Neutral Citation Number: [2022] EWHC 215 (QB)

Case No: QB-2021-002090

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 04/02/2022

Before :

PRESIDENT OF THE QUEEN'S BENCH DIVISION
and
MR JUSTICE SAINI

- -

Between :

HER MAJESTY'S SENIOR CORONER FOR WEST SUSSEX	**Claimant**
- and -	
(1) CHIEF CONSTABLE OF SUSSEX POLICE **(2) SECRETARY OF STATE FOR TRANSPORT** **(3) MR ANDREW HILL**	**Defendants**
- and -	
SUE AND PHILIP GRIMSTONE **JONATHAN SMITH AND JULIE SMITH** **ROBERT HENRY JACK SCHILT AND CAROLINE LOUISE SCHILT**	**Interested Parties**

- -
- -

Bridget Dolan QC and **Alexander dos Santos** (instructed by **West Sussex County Council**) for the **Claimant**
Martin Downs (instructed by the **Chief Constable of Sussex Police**) for the **First Defendant**
Jason Beer QC and **David Manknell** (instructed by **Government Legal Department**) for the **Second Defendant**
Mr Andrew Hill in person
Gerard Forlin QC and **Kirsten Heaven** for the **Interested Parties**

Hearing dates: 20 December 2021

- -

Approved Judgment

Covid-19 Protocol: This judgment will be handed down remotely by circulation to the parties or their representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand-down will be deemed to be 10:30am on 4 February 2022.

Dame Victoria Sharp P:

Introduction

1. This is the judgment of the Court.

2. This Part 8 claim is brought by the Senior Coroner for West Sussex, Penelope Schofield (the Coroner). On the 22 August 2015, a Hawker Hunter aircraft crashed onto the A27 road Shoreham Bypass, while performing at the Shoreham Airshow. The crash tragically killed eleven men and the Coroner has the conduct of eleven inquests (the Inquests) into their deaths. In addition to those deaths, a further 13 people were injured. The pilot, Mr Andrew Hill, who is the third defendant, survived the accident. He was thrown clear of the aircraft on impact but was seriously injured.

3. The Coroner seeks an order pursuant to Regulation 25 of the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 2018/321 that specified records which may be protected under Art 14 of the EU Regulations on the investigation and prevention of Air Accidents No.996/2010 be made available to her for the purpose of the Inquests. The main record sought by the Coroner is the cockpit video recording from the aircraft. Under international, EU and domestic law, cockpit recordings have a very high degree of protection from disclosure for purposes other than safety investigations. As we describe in more detail below, the protection arises for reasons of the substantial public interest in the effective investigation and prevention of accidents.

4. The accident was investigated by the United Kingdom's specialist independent air accident investigators, the Air Accidents Investigation Branch (AAIB) who are represented in this claim by the second defendant. The AAIB published its main report on 3 March 2017.

5. The accident was also investigated by the Sussex police. During the criminal investigation, the police sought a range of materials arising from the AAIB investigation. Following a contested hearing in 2016, the High Court refused to grant the police access to any of this material, save for one item, the *Go-Pro* camera footage of the flight, recorded within the cockpit by Mr Hill, using his own camera: see [2016] EWHC 2280 (QB).

6. Following the investigation by Sussex police, Mr Hill was charged with 11 counts of gross negligence manslaughter and between January and March 2019, he was tried on those charges, before Edis J and a jury, at the Central Criminal Court. The *Go-Pro* camera footage was set up as a split screen montage by the police and was shown to the jury in open court during the trial. An issue raised at the trial on behalf of Mr Hill was whether he had suffered some form of cognitive impairment which had led him to fly the aircraft in that way that he did. Expert evidence on that matter was before the jury by way of reports and oral evidence. Mr Hill was acquitted on all counts on 8 March 2019.

7. The High Court's Order granting the police permission to use the footage, required them to return the footage to the AAIB at the conclusion of the criminal proceedings. Whilst they did return the footage, they retained copies of the original footage. The first defendant, the Chief Constable of Sussex, accepts that this was a serious breach of that order. It gives rise to the first defendant's separate application before us (Claim QB-2021-002113) seeking retrospective permission to retain this footage pending

completion of the current proceedings. The police, the AAIB and Mr Hill have agreed an order, subject to our approval, disposing of this separate application. The Chief Constable, represented by Mr Downs, has apologised to the Court for the failure to abide by the terms of the order of this court; and has provided assurances in evidence that processes have now been put in place to ensure that such a breach does not occur in the future.

8. After Mr Hill's acquittal, in June 2019 the AAIB reviewed their original investigation and considered the theory that the aircraft was flown in the manner that it was because Mr Hill had suffered a cognitive impairment during the looping manoeuvre. A supplementary review report was published on 19 December 2019. This concluded: "there was no new and significant evidence of cognitive impairment" and that "the findings of the (2017) AAIB investigation remain valid". The AAIB accordingly declined to re-open their investigation.

9. The Inquests were resumed by the Coroner following Mr Hill's acquittal. In September 2020, Mr Hill presented to the Coroner what she describes in the skeleton argument submitted on her behalf as an "expert medical report" prepared by a Dr Mitchell. In his paper dated 12 September 2020, Dr Mitchell postulates a theory that a particular mechanism of cognitive impairment resulting from cerebral hypoxia may have been suffered by Mr Hill during the flight. Mr Hill asserts this mechanism was not investigated by the AAIB. We note at this stage that Dr Mitchell is a friend of Mr Hill who is a paediatric oncologist; he professes no expertise in aviation medicine or neurology. We will return to this matter in more detail below.

10. The Coroner now applies for an order permitting her to obtain and use the material listed at [11] below (some of which is still held by the police), for the purposes of assessing whether Dr Mitchell's paper amounts to credible evidence that the AAIB investigation into the air crash was incomplete, flawed or deficient. If she finds so, she says as part of her coronial investigation she will seek to further investigate the matters within the AAIB's reports. Bridget Dolan QC on behalf of the Coroner, says the Coroner considers Dr Mitchell's paper presents a credible *suggestion* that the AAIB's investigation of the cognitive impairment issue was incomplete. The Coroner makes it clear however that she does not currently have credible *evidence* that the investigation was incomplete.

11. The material sought by the Coroner is: (i) the *Go-Pro* camera footage recorded by Mr Hill (including both the original footage and the split screen montage created for the criminal trial); (ii) expert reports produced at his trial which addressed the issue of cognitive impairment; and (iii) the transcripts of evidence given during the criminal trial. These materials are held by the police who are neutral as to the Coroner's application.

12. Mr Hill acting in person, supports the Coroner's application but makes a broader submission as to the inadequacies of the AAIB investigation. He argues that the AAIB's investigation in relation to the accident was *actually* incomplete, flawed or incomplete (as opposed to the Coroner's position that there is a credible suggestion to this effect). The Coroner does not support this position.

13. Members of the families of three of those who died in the accident have been joined as Interested Parties to this claim and have made helpful written and oral submissions. They are Sue and Phillip Grimstone (the family of Matthew Grimstone), Jonathan and Julie Smith (the family of Richard Smith) and Robert and Caroline Schilt (the family of Jacob Schilt). They each support the Coroner's application and emphasise the importance of a full, fair and thorough investigation. They are concerned about the regrettable substantial delays which have beset the progress of the Inquests. The statement from the parents of Matthew Grimstone notes that the *Go-Pro* footage was deployed in the criminal trial, and they believe that the Coroner should also see it. They indicate that they have a lot of questions relating to what was said during the criminal trial. The Grimstone family did not appear by Counsel. The Smith and Schilt families were represented by Gerard Forlin QC and Kirsten Heaven.

14. The AAIB resists the application for disclosure on a number of grounds. In particular, it says that that there is no public interest in re-examination of a matter which it has already considered, and Dr Mitchell's views as expressed in his paper do not present credible evidence to question the AAIB's examination of the cognitive impairment issue. It also argues that disclosure would have a significant potential adverse impact on future safety investigations. The British Air Line Pilots Association (BALPA) has served evidence which strongly supports the AAIB in its opposition to disclosure.

15. Prior to the hearing we were provided with both OPEN and CLOSED materials and evidence. The CLOSED evidence included statements from Mr Hill, Richard Verrall (an aviation consultant assisting Mr Hill), and Julian Firth, Principal Inspector of the AAIB. Their evidence included substantial exhibits. Having considered the CLOSED materials in advance of the hearing, we indicated to the parties that we did not consider a CLOSED hearing was necessary. That course was not opposed by any party. Given our conclusion on the issues argued in the OPEN hearing we do not consider it necessary to provide a CLOSED judgment but we have taken into account the CLOSED submissions and in particular those aspects drawn to our attention by Mr Hill in his post-hearing note.

16. The premise of the Coroner's application is that the *Go-Pro* footage (and related materials from the criminal trial which refer to that footage) are protected under the relevant legislation and require a court order authorising use. Her position on the issue of protection was less clear before us however, and she asked for further guidance. Moreover Mr Forlin QC challenged the proposition that the footage was protected on the basis that the footage was made by Mr Hill for his own personal purposes rather than under any legal obligation. It is therefore necessary for us to consider the issue in some detail by reference to the legislative framework and three cases where that framework has received extensive consideration: *Secretary of State for Transport v Senior Coroner for Norfolk* [2016] EWHC 2279 (Admin) (the *Norfolk* case); *Chief Constable of Sussex Police v Secretary of State for Transport, British Airline Pilots Association* [2016] EWHC 2280 (QB) (the *Sussex* case); and *BBC v Secretary of State for Transport* [2019] 4 WLR 23 (the *BBC* case). The *Sussex* and the *BBC* cases were concerned with the same *Go-Pro* footage with which we are concerned in this application.

