IN THE WEST SUSSEX CORONERS' COURT
IN THE MATTER OF THE INQUESTS TOUCHING THE DEATHS OF THOSE WHO DIED AT THE SHOREHAM AIR SHOW ON 22ND AUGUST 2015

Ruling on Conclusions

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1. Under section 5 of the Coroners and Justice Act 2009, the specific statutory duty of a coroner in respect of a violent or unnatural death, such as that suffered by the eleven men with whom these inquests are concerned, is to determine: (1) who the deceased person was; (2) how, when and where the deceased came by his death; and (3) the particulars for registration of the death. Where Article 2 of the European Convention on Human Rights is engaged, this question of 'how' is treated more broadly and is to be read as including the purpose of ascertaining *in what circumstances* the deceased came by their death.

2. Having heard all the evidence and having come to my findings of fact, I must record a conclusion as to each of the deaths in question. Whilst that conclusion may not be framed in such a way as to appear to determine any question of: (a) criminal liability on the part of a named person, or (b) civil liability, it is nevertheless permissible to return conclusions that attribute blame or fault. In particular a coroner may now return a finding of unlawful killing if satisfied that the requisite elements of a homicide offence are made out on the balance of probabilities: *R (Maughan) v Her Majesty's Senior Coroner for Oxfordshire* [2020] UKSC 46.

3. In coming to my conclusions in respect of these inquests I am also bound by law to accept the findings of the AAIB investigation. All interested persons are well aware of the Norfolk case [2016] EWHC 2279, and the subsequent Divisional Court

decision of 4 February this year following my own application (at [2022] EWHC 215 (QB)) which made it clear that "at the level of principle, there should not be duplicative investigations" as there is no public interest in doing so, and that I "**would comply sufficiently with the duties of the coroner by treating the findings and conclusions of the report of the independent body as the evidence as to the cause of the accident.**"

4. I have heard from three of the AAIB investigators who have explained their findings to me, it has been made clear by each of the AAIB witnesses that, whilst they have taken care to ensure the presentation of oral evidence does not differ in fact or interpretation from the published material, if there is a difference, the published material is definitive.

5. I could then, as outlined by Lord Thomas CJ in the Norfolk case at §56, simply refer those who wish to know the cause of this crash to the various AAIB publications and return a very short inquest conclusion. But that would not, in my view, be an adequate way to meet my s.5 CJA duties. In my view the public record of these inquests should not be so anodyne.

6. Returning a conclusion in box 4 of the record of inquest that describes in much more than a word or two 'how' a death occurred is open to me in all inquests, whether Art 2 ECHR is engaged or not. It is for the coroner to decide what wording to use in their conclusion. The footnotes on a non-statutory form have given rise to a practice of referring to 'short form' and 'narrative' conclusions. But, in reality, there is no such binary distinction in law. The coroner's conclusion should be formed of whatever words the coroner deems most appropriate to the case in question. There is no rule of law that requires any coroner to adopt what is known as a short form conclusion taken from note (i) to Form 2 (the Record of Inquest form), whether alone or as part of a longer series of words. All that can be

said is that the higher courts have repeatedly emphasised the need for brevity in any conclusion.

7. In *Longfield Care Homes v HM Coroner for Blackburn* [2004] EWHC 2467 (Admin) the court indicated how, in more complex cases, a narrative will often be required. I have decided that I too shall use a longer narrative to describe these inquests' conclusions in respect of each of these eleven deaths. No interested person has sought to dissuade me from that course of action.

8. The bereaved however urge me to return a conclusion that is or contains a finding that the deceased were unlawfully killed on the basis of their deaths coming about due to gross negligence manslaughter.

Gross negligence manslaughter

9. In respect of criminal liability, judged on a criminal standard, the answer to whether or not these eleven deaths were a result of an unlawful killing has already been given – after an eight week trial a jury unanimously acquitted the pilot, Mr Hill, of gross negligence manslaughter.

