death was;

I a Fall from height

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

Mr WESTLAKE had traveled from the UK to Turkey on holiday, during his time overseas he had been asked to leave his hotel and was without money, mobile telephone or other belongings. It is believed he spent the last 2-3 days of his holiday at the Dalaman Airport, Turkey awaiting his return flight home with carrier JET2.COM.

He boarded the aircraft just prior to midnight (Turkish Time) on 28th May 2018. His behaviour was erratic and unnerving for other passengers. He believed the air conditioning would poison him and threw a cup of water over cabin crew claiming it was poisoned.

The Captain took the decision to disembark him and he was taken off the aircraft. He was described by witnesses as scared, frightened and sad. He feared ground staff would assault him. He was asked by ground staff to go the handling agents who would process his return through passport control to the 'landside' of the airport.

The JET2 staff indicated he could come to their office if he needed assistance after confirming he

could fly with JET2 on the next flight (which would be later that day). He did not attend their office.

Mr WESTLAKE was later found by police trying to enter a secure area of the airport and returned to the terminal. He was left with a member of airport staff who asked him to wait by the information desk.

Mr WESTLAKE left this area went to the 2nd floor of the terminal building and jumped over a barrier and fell 10.2 metres to the ground floor level of the terminal. He sustained serious injuries which led to his death in hospital shortly afterwards.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)

1. Mr WESTLAKE appears on the evidence to have been mentally unwell when he was disembarked. He was not aggressive, violent or abusive - toxicological evidence showed he had not consumed alcohol or any drugs prescribed or illicit. He was travelling alone. He had no possessions, money, mobile telephone, this was his first trip outside the UK as an adult and he could not speak Turkish.
2. A witness for JET2.Com confirmed no policy or procedure exists for disembarking a passenger other than for a disruptive passenger. She could not recall any training on this situation or in relation to passengers that may be vulnerable through mental illness.
3. A number of witnesses gave evidence on the distress and confusion of Mr WESTLAKE within the terminal, aircraft and air bridge.

Mr WESTLAKE was disembarked from the aircraft. He found himself without support in a foreign country and it would appear, was in some form of mental health crisis.

My concerns centre on;

- Training for airline and ground staff (employed by UK Airlines) on vulnerability of lone passengers when disembarked overseas.
- Procedures for safeguarding vulnerable passengers such as Mr WESTLAKE.

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 27 January 2021. 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], on behalf of the Westlake family.

- Head of Consular Assistance, Foreign, Comonwealth & Development Office

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

James E THOMPSON
Assistant Coroner for
County Durham and Darlington
Dated: 03 December 2020