17. We preface our analysis by noting that though there was no apparent dispute in either the *Sussex case* or the *BBC* case that the material under consideration was protected,

both the Divisional Court in *Sussex* (the LCJ and Singh J) and Edis J in the *BBC* case, set out in some detail the relevant legal framework regarding protection and its underlying rationale; and the analyses undertaken formed a necessary step in the courts' reasoning. Further, as described below, Edis J also made a number of interlocutory rulings in the criminal trial which proceeded on the same basis viz, that the material under consideration was protected. As we observed during the course of the hearing before us, if the submissions by the Coroner and Mr Forlin QC are correct, it would follow that both the *Sussex* and the *BBC* cases were decided in error.

18. Mr Forlin QC drew our attention to a decision of 10 December 2007 of Master Rose in *Linatex v Kreisky* (relating to a crash at Blackbushe Airport in 2000). That case was concerned with whether there should be disclosure under the balancing exercise, and does not touch on the issues raised before us.

Legal framework: Aviation law

19. The law governing the disclosure of records and information obtained by the AAIB during the course of an AAIB investigation and disclosure of material produced during the course of an investigation is set out in Retained EU Regulation No 996/2010 (the EU Regulations) and the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 2018 (S.I 2018/321) (the 2018 UK Regulations). The EU Regulations continue to apply in the United Kingdom as Retained EU law under the European Union (Withdrawal) Act 2018.

20. The framework for this domestic and EU law legislative scheme is the Convention on International Civil Aviation, signed at Chicago on 7 December 1944 (Treaty Series No. 8 (1953)) (Cmd 8742) (the Chicago Convention). Annex 13 to that Convention, which has the title 'Aircraft Accident and Incident Investigation' provides the framework that was implemented in the EU and domestic legislation. Annex 13 is now in its 12th edition (2020).

21. The material part of Annex 13 provides as follows:

> "Protection of accident and incident investigation records
>
> 5.12 The State conducting the investigation of an accident or incident shall not make the following records available for purposes other than the accident or incident investigation, unless the competent authority designated by that State determines, in accordance with national laws and subject to Appendix 2 and 5.12.5, that their disclosure or use outweighs the likely adverse domestic and international impact such action may have on that or any future investigation:
>
> (a) cockpit voice recordings and airborne image recordings and any transcripts from such recordings; and
>
> (b) records in the custody or control of the accident investigation authority being:

(1) all statements taken from persons by the accident investigation authority in the course of their investigation;

(2) all communications between persons having been involved in the operation of the aircraft;

(3) medical or private information regarding persons involved in the accident or incident;

(4) recordings and transcripts of recordings from air traffic control units;

(5) analysis of and opinions about information, including flight recorder information, made by the accident investigation authority and accredited representatives in relation to the accident or incident; and

(6) the draft Final Report of an accident or incident investigation.

5.12.1 Recommendation. – *States should determine whether any other records obtained or generated by the accident investigation authority, as part of an accident or incident investigation, need to be protected in the same way as the records listed in 5.12.*

5.12.2 The records listed in 5.12 shall be included in the Final Report or its appendices only when pertinent to the analysis of the accident or incident. Parts of the records not relevant to the analysis shall not be disclosed.

Note. – The records listed in 5.12 include information relating to an accident or incident. The disclosure or use of such information for purposes where the disclosure is not necessary in the interest of safety may mean that, in the future, the information will no longer be openly disclosed to investigators. Lack of access to such information would impede the investigation process and seriously affect aviation safety.

5.12.3 The names of the persons involved in the accident or incident shall not be disclosed to the public by the accident investigation authority.

5.12.4 States shall ensure that requests for records in the custody or control of the accident investigation authority are directed to the original source of the information, where available.

> 5.12.4.1 Recommendation. – *The accident investigation authority should retain, where possible, only copies of records obtained in the course of an investigation.*
>
> 5.12.5 States shall take measures to ensure that the audio content of cockpit voice recordings as well as image and audio content of airborne image recordings are not disclosed to the public.
>
> 5.12.6 States issuing or receiving a draft Final Report shall take measures to ensure that it is not disclosed to the public.
>
> *Note. – Appendix 2 contains additional provisions on the protection of accident and incident investigation records. These provisions appear separately for convenience but form part of the SARPs".*

22. Appendix 2, Section 4 of Annexe 13 provides a list of factors which a competent authority should take into account when administering the balancing test under Standard 5.12 above.

23. The International Civil Aviation Organisation (ICAO) has supplemented Annex 13 to the Convention by a publication entitled the "Manual on Protection of Safety Information" (1st edition, 2016) (the Manual). The Manual contains detailed guidance on the interpretation of Annex 13, particularly in Chapter 3 (entitled "Protection and use of certain accident and incident investigation records"). We will refer to material provisions of the Manual further below.

24. As to Annex 13 of the Convention, United Kingdom Courts are required to interpret relevant legislation consistently with any binding obligations under Annex 13 insofar as possible. That is because: (i) the EU Regulations are based upon Annex 13, and state that account should be taken of it; and (ii) Section 75(1)(b) of the Civil Aviation Act 1982 provides powers for the application of Annex 13 under the 2018 Regulations.

25. The material parts of Article 14 of the EU Regulations provide as follows :

> "1. The following records shall not be made available or used for purposes other than safety investigation:
>
> (a) all statements taken from persons by the safety investigation authority in the course of the safety investigation;
>
> (b) records revealing the identity of persons who have given evidence in the context of the safety investigation;
>
> (c) information collected by the safety investigation authority which is of a particularly sensitive and personal nature, including information concerning the health of individuals;

> (d) material subsequently produced during the course of the investigation such as notes, drafts, opinions written by the investigators, opinions expressed in the analysis of information, including flight recorder information;
>
> (e) information and evidence provided by investigators from other Member States or third countries in accordance with the international standards and recommended practices, where so requested by their safety investigation authority;
>
> (f) drafts of preliminary or final reports or interim statements;
>
> (g) cockpit voice and image recordings and their transcripts, as well as voice recordings inside air traffic control units, ensuring also that information not relevant to the safety investigation, particularly information with a bearing on personal privacy, shall be appropriately protected, without prejudice to paragraph 3.
>
> The following records shall not be made available or used for purposes other than safety investigation, or other purposes aiming at the improvement of aviation safety:
>
> (a) all communications between persons having been involved in the operation of the aircraft;
>
> (b) written or electronic recordings and transcriptions of recordings from air traffic control units, including reports and results made for internal purposes;
>
> (c) covering letters for the transmission of safety recommendations from the safety investigation authority to the addressee, where so requested by the safety investigation authority issuing the recommendation;
>
> (d) occurrence reports filed under Directive 2003/42/EC.
>
> Flight data recorder recordings shall not be made available or used for purposes other than those of the safety investigation, airworthiness or maintenance purposes, except when such records are de-identified or disclosed under secure procedures
>
> …".

26. Article 14, paragraph 1 is subject to paragraphs 3 and 4, which provide:

> "3. Notwithstanding paragraphs 1 and 2, the administration of justice or the authority competent to decide on the disclosure

> of records according to national law may decide that the benefits of the disclosure of the records referred to in paragraphs 1 and 2 for any other purposes permitted by law outweigh the adverse domestic and international impact that such action may have on that or any future safety investigation.
>
> …
>
> 4. Only the data strictly necessary for the purposes referred to in paragraph 3 may be disclosed."

27. Article 14(3), accordingly identifies the circumstances in which the prohibition against disclosure of the records referred to in Article 14(1) and (2), can be displaced. Once material is identified as being covered by Article 14 (which we will refer to as "protected material") the starting point is that no protected material shall be made available to any person for purposes other than the safety investigation by the safety investigation authority (the AAIB in the United Kingdom) as per Article 14(1).

28. The question of which Court or authority is the "administration of justice or the authority competent to decide" is left to domestic law to determine. It is common ground that in this jurisdiction it is only the High Court that can make that decision.

29. These prohibitions are reflected in domestic law. Regulation 25 of the 2018 United Kingdom Regulations provides (with our underlined emphasis):

> "25. (1) Subject to paragraphs (3) and (4), any relevant person who knowingly contravenes any of the prohibitions in paragraphs 1 or 2 of Article 14 of Regulation 996/2010 also contravenes these Regulations.
>
> (2) In paragraph (1) ″relevant person" means—
>
> (a) an Inspector;
>
> (b) any other officer of the Secretary of State; or
>
> (c) any person to whom any relevant record has been made available by such an Inspector or other officer.
>
> (3) Paragraph (1) does not apply to information which is included in a final safety investigation report.
>
> (4) Paragraph (1) does not apply where a relevant person makes a relevant record available to another person ("person A") in the following circumstances—
>
> (a) in a case where person A is a party to or otherwise entitled to appear at judicial proceedings and the relevant court has ordered

> that that record must be made available to person A for the purposes of those proceedings; or
>
> (b) in any other case, where the relevant court has ordered that that record must be made available to person A for other specified purposes.
>
> (5) The relevant court must not make an order under paragraph (4) unless it is satisfied that the benefits of the disclosure of the record concerned outweigh the adverse domestic and international impact which the disclosure might have on the safety investigation to which the record relates or any future safety investigation.
>
> …".