10. Since the Supreme Court's decision in *Maughan* [2020] UKSC 46 it is now the case that an inquest conclusion of unlawful killing, applying the lower civil standard of proof, would no longer offend against Schedule 1 Part 2 para 8(5) CJA 2009. A finding of unlawful killing in an inquest is not inconsistent with an acquittal in earlier criminal proceedings which applied the higher standard of proof. Indeed, all Interested Persons have seen the advice provided to me by Counsel to the Inquest on that issue in December 2020, and no interested person has argued against Counsel to the Inquest's interpretation of the law, which I also accept. I set out its substance below:

Conflict with criminal findings

1. Schedule 1, para 8 CJA 2009 deals with the resumption of investigations that have been suspended pending a homicide trial at paragraph 2. Specifically, sub-paragraph (5) contains a prohibition on a subsequently resumed inquest arriving at conclusions on the statutory questions which are inconsistent with the outcome of criminal proceedings in respect of the same death:

> "8(5) In the case of an investigation resumed under this paragraph, a determination under section 10(1)(a) may not be inconsistent with the outcome of—
>
> (a) the proceedings in respect of the charge (or each charge) by reason of which the investigation was suspended;
>
> (b) any proceedings that, by reason of sub-paragraph (2), had to be concluded before the investigation could be resumed."

2. The enactment of schedule 1 puts on an explicit statutory footing for coroners courts that which the House of Lords had earlier determined: that a final decision by a competent court in which the identical question sought to be raised has been already decided must be respected unless and until successfully appealed (see *Hunter v CC West Midlands* [1981] AC 529) (here).

3. More recently the Divisional Court in *Skelton v Senior Coroner for West Sussex* [2020] EWHC 2813 (here) confirmed the same principle will apply to a fresh inquest following a homicide conviction, albeit that the statutory provision within the schedule only covers a resumed inquest.

Relevance of a criminal acquittal

4. In respect of an acquittal by a criminal jury, as Lord Diplock went on to state in *Hunter* [543B]:

> "a decision in a criminal case upon a particular question *in favour* of a defendant, whether by way of acquittal or a ruling on a voir dire, is not inconsistent with the fact that the decision would have been *against* him if all that were required were the civil standard of proof on the balance of probabilities. This is why acquittals were not made admissible in evidence in civil actions by the Civil Evidence Act 1968"

5. In *Skelton* (here) the court drew attention to the above proposition from *Hunter* when noting (at §116) that "an acquittal by a jury in a criminal trial does not depend on the proof of an affirmative proposition (to any standard)" (albeit that this was only judicial comment, as the issue did not arise on the facts of the *Skelton* case).

6. The present position in law, therefore, is that should a coroner or inquest jury find that the requisite elements of murder, manslaughter or infanticide are established 'on the balance of probabilities' then an inquest conclusion of unlawful killing will be permissible even though there has already been an acquittal of following a homicide trial. Such an inquest conclusion would not be inconsistent with a criminal jury having already found that they were not satisfied of the very same matters 'beyond reasonable doubt'.

11. To that extent the position seems clear. There is, however, no Common Law or direct guidance available to me, or even any obiter comment in *Maughan,* as to whether it is appropriate or desirable and if so, in what circumstances, to come to such a conclusion after a criminal acquittal.

Evidence relating to gross negligence manslaughter

12. In considering the question of a potential unlawful killing finding based on gross negligence manslaughter, the only evidence which I have been permitted to adduce as to how these eleven men came by their deaths is that within the reports of the AAIB which set out the AAIB's findings and conclusions as to the cause of the air crash.

13. I note the submissions of Mr Prynne on behalf of Canfield Hunter Ltd. and Mr Spence on behalf of the pilot, that the High Court's requirement for a Coroner conducting an air crash inquest to rely solely upon the AAIB's findings and conclusions means that I must also take heed of the caveats the AAIB place on their reports and which Mr Firth confirmed in his evidence. These appear on the opening pages of the AAIB report and state:

    The sole objective of the investigation of an accident or incident under these Regulations is the prevention of future accidents and incidents. It is not the purpose of such an investigation to apportion blame or liability. Accordingly, it is inappropriate that AAIB reports should be used to assign fault or blame or determine liability, since neither the investigation nor the reporting process has been undertaken for that purpose.

