Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Civil Aviation Authority (CAA) 2. British Gliding Association (BGA)
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 06/08/2019 an investigation was opened into the death of **Steven Phillip Evans** The investigation concluded at the end of the inquest on: **26/10/2021** when a jury determined the following: <u>The conclusion of the inquest was recorded as</u> **Death by Accident** <u>The medical cause of death was:</u> **1a) Polytrauma following a glider crash**.
4	**CIRCUMSTANCES OF THE DEATH** The jury determined the following: On 27th July 2019, Steven Evans was preparing to fly his glider at South Wales Gliding club. Unfortunately, Steven's failure to secure the tail plane correctly left the glider unsafe to fly. At the point of launch, the tail plane became dislodged, causing the glider to crash to the ground. Steven sustained serious injuries in the impact and despite receiving prompt clinical care, died on 1st August 2019 at the University Hospital of Wales.

5	**CORONER'S CONCERNS** During the course of the inquest, 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. <u>Mandatory radio communication between ground crew and aircraft pilots.</u> During the course of the inquest the jury heard that problems with Steven's glider were observed before the glider was launched however the system of communication did not alert either the tug plane operator or Steven Evans to the problems prior to his launch. In the circumstances I consider this constituted a failure to adopt an effective communication system at launch, a finding endorsed by the Air Accident Investigation Branch. However, there was insufficient information to determine that this contributed to Steven's death as the glider crashed within seconds of the fault being identified. In evidence it became clear that the CAA do not mandate the use of radios in the relevant aircraft and by the ground crew and whilst this was previously recommended by the BGA it was not usual practice at South Wales Gliding Club until after Steven's death. Whilst it was not determined that the failure to have radio communication contributed to Steven's death it appears that radios may still not be in use in other clubs and therefore lives may be put at risk in the future. I consider that further consideration should be given by the CAA to require effective radio communication not only at launch but throughout the glider flight and that the BGA further strengthen the current guidelines that radios are strongly recommended.
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. <u>I should be grateful if the following information be provided to me:</u> 1. Confirm whether any steps have or will be taken to enforce the use of radios in all aircraft and with groundcrews in gliding clubs.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **29th December 2021**, I, the Coroner, may extend this 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 necessary.

8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) • **The family of Steven Phillip Evans.** 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 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	**DATE 03/11/21** Signed Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**