30. A "relevant record" for the purposes of Regulation 25 of the 2018 UK Regulations means any of the records specified in paragraphs 1 and 2 of Article 14 of the EU Regulations (which we have set out at [25] above).

31. It is a criminal offence to violate the Regulation 25(1) provisions: see Article 29 of the 2018 UK Regulations read together with section 75 of the Civil Aviation Act 1982.

32. Although all material under Article 14 of the EU Regulation is protected, and cannot be disclosed without an Order of the High Court, the particular sensitivity of cockpit recordings (the main material in issue before us) is given particular emphasis. The legislative scheme and international law recognise that they need to be afforded greater protection than other materials.

33. In this regard, we note that in Standard 5.12 of Annex 13 there is a distinction drawn between cockpit voice and image recordings which are always protected, in anyone's custody or control (Standard 5.12(a)), and the other records which are protected only where they are "in the custody or control of the accident investigation authority" (Standard 5.12(b)).

34. Further, Annex 13 (as amended since the *Sussex* case) makes clear that where an application is made to the competent authority for disclosure to the public, the balancing test will apply for other items, but cockpit footage should not be disclosed to the public under *any* circumstances. See, in this regard, Edis J's analysis in the *BBC* case at [7]-[8], which we respectfully adopt. We will refer to the *BBC* case in more detail below.

35. The EU Regulations also reflect the difference between Arts.14(1)(a) and (c)-(f), which relate to records obtained in or resulting from the investigation, and Art 14(1)(g), which refers to cockpit recordings without any such qualification.

36. Consistently with this, Sections 3.2.1, and 3.2.2, of the Manual also draw a distinction between cockpit voice and image recordings and other records. Cockpit voice and image recordings are protected from the time of an accident *regardless of who has custody*. By contrast, as regards other records, at Section 3.2.2 it is said that "…For other

records listed in Standard 5.12, protections are afforded *only when they are in the custody or control of the accident investigation authority*. …". (emphasis added).

37. Sections 3.1.4, 3.3.21 and 3.3.22 of the Manual (with emphasis added) provide:

> "3.1.4 In addition, and in agreement with Standard 5.12.5 of Annex 13, the public disclosure of highly sensitive accident and incident investigation records, such as audio content of cockpit voice recordings and image and audio content of airborne image recordings, must be prevented. The objective of preventing the public disclosure of those records is not only for safety enhancement but also to prevent privacy violation of persons involved and ensuring moral dignity (see section 3.5 for more details)".
>
> "3.3.21 Standard 5.12 of Annex 13 does not protect every record associated with an accident or incident investigation. So, there is a need to confirm the status of the record to determine its level of protection. For instance, CVRs and AIRs recordings as well as their transcripts, contemplated in Standard 5.12, a), are protected no matter who has possession of the recording or transcript. The protection afforded to CVRs and AIRs is based on the fact that these records are extremely sensitive and critical for the investigation. In fact, these types of recordings were installed onboard originally for accident and incident investigation purposes. The recordings usually contain some of the most critical information which help investigators understand how an accident or incident occurred. Any action that jeopardizes the future availability of this information jeopardizes aviation safety."
>
> "3.3.22 The records in Standard 5.12, b) are treated differently and the protections only apply when these records are in the custody or control of the accident investigation authority."

38. The Coroner recognises the importance of protecting cockpit footage but submits that there may be a distinction between different types of cockpit footage when it comes to protection. Ms Dolan QC (supported by Mr Forlin QC) tentatively submits that there may be a difference between footage from cameras which are required to be installed, and those which are not, such as Mr Hill's *Go-Pro* camera in this case. We do not accept that submission.

39. Firstly, no such distinction is to be found in the language of the legislative scheme. The term in Article 14(1)(g) of the EU Regulations (which is the binding instrument) bears its natural meaning ("*cockpit voice and image recordings and their transcripts*"), and applies to <u>all</u> such image recordings, regardless of whether the pilot was required to have installed the image recorder or not. In terms of Annex 13, the obligation in Standard 5.12.5 is in our judgment equally clear: "*States shall take measures to ensure that audio content of cockpit voice recordings as well as image and audio content of*

airborne image recordings are not disclosed to the public." The reference to *"image and audio content of airborne image recordings"* at Standard 5.12(a) is deliberately broad and intended to capture all airborne image recordings.

40. We were not persuaded by the Coroner's other arguments which we address for completeness. The definition of "*flight recorde*r" in the definitional part of Chapter 1 of Annex 13 does not assist in any way, as the phrases which are in issue are "*cockpit voice and image recordings and their transcripts*" in Article 14(1)(g) of the EU Regulations or "*Airborne image recordings*" in Annex 13 itself. These are plainly not synonymous with "*flight recorder*". The reliance by the Coroner on the definition of "*flight data recorder*" in a Note in Part 1 of Annex 6 (and Appendix 8) is similarly misplaced.

41. Secondly, having regard to the underlying rationale for the protection of 'cockpit footage' the absence of the distinction contended for in the language of the legislative scheme is not surprising. The evidence of the AAIB is that cockpit recording devices are required in some but not all aircraft. The AAIB is right to say that image recordings provide significant and unique evidence which can greatly assist in the effective investigation of accidents and the ability to identify measures to prevent reoccurrence. This benefit is the same, as is the risk of discouraging the fitting such devices, regardless of whether the image recording is from a device that was required to be fitted, or was fitted voluntarily for any reason.

42. In our view therefore, the courts in the *Sussex* and *BBC* cases were correct to proceed on the basis that the *Go-Pro* footage was protected material.

43. It follows that the footage and the evidential material in the trial which is derived from or which refers to that footage, is protected material within the 2018 United Kingdom Regulations and may only be disclosed to the Coroner where the High Court is satisfied, pursuant to regulation 25(5) of the 2018 United Kingdom Regulations: "*that the benefits of the disclosure of the record concerned outweigh the adverse domestic and international impact which the disclosure might have on the safety investigation to which the record relates or any future safety investigation.*"

44. It is common ground that this is a high bar, as the courts in the *Sussex* and *BBC* cases held.

Coronial law

45. When conducting an investigation into a death, the Coroner has a duty to conduct a full, fair and fearless investigation: see the well-known observations of Sir Thomas Bingham MR in *R v HM Coroner for North Humberside and Scunthorpe ex parte Jamieson* [1995] 1 QB 1 at 26.

46. 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.

47. At the end of the inquest the Coroner, or jury if there is one, must record a conclusion as to the death 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.

48. The role of an inquest where a death has occurred following an air accident has been considered by a Divisional Court in the *Norfolk* case. It is common ground between the Coroner, the Police and the AAIB, that the approach set out in that case should be followed by the Coroner in respect of these inquests. The *Norfolk* case was heard by the same constitution at the same time as the *Sussex* case.

49. The context in which the *Norfolk* case was decided is instructive. It concerned an analogous situation to that before us, namely a fatal air crash (in that case resulting in the deaths of four men) that had caused public concern. By the time of the inquest, the AAIB had, produced its final report. The Divisional Court in *Norfolk* was aware of the pending inquest into the Shoreham air crash and must have had it in mind when giving judgment.

50. The central issue in the *Norfolk* case was whether a coroner could compel disclosure of protected material. The answer to this question (which was in the negative) depended on an analysis of two legal regimes, that governing inquests and Coronial law, and the EU regime which governs air accident safety investigations, conducted in the UK by the AAIB. We have set out the material legal provisions above.

51. Having analysed that regime at Singh J concluded [49]:

> "49. Finally, in my view, it is important to emphasise that there is no public interest in having unnecessary duplication of investigations or inquiries. The AAIB fulfils an important function in that it is an independent body investigating matters which are within its expertise. I can see no good reason why Parliament should have intended to enact a legislative scheme which would have the effect of requiring or permitting the Coroner to go over the same ground again when she is not an expert in the field. The Coroner's functions are of obvious public importance in this country and have a long pedigree. In recent times they have to some extent been extended, as Ms Hewitt has reminded this Court, in order to ensure compliance with the procedural obligations which may be imposed on the state by Article 2 of the Convention rights. However, none of that, in my view, points to, still less requires, an interpretation of Sch. 5 to the 2009 Act which would have the effect for which Ms Hewitt contends. On the Secretary of State's interpretation, there will still remain the possibility of disclosure being ordered – but that

disclosure can only be ordered by the High Court, which must weigh the different public interests in the balance, as required by Regulation 18 of the 1996 Regulations."

52. Lord Thomas CJ agreed with Singh J's judgment and said at [55]-[57]

"55. I consider it important to underline the significance of paragraph 49 of the judgment of Singh J in the light of the submission made to us on behalf of the coroner that she had a duty to conduct a full inquiry into the accident as a death had occurred during the accident. The submission reflected the tendency in recent years for different independent bodies, which have overlapping jurisdictions to investigate accidents or other matters, to investigate, either successively or at the same time, the same matter. On occasions each body considers that it should itself investigate the entirety of the matter rather than rely on the conclusion of the body with the greatest expertise in a particular area within the matter being investigated. The result can be that very significant sums of money and other precious resources are expended unnecessarily.