14. It appears to me that the first sentence of the caveat above arises from Article 16 of the EU Regulation 996/2010 concerning the investigation and prevention of civil air accidents, which binds me, and which states:

> 1. Each safety investigation shall be concluded with a report in a form appropriate to the type and seriousness of the accident or serious incident. The report shall state that the sole objective of the safety investigation is the prevention of future accidents and incidents without apportioning blame or liability. The report shall contain, where appropriate, safety recommendations.

15. However, the second part of the AAIB's caveat (the words after 'Accordingly') appear to me to be an additional gloss on Article 16, that is not a matter of law. As such I do not accept the submission of Canfield Hunter Ltd. that the AAIB report's caveat provides the final answer to the question of whether a Coroner may use matters determined by the AAIB as the foundation for a perjorative inquest conclusion.

16. Indeed, it seems to me that it would be perverse for an AAIB report to conclude that a pilot in a hypothetical air crash had been flying drunk, under the influence of cocaine, without a licence to take passengers, when not authorised to fly the particular plane in which he and his passenger were killed and that he made several errors in control of the flight, yet a coroner still would not be entitled to return an inquest conclusion of unlawful killing of the passenger based upon gross negligence manslaughter.

17. As Mr Manknell on behalf of the AAIB put it, the AAIB's understanding is that their caveat does not mean I may not use the facts found by the AAIB and recorded in their report to <u>support</u> a finding of unlawful killing. But what I must not do is add to them from extraneous material. I am prevented from investigating the AAIB's findings any further as a result of the *Norfolk* and *West Sussex* decisions. The AAIB submit that I am:

> *'**confined to considering the facts and conclusions as found and recorded by the AAIB**. It is not open to a Coroner to supplement the AAIB evidence with other evidence in order to complete any perceived gap, or give clarification where it does not exist in the report, in order to reach a particular conclusion that would not otherwise be available. Nor should the Senior Coroner draw inferences from the AAIB's findings which have not been drawn by the AAIB.*
>
> *Departing from the AAIB's findings on issues investigated by the AAIB (either by taking account of additional evidence, or drawing inferences) would impermissibly*

"reopen" the AAIB's findings, contrary to Norfolk. If the findings of the AAIB are not sufficient to support a particular conclusion, then it is submitted that the conclusion is not one which is available to the Coroner.'

18. I accept that submission, which appears to me to be the outcome of the two relevant High Court decisions and note that no other Interested Person argues against the approach of the AAIB on this specific point (and which Canfield Hunter also accept as their fall-back position). What is said by the bereaved and the CAA (who argue in favour of an unlawful killing conclusion) is that there is already sufficient within the AAIB reports to find a safe conclusion that these deaths were a result of gross negligence manslaughter. Mr Hill says that without expert evidence regarding standards to be expected of a professional pilot the AAIB reports alone are insufficient for a safe and fair finding.

19. It is to that issue that I now turn.

20. The elements of gross negligence manslaughter are set out in *R v Rose* [2017] EWCA Crim 1168 at §77. I have been addressed only briefly on the first few elements as no one is seriously arguing that Mr Hill did not (i) owe a duty of care to the victims and (ii) breach that duty nor is anyone arguing that a breach of the duty owed did not (iii) give rise to a foreseeable serious and obvious risk of death nor (iv) cause these deaths. It is my view that each of these elements of gross negligence manslaughter are made out to the civil standard on the facts of this case.

21. The plane crashing was, as the AAIB found, a result of the manner in which it was flown in that it did not achieve sufficient height at the apex of the accident manoeuvre to complete it before impacting the ground because the combination of low entry speed and low engine thrust in the upward half of the manoeuvre was insufficient to carry out the manoeuvre from a safe height. An escape manoeuvre was not carried out, despite the aircraft not achieving the required minimum apex height.

22. This manner of flying was in my view, when applying the civil standard, prima facie negligent. Unless the pilot had some reasonable excuse, he is responsible for that negligence. As I have explained in my findings of fact, the AAIB could not fully exclude a cognitive impairment having arisen that *might* provide an excuse for this poor flying. But as far as could be determined from cockpit image recordings, Mr Hill appeared alert and active throughout the flight and the AAIB found that the g experienced by the pilot during the manoeuvre was probably not a factor in the accident. Although they could not be specific as to why the plane was so badly flown options included possible misreading or misinterpretation of speed and height indications during the manoeuvre or recall of the speed and height for a different aircraft type that the pilot had flown more often.