56. The circumstances of the present case provide an illustration of what in many cases will be the better approach. There can be little doubt but that the AAIB, as an independent state entity, has the greatest expertise in determining the cause of an aircraft crash. In the absence of credible evidence that the investigation into an accident is incomplete, flawed or deficient, a Coroner conducting an inquest into a death which occurred in an aircraft accident, should not consider it necessary to investigate again the matters covered or to be covered by the independent investigation of the AAIB. The Inquest can either be adjourned pending the publication of the AAIB report (as the Memorandum of Understanding between the Coroners Society and the AAIB and others dated May 2013 (MoU) suggests) or proceed on the assumption that the reasons for the crash will be determined by that report and the issue treated as outside the scope of the Inquest.

57. It should not, in such circumstances, be necessary for a coroner to investigate the matter *de novo*. The coroner 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. There may be occasions where the AAIB inspector will be asked to give some short supplementary evidence: see, for example, *Rogers v Hoyle* [2015] QB 265 at paragraph 94. However, where there is no credible evidence that the investigation is incomplete, flawed or deficient, the findings and conclusions should not be

> reopened. It is clear that the terms of the Coroners (Inquests) Rules 2013 require some further elucidation to set out clearer provisions to deal with these issues; no doubt the Chief Coroner can in conjunction with the Coroners' Society and other interested parties consider what is necessary. It would also be desirable for the Chief Coroner to reconsider the terms of the MoU with the AAIB in the light of the judgments in this case and for the future be responsible for the guidance and arrangements contained within the MoU."

53. The observations of Christopher Clarke LJ in *Rogers v Hoyle* [2015] QB 265 (made in the different context of the admissibility of such a report in civil proceedings but cited by Lord Thomas CJ in *Norfolk*) underline the value of AAIB reports:

> "80. First, the Report is, as I would hold, admissible evidence. It is also of particular potential value on account of (i) the independence of the AAIB; (ii) the fact that its reports will be the product of an impartial investigation into the causes of the accident by experts who are not concerned to attribute blame and in whose investigations injured passengers and the families of deceased passengers do not actively participate; and (iii) the fact that it has a much greater ability than anyone else to obtain and analyse data relating to an accident which is likely not otherwise to be available or only with considerable difficulty and at considerable cost. The circumstances in which it is appropriate to exclude evidence that is admissible and likely to be helpful must be limited. For the judge to be denied sight of a report of this character – authoritative, independent, prompt and detailed – and for any experts called to be unable to refer to it in court, when it is freely available to the public, is difficult to justify. Some measure of the value of AAIB reports is to be found in the fact that, according to the evidence of Mr Healy-Pratt, AAIB reports have been routinely referred to and used as evidence in English litigation; their use considerably assists the efficient and speedy resolution of claims; and the majority of potential civil claims arising from civil aviation accidents settle on the basis of AAIB reports."

54. We turn to the facts.

The AAIB Report

55. The Accident was investigated by the AAIB over a period of 18 months, leading to a lengthy report of 3 March 2017, presented to the Secretary of State ("the Report). We have considered the material parts of that Report, as identified by the parties. It shows there was a comprehensive investigation. The witness statement of Mr Julian Firth, Principal Inspector of the AAIB, describes in substantial detail the process undertaken

by the AAIB in the investigation (and further review in 2019), including the approach taken to the cognitive impairment issue. Given that the issue disclosure is said to go to is the safety of the AAIB's conclusions, we will set out some detail of the Report below in relation to the matter of cognitive impairment. Before we do so we will outline the role of the AAIB.

56. The United Kingdom has obligations under the Chicago Convention and the EU Regulations to carry out investigations into accidents and incidents which occur in association with the operation of aircraft. The AAIB carries out these investigations in accordance with the Civil Aviation Act 1982, as supplemented by secondary legislation.

57. The objective of AAIB investigations is to determine the circumstances and causes of the accident and to make safety recommendations, if necessary, with a view to the preservation of life and the avoidance of accidents in the future. It is important to stress that these investigations are not permitted to apportion blame or liability.

58. Returning to the investigation in this case, and by way of broad summary, the AAIB's investigation considered the circumstances in which the aircraft came to be in a position from which it was not possible to complete its intended manoeuvre, and the reasons for the severity of the outcome.

59. In the Report, the investigation identified the following causal factors in the accident:

    (i) The aircraft 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.

    (ii) An escape manoeuvre was not carried out, despite the aircraft not achieving the required minimum apex height.

60. The following contributory factors were identified:

    (i) The pilot either did not perceive that an escape manoeuvre was necessary, or did not realise that one was possible at the speed achieved at the apex of the manoeuvre.

    (ii) The pilot had not received formal training to escape from the accident manoeuvre in a Hunter and had not had his competence to do so assessed.

    (iii) The pilot had not practised the technique for escaping from the accident manoeuvre in a Hunter, and did not know the minimum speed from which an escape manoeuvre could be carried out successfully.

    (iv) A change of ground track during the manoeuvre positioned the aircraft further east than planned, producing an exit track along the A27 dual carriageway.

61. Regarding the severity of the outcome, it was said in the Report that:

(i) The manoeuvre took place above an area occupied by the public over which the organisers of the flying display had no control.

(ii) The severity of the outcome was due to the absence of provisions to mitigate the effects of an aircraft crashing in an area outside the control of the organisers of the flying display.

62. In respect of Mr Hill's actions, the investigation concluded, amongst other things, that: "There was no evidence of any g-related impairment of the pilot during the aerobatic sequence flown. If the pilot was unwell before the accident, it was not established in what way he was unwell or when the onset of any condition was first experienced". The Report said: "The g experienced by the pilot during the manoeuvre was probably not a factor in the accident."

63. Mr Hill's actions within the cockpit were considered in detail during the AAIB investigation. It was noted in the Report that evidence was limited because the pilot did not recall the accident and his plan for the display was not documented in detail. The AAIB said that it was not possible to draw firm conclusions about what influenced his performance on the day. The Report makes it clear that the footage and his physical movements as shown were considered as part of the exercise.

64. The AAIB sought to understand the factors that might have shaped Mr Hill's performance at points where decisions might have been taken that would have resulted in a safer outcome. In doing so, we note that the AAIB applied the experience of its own inspectors, including those familiar with fast jet operations, and the expertise of external consultants in aviation human factors and other disciplines.

65. The AAIB's analysis focused on two decision points where Mr Hill may have been able to recover from any deviations in the planned manoeuvres that had occurred and prevent the situation from progressing into an accident. These were the entry to the accident manoeuvre, and the apex of the accident manoeuvre. The Royal Air Force Centre for Aviation Medicine (RAFCAM) conducted a human factors analysis of these decision points for the AAIB. It used a range of evidence sources such as the cockpit action camera footage, results from flight trials and notes from interviews with Mr Hill.

66. The RAFCAM applied recognised systematic human factors analysis techniques. Its analysis identified the credible errors and performance shaping factors that could have been present at the entry to the loop manoeuvre, during the climb and at the apex of the manoeuvre. The factors identified were within the range of normal human performance in the circumstances and did not require any novel form of impairment. It was said that as far as could be determined from cockpit image recordings, Mr Hill appeared alert and active throughout the flight. This is of some significance given the assertions by Dr Mitchell that the footage might suggest some form of hypoxia-related cognitive impairment.

The AAIB Review and Supplemental Report

67. Following the acquittal of Mr Hill, further information and evidence was provided to the AAIB in respect of the Accident and a review ("the Review") was undertaken. On 19 December 2019 the AAIB published a Supplement to the Report ("the Supplement") as the result of the Review.

68. The nature of the Review is highly relevant to the issues before us and we will seek to summarise, in non-technical terms, the process and outcome.

69. The Review was conducted from June 2019 onward to determine if the additional information contained new and significant evidence of cognitive impairment. For the purpose of the Review, the AAIB defined cognitive impairment as a physiological state in which an individual cannot think as well as usual, so is less able to do a task reliably and the probability of error is increased. It accordingly approached this issue on a broad basis without seeking to narrow the cause of potential impairment to any specific factor.

70. As part of the process of considering the significance of the new material presented, the Review applied additional modelling techniques to determine the aircraft's flight path, and to provide more detailed estimates of +Gz (that is, the "head to foot" acceleration experienced by the pilot, normal to the flightpath), in the manoeuvres preceding the crash. We note that the Review involved other Inspectors, who had not been part of the original AAIB investigation.

71. The Review team included an Inspector (Human Factors), an Inspector (Recorded Data) with expertise in aircraft performance, and two Inspectors (Operations) who were formerly fast jet pilots with experience in instruction and display flying.

72. During the Review, videos of the accident flight and previous displays and practices by Mr Hill at Shoreham in 2014, Duxford 2014, Bray 2015, Shuttleworth 2015 and Eastbourne in 2014 and 2015 were re-examined by the two AAIB Inspectors of Air Accidents (Operations). Their experience included flying, displaying and instructing in various aircraft types including the Hunter.

73. These Inspectors, familiar with observing students while sat behind them in tandem cockpits, concluded that Mr Hill's head and body movements were consistent with what they would expect from someone flying a loop manoeuvre. It is significant that they did not observe any significant differences in behaviour between the accident flight and previous displays, and they could not identify a point at which Mr Hill's behaviour changed in an observable way that would indicate impairment of any type.

74. Given the nature of Dr Mitchell's opinions in his Paper, we should note that one of the aeromedical experts reviewed the cockpit action camera footage preceding the Crash and the Shoreham display in 2014. He explained that these showed, among other things, behaviour he described as an example of optokinetic cervical reflex (which we understand is simply head-tilt). The evidence is that this is a well-documented phenomenon in low-level flight in visual meteorological conditions, in which a pilot orients their head with respect to the visible horizon rather than the aircraft's attitude. This aeromedical expert noted that "the presence of these typical flight-related head movements is entirely consistent with normal, routine flight operations." Of significance is that he concluded: "there was no discernible significant difference between the head movements of the pilot in either of the two flights. What movements were seen were entirely consistent with a pilot attempting to maintain an adequate lookout during low-level aerobatic manoeuvring*"*.

75. We have here only touched at a high level upon a very detailed analysis in the Review of the cognitive impairment issue, which Mr Firth's addresses in his witness statement in more detail.

76. Overall, the Supplement concluded that following the Review:

> "The AAIB found no new and significant evidence of cognitive impairment. There are credible alternative explanations for the pilot's actions which are supported by evidence presented in the AAIB final report and are considered more likely. The findings of the AAIB investigation remain valid.".

77. So, in short, the AAIB found that the forces experienced on the accident flight were unlikely to have affected Mr Hill's flying, although it has not ruled out cognitive impairment as a factor in the accident.

The CAA Investigation

78. Independently of the AAIB, the Civil Aviation Authority ("CAA") also carried out a broader review of whether there was a risk to civil aviation safety from cognitive impairment in pilots experiencing low level g-forces at levels, and for durations, likely to be experienced in commercial and recreational, civil air operations. The results were published in a report entitled "Enquiry into the Risk of Cognitive Impairment Due to G Forces" in December 2020.

79. This report stemmed from the suggestion during Mr Hill's criminal trial that g-forces may have affected his cognitive abilities. The CAA's conclusions included that there was no identifiable risk of cognitive impairment in civil pilots experiencing g-forces at levels, and for durations, consistent with those stated by accident investigators as having been experienced by Mr Hill. As between all parties save for Mr Hill (who did not express any view) it was common ground that the conclusions of the CAA were entirely consistent with those of the AAIB.

The Chief Constable seeks disclosure for the criminal proceedings

80. As part of the Police's investigation, the Chief Constable made an application in 2016 to the High Court for disclosure of certain materials held by the AAIB pursuant to regulation 18 of the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 1996 (SI 1996 No. 2798) ("the 1996 Regulations"), the predecessor to the 2018 UK Regulations.

81. Of the items sought, the Divisional Court (Lord Thomas CJ and Singh J) ordered disclosure of only a single item: the *Go-Pro* cockpit footage from cameras that Mr Hill had fitted to the aircraft for leisure and private commercial purposes, refusing all other applications. This was the *Sussex* case which, as we have explained, was decided at the same time as the *Norfolk* case. The Court's order permitted the Chief Constable to use this film footage for the purposes of the criminal investigation, and also permitted its onward disclosure to any experts instructed by the Police or CPS in furtherance of their investigation, and any experts instructed by the CPS.

82. The Divisional Court's order also provided that the material, as well as "the results of any analysis" and "any subsequent opinion" (so including reports based on that footage)

would remain protected and that: "The material shall be returned to the AAIB at the conclusion of any criminal proceedings".

83. Following the obtaining of this footage, the Police investigated the matter and in due course the CPS decided to charge Mr Hill and proceed to trial. However, due to error or misunderstanding by the Police or CPS and miscommunication between them and the AAIB, no application was made by the Police or CPS for them to use the protected material (the film footage) during the criminal trial, or for Mr Hill's experts to have access. This difficulty only came to the attention of the Police and CPS after the trial had started and Edis J had empanelled the jury. As a result, a series of urgent Part 8 applications were made by the Police and CPS to the Judge, sitting in his capacity as a High Court judge, for permission for use of the protected material in the trial.

84. Edis J granted permission for its use in certain respects in a series of 5 decisions as follows: (i) Ruling of 14 January 2019 for retrospective permission for Mr Hill's experts to have access to the material, and for permission for the CPS and Defence to use the protected material during the trial; (ii) Ruling of 23 January 2019 in respect of test results concerning a piece of equipment on the aircraft; (iii) Judgment of 1 February 2019 in respect of the evidence of the individual referred to as "Image Analyst 1"; (iv) Judgment of 5 February 2019 in respect of the use of the cockpit footage during the trial; and (v) Judgment of 8 February 2019 in respect of certain items of protected material used as evidence. We have been provided with these rulings/judgments and the parties have identified the relevant aspects. These rulings all (rightly) proceed on the basis that the footage is protected material, as we have described above.

85. We note that these rulings and judgments were made in the particular context of the criminal trial which had just commenced at the Old Bailey. Due to misunderstandings, the court was faced with a pressing situation where the public interest in disclosure was of a serious nature. Edis J explained in his judgment of 23 January 2019 that:

> "The general rule that the court will apply is that, rather than seeking to ascertain what the AAIB discovered, the police should carry out their own independent investigation which may or may not arrive at the same conclusions. For reasons I have attempted to explain, that cannot be done in this situation.
>
> …
>
> It seems to me that the additional damage to the integrity of the air accident investigation system which will transpire from the order I propose to make is much less serious on these particular facts than would generally be the case. It also seems to me that, where, as a result of a completed criminal investigation, a jury trial is on foot in which the jury is considering 11 counts of homicide, the interest in public justice is unusually high. And, therefore, it seems to me that both sides of this balance are unusual but that, on the particular facts of this case, I should make the order sought. It follows, I trust, from the way in which I have sought to express myself, that the decision I have made offers no departure from the principles set out in the Convention and the two sets of regulations and the manual. This is a highly fact

> specific decision on facts which are likely to be highly unusual, if not unique".
>
> (The "manual" referred to be Edis J is the ICAO manual, to which we have made reference above)

86. Edis J also had to determine a Part 8 Claim (the *BBC* case) made on behalf of the Press Association and the BBC, seeking to obtain the protected cockpit video footage that was being played during the trial for use in the press. Despite recognising at [21] "that there is a strong presumption in the criminal courts in favour of open justice, and that release of material produced in evidence to the media for the purposes of fair reporting is an essential part of that", he refused the application based on the principles in the Chicago Convention and the EU Regulations, as interpreted by the Divisional Court in the *Sussex* case.

87. The criminal proceedings concluded on 8 March 2019 and the Inquests were reactivated.

The Mitchell Paper

88. Dr Chris Mitchell is a friend of Mr Hill. He has prepared a research paper dated 12 September 2020 entitled *Cognitive Impairment in Fast Jet Flight* ("the Mitchell Paper"). In this paper, Dr Mitchell offers a theory on the issue of cognitive impairment as it may have applied in the Accident. In particular, he postulates what he describes as a "mechanism" of cognitive impairment (caused by cerebral hypoxia) which he suggests the AAIB did not consider in its various reports. His focus is on a pilot's "head tilt" in the Hunter, which he says is "fundamental to understanding the possible explanation of the Shoreham accident". That head tilt is suggested to cause hypoxia because, together with the effect of the pilot's helmet and lifejacket, it may have caused a significant reduction in blood flow in the arteries to the brain.

89. Dr Mitchell recognizes that this theory is rather unorthodox and prefaces the Paper by observing that the form of cognitive impairment he postulates is "neither widely recognised nor accepted by the aviation medical community".

90. Dr Mitchell does not express any final conclusions as to whether there was cognitive impairment accounting for the crash, but proffers his Paper to the Coroner for the following purposes:

> "(22) This version of the paper is intended to draw to the attention of the Senior Coroner the author's medical conclusions. This is not a formal paper or inquest submission. The author cannot be deemed an independent expert, nor has he been instructed by the Senior Coroner. The author is unable to be provided with, or refer to, much available evidence because of legal restrictions.
>
> (23) The Senior Coroner is recommended to evaluate the issues raised in this paper, and consider: (i) Appointing, for the purposes of the Coroner's Inquests, an independent expert to peer review this paper,

> and the conclusions and research papers referred to; (ii) Whether this paper (as presented or adapted) should be forwarded for consideration by other parties e.g. the CAA or AAIB".

91. We will return to the Mitchell Paper in more detail below but for present purposes we note the following:

    (i) The Paper is presented in the form of expert opinion of a medical and academic nature. Dr Mitchell is however not an expert in either aviation medicine or neurology. At the start of the Paper, it was recorded that Dr Mitchell is a paediatric oncologist and he offers no specific qualifications which would enable him to offer an expert opinion on the matter of cognitive impairment in the aviation context. On the face of the Paper, Dr Mitchell does not appear to be a suitably qualified expert in the relevant field.

    (ii) The Paper does not provide any indication of why and how Dr Mitchell came to write the Paper (as one would have in the form of an expert's instructions). See, by analogy, CPR 35.10(3) and Crim PR 19.4.