23. The totality of the AAIB investigation of this crash, which binds me, found no evidence of cognitive impairment but, if present, it did not affect the pilot's observable behaviour and the source of any impairment was unknown. Other performance shaping factors like those above were considered more likely than impairment to have contributed to this accident.

24. It is against this background that I must consider the final element of gross negligence manslaughter: it must be found that the circumstances of any identified breach of duty must be truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence requiring a criminal sanction. I bear in mind that in R -v- Misra [2005] 1 Cr App 21 the court approved the following direction to a jury on the question of 'grossness' at §25:

> 'Mistakes, even very serious mistakes and errors of judgment, even very serious errors of judgment are nowhere near enough for a crime as serious as manslaughter to be committed….the conduct [has to fall] so far below the standard to be expected of a reasonable competent and careful [pilot] that it was something in your assessment truly exceptionally bad and which showed such an indifference to an obviously serious risk of life…and such departure from the standard to be expected as to amount, to a criminal act or omission and so be the very serious crime of manslaughter'.

25. I also bear in mind that I must look only at the quality of the pilot's actions and not at the consequences of his actions when addressing whether any failures were gross.

26. Although it is clear from the AAIB conclusions that this aircraft crashed because of the way in which it was flown, the AAIB reports do not pass any comment or judgment upon <u>how badly</u> it was flown. The reports do not state how bad or how serious or how far below expected standards any relevant error by the pilot might have been.

27. The families represented by Stewarts submit that I can determine whether Mr. Hill's actions were a gross departure from the standard to be expected without any expert evidence by simply referring to the actions that Mr. Hill himself stated to the AAIB he would normally take as a matter of best practice. It is submitted that Mr. Hill's failure to ensure he adhered to his usual practice allows me to judge his failure as gross when placed in the context of flying a dangerous fast jet in aerobatic manoeuvres.

28. The CAA submit that I can look at the fact Mr Hill was a skilled professional and was under a number of statutory duties combined with a number of findings of fact by the AAIB as evidence of the grossness of his negligence.

29. Mr Hill argues that he is placed in a grossly unfair position because he cannot in this inquest deploy the material or arguments that he could put before the criminal court and because I have not heard from any pilot witness as to professional standards that might allow me to benchmark the degree of any negligence.

30. I am informed in his written submission that a 'substantial part' of Mr Hill's successful defence at the criminal trial was the proposition that he had suffered a cognitive impairment. But as I have accepted above, an acquittal is not to be

taken as proof of an affirmative proposition to any standard and that since the *Maughan* decision I must apply a different standard of proof than a criminal court.

31. Whatever material was deployed in the criminal proceedings, it appears that the AAIB's 2019 review *after* the trial provided an opportunity for Mr Hill to put this material before the AAIB. Mr Hill has since produced more medical evidence in the form of a report from Dr Mitchell, but the Divisional Court found in their judgment on my application that Dr Mitchell, who is a paediatric oncologist, (i) was not a suitably qualified expert in either aviation medicine or neurology and (ii) his paper was not a safe basis to argue that the AAIB's conclusions on the issue of cognitive impairment were even arguably incomplete.

32. Whilst the AAIB reports do not pass any comment on the quality of the flying. I consider that I do not in this case require evidence from an aviation expert to assist me with a benchmark as to the degree of any alleged shortcomings in making my judgment of whether this was 'gross' negligence.

33. It seems to me that I can look at what is factually available in the AAIB findings to assess whether the flying was below the standard to be expected of a reasonable competent and careful pilot and whether this crash arose from something more than a very serious mistake or very serious error of judgment, but from flying that was truly exceptionally bad so as to be considered to amount, to a criminal act or omission.

34. The evidence I have considered from the AAIB report is first, the number of errors made in the manoeuvre itself, having a low entry speed, applying insufficient thrust and so failing to achieve sufficient height at the apex. It seems to me that one does not need expert evidence to tell me that a fast jet display pilot should have in mind how much height would likely be lost during the downward part of any looping manoeuvre. This is what will define a clearly unsafe apex from which a looping plane could never avoid hitting the ground. In fact the aircraft failed to

reach the height required by quite a significant margin. The ideal apex was 3,5000 ft and Mr Hill only reached around 2,700ft. This was not a small misjudgement; the aircraft was approximately 800 feet below the pilot's own stated minimum at the loop's apex.