    (iii) Even though the Paper was not presented for proceedings to which the CPR applies, we note the Paper does not include in substance anything like the form of declaration to the Coroner specified in CPR 35.10 (in which an expert certifies their understanding of their overriding duties to the Court). See also Crim PR 19.2.

    (iv) Dr Mitchell accepts that he is not independent.

The Coroner's application to this court

92. The Coroner made a ruling on 21 April 2021 ("the Ruling") on the issue of whether there were any matters already investigated by the AAIB which she would need to reinvestigate. It is on the basis of the Ruling, and for the reasons set out in her helpful witness statement, that the Coroner has made the present application.

93. In the Ruling, the Coroner explained that she accepted that she should act in accordance with the principles established in the *Norfolk* case. We have set these out above. In practical terms, the Coroner said this meant that in the absence of evidence that the investigation into the Crash was "incomplete, flawed or deficient", she should <u>not</u> consider it necessary to re-investigate matters covered by the AAIB in its investigation. It is common ground that this was a correct direction in law.

94. With one exception, the Coroner ruled that, applying the *Norfolk* test, she should not reinvestigate any matters that had already been investigated by the AAIB. That ruling has not been challenged (although the Mr Hill's submissions appear to involve a collateral attack on it, as we describe later in this judgment).

95. The exception is "issue 7" of the Coroner's list of issues, namely:

> "7. The cause of the Hunter crashing including:
>
> • the extent to which, if any, the pilot's conscious and deliberate conduct caused or contributed to the crash;
>
> • the extent to which, if any, the pilot suffered a cognitive impairment which affected his flying abilities;
>
> • the extent to which any cognitive impairment found to have arisen caused or contributed to the crash."

96. At the core of the Coroner's reasoning for making this decision is the Mitchell Paper. Rather than paraphrasing her reasons we should set out her reasoning in the Ruling:

> "24. Dr Mitchell postulates three key contributory factors in relation to the Shoreham crash:
>
> "(i) The (almost uniquely) poor visibility from the Hunter T7 cockpit due to the canopy structure; and (as a consequence) the requirement, unlike other aircraft types, for significant head movement in order to maintain the visual reference in specific situations.
>
> (ii) The layout of the Shoreham display area, including unusual 'avoidance' areas, requiring adaptation of a typical display sequence, and necessitating atypical head movements to ensure compliance.
>
> (iii) Research conducted into the effects of +Gz on pilots being predominantly in centrifuges under academic conditions, specifically where the subject sits head upright and facing forward."
>
> 25. However, he asserts that the non-G force related factors effecting [sic] the Shoreham pilot cannot be fully explored since the evidential material is protected by the AAI Regulations. Dr Mitchell's substantive conclusions are, he states, restricted by the evidence that can be referenced by him.
>
> 26. The AAIB's submissions to me in June 2019 stated that "in respect of any issue of cognitive impairment suffered by the pilot, in the event that the Senior Coroner is in possession of relevant evidence that was not before the AAIB, the Coroner will need to decide whether the test set out by Lord Thomas is met". It is with those words in mind that I have decided to bring a part 8 claim.
>
> 27. Importantly the AAIB report 1/2017 appears to be silent on the mechanism of cognitive impairment now postulated by Dr Mitchell. Dr Mitchell's paper was produced in September 2020,

> almost a year after the AAIB declined to re-open their investigation in Autumn 2019, and so I do not understand it to have been available to the AAIB for their subsequent review
>
> ….
>
> 31. My duty is to conduct a full, fair and fearless inquiry in circumstances where the inquest's scope specifically includes consideration of the extent to which, if any the pilot suffered a cognitive impairment which affected his flying abilities and caused or contributed to the crash.
>
> 32. It appears to me that the matters raised by Mr Hill through Dr Mitchell's paper do raise a significant question as to whether the AAIB investigation is incomplete in this respect that I should further explore".

97. For completeness, we should set out the further explanation in the Coroner's witness statement as to the basis for the present application:

> "There has as yet been no determination in any investigation as to what, on the balance of probabilities, led to the plane being flown as it was. Mr Hill's defence at the criminal trial was that he had suffered a cognitive impairment, but his acquittal by the jury did not depend on the proof of an affirmative proposition to any standard. The AAIB Report reached no conclusion as to what probably occurred. As the AAIB later summarised the position "*the AAIB investigation considered possible reasons why the pilot entered and continued the accident manoeuvre, but could not determine which of these was the case. It found no evidence for cognitive impairment but did not rule it out."* The AAIB investigation found no evidence of g-related impairment of the pilot during the acrobatic sequence and the report concluded (at p.124) that it was 'unlikely that the pilot was partially or totally incapacitated by g-forces'. However, importantly, the AAIB's published report is silent on the alternative mechanism of cognitive impairment now being postulated by Mr Hill's medical expert, Dr Mitchell…"

98. Accordingly, the protected material is sought to assess whether the AAIB's conclusions on the cognitive impairment issue may have been incomplete. The Coroner considers that the Mitchell Paper raises what she has termed "a significant question" as to the completeness of the AAIB investigation. As we have said above, Ms Dolan QC also calls this a "credible suggestion".

99. On the basis of the Ruling, the Coroner seeks disclosure of the following 3 types of material in this application (which are each accepted to be protected material if the film footage is- as we have found- itself protected):

(i) The "Split screen footage". This is derived from the footage filmed by Mr Hill which was disclosed to the Police as a result of the *Sussex* case. The Police converted this footage to a "split screen" format, showing it alongside footage of a similar manoeuvre by Mr Hill on a different occasion.

(ii) The ten expert reports which were prepared for use in the criminal trial and which are said to deal with the issue of cognitive impairment. These reports are said to contain "analysis" and/or "subsequent opinion" based on the cockpit footage.

(iii) The transcripts of the evidence from the criminal trial, including those parts which reference the expert evidence referred to in item (ii) above and/or describe and analyse the cockpit footage.

100. Although the Coroner applies to obtain the material in order for her to assess whether there is credible evidence that the AAIB's investigation on this issue was incomplete, flawed or deficient (the *Norfolk* test), her draft order proposes that if she then decides that the investigation was incomplete, flawed or deficient, that she have permission to disclose the material to all Interested Persons in the Inquests, and to use the material (in public) in the Inquests. We note however that the putative public disclosure of the footage is subject to an absolute bar: see [34] above.

101. We understand that the provisional date for the start of the Inquests is currently 28 February 2022.

The disclosure arguments

102. In support of her application for disclosure, the Coroner submits that the AAIB's position that there is no public interest in re-investigation of matters investigated by the AAIB is misconceived and premature. Ms Dolan QC argues that the Coroner is not seeking to re-investigate those matters determined by the AAIB and her application relates to a very focussed and proportionate consideration a single issue, which may be of importance to the inquest. Ms Dolan QC further argues that before she determines whether or not it is "necessary" to traverse the very limited matters in issue, the Coroner must be in a position to assess such necessity. It is emphasised that she is faced with what is described in the Coroner's skeleton argument as "an expert medical report" and is unable to safely reject that report. It was also submitted that the consequence of the AAIB position is to restrain a proper judicial function and exercise. Overall, Ms Dolan QC argued that the Coroner wishes to make an assessment of *whether* Dr Mitchell's Paper is, or is not, 'credible evidence' and the AAIB investigation was incomplete, flawed or deficient. In oral submissions Ms Dolan QC underlined that it is not certain that the material would be deployed in the Coroners Court in any event, as the Coroner may yet conclude that it is not necessary to consider the potential issues under consideration.

103. Ms Dolan QC placed particular emphasis on the fact that the material sought to be considered by the Coroner has already been considered and shown in public proceedings in the criminal trial of Mr Hill. The families also emphasised this point. Ms Dolan QC also strongly relied upon the fact that the material is derived from a *Go-Pro* camera in circumstances where the owner of that camera and the footage (Mr Hill) positively wants his material to be deployed. In this regard, we were taken to the factors identified in Appendix 2, para.4 of Annex 13 (concerned with administration of the balancing test). It was submitted that it is difficult to understand how acceding to the application could sensibly have any chilling effect on the provision of material in support of future air accident investigations.

104. Mr Hill supports the Coroner's application but went further in submitting that the AAIB investigation *was* in fact incomplete, flawed and deficient (as opposed to the Coroner's position that she wished to investigate *whether* it was incomplete). In his OPEN and CLOSED submissions, he sought to persuade us that the AAIB's "human factors" analysis was deficient and stressed his desire that his own footage be shared with the Coroner. As to Dr Mitchell's expertise, Mr Hill submitted that the Mitchell Paper was not a matter of expertise, but "basic medicine" concerned with hypoxia. Without going into the CLOSED submissions he made, we note that he emphasized in particular, the issues concerned with his alignment with the A27 prior to the crash, and the issue of head tilt. He submits that the AAIB is using the regulations to close off any debate or examination or oversight of its investigation. He underlined that there is no appeal or complaints process available to him. It is clear to us that his complaints about the AAIB's reports go much further than the narrow point raised by the Coroner, and indeed he does not accept the limitations of the Ruling.

105. The families strongly supported the application and underlined their understandable concerns at the substantial delays and the need for them to understand how their loved ones came to die on the day of the Accident. We have described above Mr Forlin QC's challenge to the proposition that the footage is protected material.

106. In opposition to the application, the AAIB makes the following main points. First, Mr Beer QC emphasises the experience and independence of the AAIB and the fact that no aspect of its investigation and conclusion had been criticised by reference to the requirements imposed in the governing international law, EU law or domestic regimes. Second, he relies upon the fact that the Coroner was not able to say that she had credible evidence of incompleteness of the AAIB reports. Third, he submits that in all of the circumstances of this case (in particular the lack of credible evidence of incompleteness) the benefits of the disclosure sought by the Coroner do not outweigh the adverse domestic and international impact which the disclosure might have on the safety investigation or any future safety investigation. He said that in the absence of credible evidence that the AAIB's investigation was incomplete, flawed or deficient, the Coroner should not be permitted or required to investigate matters in order to assess whether such evidence might exist. Related to this, Mr Beer QC argued that the Mitchell Paper (authored by a person who is a paediatric oncologist and friend of Mr Hill), does not justify such further investigation by the Coroner.

Analysis

107. The concrete question for us to answer is whether we are satisfied, pursuant to Regulation 25(5) of the 2018 UK Regulations, that the benefits of the disclosure sought would outweigh the adverse domestic and international impact which the disclosure might have on the safety investigation or any future safety investigation.

108. There are two sides to this balancing exercise (a *harm* issue and a *benefit* issue) which are both fact specific:

(i) First, the *harm* or detriment that would be caused through disclosure, and the harm, in particular, to the AAIB's ability to improve safety through future investigations; and

(ii) Second, what the *benefit* would be from disclosure. That raises in a stark form the issue of why the Coroner seeks this material, in circumstances where the cognitive impairment issue has already been investigated by the AAIB (the *Norfolk* issue).

109. The Coroner relies strongly upon the conclusion in the *Sussex* case in support of her submission that the balance comes down in favour of disclosure. One however needs to approach comparisons with caution because each case depends on its own facts. In the *Sussex* case, it was common ground that to be balanced against the public interest in prohibiting disclosure, there was genuine public interest in the effective investigation and detection of crime by the police. Indeed, given that this was a criminal investigation a duplicative exercise was necessary because the AAIB report would not be admissible at trial. In the *BBC* case, Edis J had to consider the balance between the public interest in protection of the footage and the important principle of open justice. In each of these cases, it was a matter for the Court to weigh the particular public interests said to require disclosure against the harm that would be caused to air accident investigation in the future should disclosure be ordered. In the *Sussex* case the investigation and detection of crime interest won out for the limited category of the footage. By contrast, in the *BBC* case the public interest in protecting future air accident investigations prevailed over the open justice principle. We turn to the evidence on the competing public interests before us.

The harm issue

110. In respect of the harm to future safety investigations, it is helpful first to consider both the nature of the material sought to be disclosed, and the use to which it would be put. The items sought by the Coroner consist of the relevant cockpit footage, and products (including expert analysis) of that footage. The circumstances in which disclosure of any type of protected material will be ordered are very rare, as indicated in the case-law. As explained above, cockpit footage is given particular heightened protection. The prohibition reflects not only the fact that information provided by these devices is of crucial importance in a safety investigation but that they may contain highly sensitive or distressing material.

111. The importance of the non-disclosure of the footage was recognised by this Court's Order in 2016 in the *Sussex* case which required all of the items in question in this application to be returned to the AAIB at the conclusion of the criminal proceedings.

112. The particular reasons for this protection and the potential adverse impact on future domestic and international safety investigations are set out in the statement of Mr Firth. He has "*significant concerns about the effect of disclosure of the material at issue on the work of the AAIB"* and considers that "*disclosure of protected materials in circumstances where there is no benefit to be gained and where disclosure is not strictly necessary would have a serious adverse impact on the AAIB's ability to effectively investigate future accidents and incidents, both domestically and abroad*". Those concerns include in particular:

    (i) The regime in respect of protected material exists to encourage all those involved in air accidents or incidents, wherever in the World they take place, to cooperate freely, openly and willingly with air accident investigations being conducted within the regime, so that the air accident investigator can obtain best evidence, and therefore be put in the strongest possible position to prevent future accidents. There is therefore a strong public interest in air accident investigations being conducted under conditions of confidentiality;

    (ii) The voluntary goodwill and trust on which the AAIB depends is important for the following four main reasons: (i) The AAIB has no powers to compel individuals or organisations to act on their recommendations and relies on its reputation for thorough and impartial investigation to influence. (ii) The AAIB has, over its more than 100-year history, built a reputation for impartiality, confidentiality and independence throughout the aviation community worldwide, and it is this reputation that has consistently enabled the AAIB to successfully carry out its work and be viewed as a global leader in air accident investigation. (iii) The investigation of accidents and serious incidents requires full and frank cooperation on the part of all those able to assist the investigation. There is a public policy interest in ensuring maximum willingness of persons to co-operate with an AAIB investigation and ensuring that they do not withhold information or evidence which may inform the investigation. If protected materials were frequently disclosed to other parties for purposes other than the safety investigation, there is the possibility that it would deter some people able to assist in an investigation from doing so in the future. This would in turn impede the AAIB's effectiveness and jeopardise aviation safety. (iv) Although the AAIB has the power to summons witnesses to answer any question or produce any evidence under regulation 12 of the 2018 Regulations, in practice it is only rarely that the AAIB needs to rely on that power and a gentle reminder of the AAIB's powers is currently sufficient to secure cooperation. If protected materials were disclosed in a wider range of circumstances, co-operation in future may be less forthcoming.

113. We accept this evidence. We consider it to be significant that Mr Firth is personally aware of occasions in the UK and abroad where the disclosure of cockpit recording devices for purposes other than safety investigation has directly influenced the behaviour of flight crews in a position to alter those recordings.

114. We accept the submission for the AAIB that one of the main benefits of the current culture of co-operation with AAIB investigations within the worldwide aviation community is that the AAIB generally receives prompt and direct access to the relevant witnesses and evidence. There is a justified concern that wider disclosure of protected materials would mean that witnesses would refer to, or be advised to refer to, their employer organisation (for example manufacturers, operators, regulators) before dealing with the AAIB. Employer organisations would be likely to refer the matter to their legal advisers with a view to the consideration of how evidence given at this time might have an effect on future litigation. This would slow down the progress of a safety investigation and could ultimately affect or delay the development and formulation of any safety recommendations. Again, there is evidence that there have been investigations in which this has occurred. Like Edis J in the *BBC* case at para. [16] we recognise real force in this "chilling effect" of disclosure on future investigations by the AAIB.

115. The evidence is also that experts providing opinions to the AAIB have become significantly more reticent in situations where it appears to them that their evidence to the safety investigation might be used in other ways. Mr Firth explains how several such experts, following an inquest in which their role in an AAIB investigation has become known, told him that they would not choose to assist the AAIB in future for this reason.

116. We also accept that because many investigations have an international dimension, there would be a significant potential adverse effect on the United Kingdom's relations with other States, international bodies and the aviation industry. If the AAIB's most sensitive records were disclosed (principal among them cockpit video and audio recordings and witness evidence), co-operation with other states' investigatory bodies and overseas manufacturers, operators and product designers would be much more difficult as they would seek to limit their own reputational damage. A consequence of that would be to the detriment of all involved in international civil aviation, as other states' investigatory bodies would no longer choose to involve the AAIB in international investigations – this is because they would deem them incapable of protecting even the most sensitive records. At worst, this could potentially endanger the safety of international civil aviation, if leaders in the field of accident investigation are excluded from investigations and the increased expertise that stems from performing them.

117. Mr Firth also stresses that cockpit recording devices are required in some but not all aircraft. There has been a long-term drive by air safety regulators over the last fifty years towards fitting recording devices in cockpits, firstly voice recorders and, latterly, image recorders. The AAIB's experience is that these can provide significant and unique evidence which can greatly assist in the effective investigation of accidents and the ability to identify measures to prevent their reoccurrence. Acceptance by those who resist the fitting of these devices depends on confidence that, in the event of an accident or reportable incident, the recorders will only be used for safety investigation purposes.

118. In our judgment, Mr Firth's evidence presents a compelling case that the release of the footage in the present case could have a chilling effect on the further progress not only of voluntary fitting of such devices but also the agreement of international standards and regulations to mandate the fitting of cockpit image recorders for safety purposes.

119. We note that Mr Firth makes the additional point that the risk to future safety investigations would be still greater if it is thought that the High Court will disclose protected material, simply because that material has been requested by a Coroner- i.e. in the absence of a determination that she needed to investigate for herself because there was credible evidence that the AAIB's investigation was incomplete, flawed or deficient. The perception of how loosely protected this material is by the UK would be very damaging, if it was granted simply in circumstances where a Coroner wants to assess, on a speculative basis, the cause of an accident for herself. This is a powerful point.

120. We also consider there is force in the AAIB's submissions as to the potentially vast numbers of persons to whom the materials might be disclosed if released for use by the Coroner. They are right to have concerns over the possibility of disclosure of what is sensitive material on such a wide scale. We accept that should it become known to the civil aviation community in the UK and internationally that sensitive material provided to the AAIB which is protected was being disseminated in this way, then the AAIB's capacity to investigate future accidents, both in the UK and worldwide, and thereby prevent future deaths through safety learning, would be compromised.