35. Second, I have considered that this was not a single error of piloting that once made could not be undone, there were two decision points (at the entry to the accident manoeuvre, and at the apex of the accident manoeuvre) where the AAIB found that Mr Hill may have been able to recover from any deviations in the planned manoeuvres that had occurred and so could have prevented the situation from progressing to the crash. Yet he continued to fly the downward part of a loop when he had not achieved sufficient height rather than flying an escape manoeuvre. In my view this goes beyond a mere mistake or even serious error of judgment. With insufficient height one is bound to hit the ground if continuing the loop and the risk to the life of anyone on the ground would be clear and obvious.

36. It is axiomatic that any fast jet pilot should know how to fly an escape manoeuvre when engaging in an air display, a pilot should be able to recognise the need to do so when it arises and be able to carry it out even though there are only a few seconds to make the decision to do so. It cannot be safe to carry out aerobatics without having that knowledge and ability. Yet the AAIB found that Mr Hill had not practised escape manoeuvres in this particular aircraft. There was no attempt made at any escape or abandonment of what was a clearly an incorrectly flown manoeuvre here. This was not a close or difficult judgment call, the plane was at a substantially lower altitude than it should have been. It seems even experienced pilots on the ground in the FCC could see it was too low.

37. Proper scrutiny of the altimeter taking heed of the reading would have immediately confirmed the height was insufficient by a significant margin, there

was no difficult judgment to make here about whether an escape was required or not. It should have been clear and obvious to a competent pilot that he was too low and the manoeuvre needed to be aborted.

38. Third, in conducting the loop the pilot changed the ground track from the intended manoeuvre and so put the aircraft in a position to crash on the A27. The poor positioning of the plane in the sky, further east than planned, was a further significant error that increased the risk of death to those using or nearby the A27. The plane should not have been lined up with the dual carriageway.

39. Whilst the source of the faulty decision making that led to this crash was not precisely identified by the AAIB what is abundantly clear from their investigation is that some type of cognitive impairment was probably not an exculpatory factor. The AAIB found that the pilot suffering a cognitive impairment was an unlikely explanation, even though it could not be completely ruled out.

40. Considering all of the matters above, I find that Mr Hill's actions were probably not due to a cognitive impairment and probably did fall very very far below the standard to be expected of a reasonably competent fast jet pilot. His flying was exceptionally bad in several aspects such that I am satisfied, applying the threshold as described in *Misra*, that this was, on the balance of probabilities, so far a departure from the standards to be expected that it meets the high threshold for the final element of gross negligence manslaughter, and I shall be reflecting that finding within my narrative conclusion.

41. I should state that although Mr Morris urged me in his submissions to consider matters such as the significant cost of training a fast jet pilot when coming to my decision, I have not supplemented the AAIB evidence with such other evidence in my mind. Many of the matters Mr Morris sought to rely upon are not found within the AAIB reports, and so I have put those suggestions aside.

42. I have also taken into account the submissions on behalf of Mr Hill that urged me not to come to a finding of a gross negligence manslaughter on his part as it is said that the consequences of an unlawful killing conclusion would be reputationally grave for him after a criminal acquittal. It is said that others may not understand the nuanced difference between the criminal and civil standards of proof.

43. I am not persuaded that this is a good reason not to return this conclusion on these facts. Indeed, this is a matter that the Supreme Court explicitly considered in Maughan (at §93) when Lady Arden stated that "*It seems to me that the public are likely to understand that there is difference between a finding at an inquest and one at a criminal trial where the accused has well-established rights to participate actively in the process."*

44. I do however wish to make it abundantly clear that the inquest finding I shall make is not a challenge to the criminal jury's determination. I am required to apply a very different standard of proof from a criminal jury. Mr Hill has been found 'not guilty' by the criminal courts and that remains the position in law. My conclusion having applied a lower standard of proof does not alter or detract from the fact of his acquittal in any way.

Penelope Schofield
Senior Coroner for West Sussex

20 December 2022