121. BALPA has provided a witness statement from Mr Stembridge-King. BALPA represent, for the purpose of these proceedings, the position of pilots generally. BALPA's evidence, which we accept, is relevant as it emphasises the importance of not damaging the trust in protection of sensitive material, the wariness that pilots would have in cooperating with the AAIB if they knew that material could be disclosed further, and the terms of the advice that they give to pilots in their role as a membership organisation. These echo concerns raised by the AAIB.

122. The *harm* side of the balance clearly has very substantial weight on the evidence before us.

The benefit issue

123. We accept that coroners' inquests are of great importance. However, whereas a criminal investigation fulfils a very different public interest to that of an AAIB investigation (being to establish blame and fault), a Coroner's investigation fulfils a similar and overlapping role to the AAIB, to consider the cause of an accident in order to answer the statutory questions which we have set out above at [47].

124. In *Norfolk* at [80], Lord Thomas CJ emphasised the evidential value of an AAIB report based on its status and expertise:

> "First, the report is, as I would hold, admissible evidence. It is also of particular potential value on account of (1) the independence of the AAIB; (2) the fact that its reports will be the product of an impartial investigation into the causes of the accident by experts who are not concerned to attribute blame and in whose investigations injured passengers and the families of deceased passengers do not actively participate; and (3) the fact that it has a much greater ability than anyone else to obtain and analyse data relating to an accident which is likely not otherwise

> to be available or only with considerable difficulty and at considerable cost."

125. In our judgment, the starting point is therefore that there is no public interest in reinvestigation to put into the balance in the exercise under Regulation 25(5) of the 2018 UK Regulations. An important and narrowly prescribed exception to this position is a situation where, as Lord Thomas CJ explained in *Norfolk,* there is credible evidence that the AAIB's investigation is incomplete, flawed or deficient: see [53] above for the full citation from Lord Thomas CJ.

126. It is clear why such a strict requirement is imposed: anything less would open the door to wasteful and duplicative reinvestigation by coroners. "Credible evidence" is the condition precedent or gateway - it is an important control mechanism.

127. The situation postulated by the *Norfolk* test is intended to cover the rare case where there might be an obvious deficiency in an AAIB's investigation. We agree with the AAIB that it was not intended that, on a topic of complexity and technical difficulty, where different experts hold different views (as is recognised by the AAIB in Mr Firth's evidence) that a coroner (who is "*not an expert in the field*") would need to seek a range of independent expert opinion, based on material that she would obtain, in order to test whether the AAIB's conclusions were correct or incomplete. Rather, the Coroner should "*rely on the conclusion of the body with the greatest expertise in a particular area"* (adopting the language used by Lord Thomas CJ).

128. We reject the Coroner's submission that the prohibition in *Norfolk* on her reinvestigating matters already investigated by the AAIB does not preclude her seeking protected material and expert opinion to determine *whether* she has credible evidence that the AAIB's investigation was incomplete, flawed or deficient. That would re-write the *Norfolk* test and make it weak to an extent that would seriously undermine its purpose, which is avoiding duplication of investigation by a non-expert body. The weakness of the test proposed by the Coroner is well-evidenced on the facts of this case where merely a *credible suggestion* of hypoxia related cognitive impairment in the Mitchell Paper (authored by a non-expert) is relied upon to open up the cognitive impairment issue and seek disclosure.

129. It is also significant that in *Norfolk* the Divisional Court's judgment was not confined to what should happen at the substantive inquest hearing – indeed, in deciding on disclosure, the Court was addressing what will inevitably happen *before* substantive hearings start. Whilst in this case the Coroner has not yet started the substantive hearings in the Inquests, she not only commenced her investigation under section 1 of the Coroners and Justice Act 2009, but has opened her Inquests under section 6 of that Act, and is clearly carrying out "investigation" for the purposes of the application of *Norfolk*. There is no basis for the submission made on her behalf that there are two stages in her investigation and that the strictures of *Norfolk* do not apply to what she would characterise as the first stage.

130. We accept that the extent of legitimate consideration of matters considered by the AAIB that a coroner can undertake at early stages in an investigation is a matter of fact and degree. If it is suggested (for example by an Interested Person) that an AAIB investigation is incomplete or flawed, then a coroner is entitled to consider this and

make a decision. This is intended to be a decision taken primarily on the basis of information available to the coroner, and with due regard to the specialist expertise of the AAIB and a corresponding threshold applied to that decision-making. A coroner should be very slow to find credible evidence that an expert investigation was incomplete, flawed or deficient.

131. However, to seek disclosure, and then new expert opinions, merely because an Interested Person in the Inquests (in this case Mr Hill) has identified an individual who takes a potentially different view from the AAIB, would amount to precisely the reinvestigation cautioned against in *Norfolk*. In our judgment, it is wrong in principle for the Coroner to seek protected information before determining that there is at least credible evidence the AAIB investigation *was* incomplete flawed or deficient. Having agreed that test is not met, her position in this case relies upon erecting a new and weaker test enabling her to apply for disclosure when there is merely a *credible suggestion* that the AAIB report was incomplete, flawed or deficient. It was put in another way by Ms Dolan QC when she argued that the theory in the Mitchell Paper was "not implausible". These tests do not reflect the law stated in *Norfolk*.

132. In any event, the AAIB is right to submit that in order to have made this application, the Coroner must have decided that Dr Mitchell's report ***might*** in principle be capable of amounting to credible evidence that the AAIB's investigation was incomplete, flawed or deficient.

133. Even such a formative or provisional conclusion was, in our judgment, not open to the Coroner for the following reasons:

(1) First, Dr Mitchell's professional position and standing mean that his Paper would never amount to credible evidence or even credible suggestion. He would not have the relevant expertise had a party sought to adduce his Paper in civil proceedings or criminal proceedings. While that is not determinative in the coronial proceedings, it is a highly material factor when one comes to assess the safety of using the Mitchell Paper as a launch-pad for a disclosure application. The evidence before us demonstrates that the issue of cognitive impairment is difficult, and has been the subject of careful analysis by the expert independent body (the AAIB) with input from RAFCAM, and by the CAA in an entirely separate study. The AAIB approached the issue with a wide focus. We have set out some of the detail of their careful and independent examination of this issue above. By contrast, Dr Mitchell is not, and indeed does not claim to be independent. He is a friend of Mr Hill and provided the Paper to assist him. He is not an expert in either aviation medicine or neurology, nor indeed in any other medical field that is concerned with cognitive function. Dr Mitchell is undoubtedly a paediatric oncologist of substantial experience but in his Paper he appears merely to have made a study of academic papers outside his field. In our judgment, Dr Mitchell could not even potentially provide credible expert evidence (or a credible suggestion) that the AAIB's investigation of this issue was incomplete, flawed or deficient. There can be little doubt but that the AAIB, as an independent state entity, has the greatest expertise in determining the cause of an aircraft crash. The Mitchell Paper is not a safe basis to argue that the AAIB's conclusions on the issue of cognitive impairment were even arguably incomplete. We note that the highest that his relevant qualifications to opine on

these issues was put by the Coroner was that he was a medically qualified person who was a FRCP.

(2) Second, it may be that experts might be found who take a different view from that of the AAIB. That would not mean that there was arguably credible evidence that the AAIB's investigation (whose conclusion was consistent with the subsequent independent review by the CAA) was incomplete, flawed or deficient. We accept the point made by Mr Firth in his evidence:

> "55. If it were possible to establish that the mechanism for cognitive impairment proposed by Dr Mitchell were plausible, it would simply become another possible mechanism for an impairment of which there was no evidence. By analogy, as revealed in the Supplement, it was in theory possible, at the margins of current aeromedical understanding, for an individual human to be affected by the levels of Gz likely to have been experienced by the pilot during the accident display. However, as an outlier, it was considered unlikely in this case. Dr Mitchell's theory, if plausible, would have the same character – it might be possible but would not change the balance of expert opinion on the available evidence.
>
> 56. Dr Mitchell has said that he requires the protected material to complete his analysis. However, completing his analysis would not resolve the matter of whether on the balance of probabilities the pilot was cognitively impaired – it would simply add a possibility of something for which there is no evidence. Consequently, access to the protected material sought cannot resolve the matter any more finely than has already been achieved in an 18-month specialist investigation by the State Authority, dedicated to that purpose."

(3) Third, on the evidence before us the protected material would not in fact enable Dr Mitchell to reach a conclusion that was more complete. We note that the Mitchell Paper states: "This paper is incomplete and is significantly impeded in being unable to provide substantive conclusions supported by clear evidence". However, as explained by Mr Firth, the cockpit image recordings provide no "clear evidence" of a sort that is not already known: the nature of the cockpit video, in terms of the things in view, is a matter of public record both in the Report and the Supplement, and the AAIB and all of the experts it consulted consider that it contains no evidence of cognitive impairment. Dr Mitchell himself appears to concur, stating in his Paper that: "The evidence available to the AAIB could not provide direct evidence of impairment."

134. In our judgment, no public interest purpose is served by disclosing the protected material for use by Dr Mitchell or other experts who may be appointed by the Coroner to reinvestigate the cognitive impairment issue. As this is the basis for the Coroner's application, there is no benefit in its disclosure to her.

135. In short there is neither credible evidence nor (even adopting her approach) a credible suggestion that the AAIB investigations were incomplete, flawed or deficient on the issue of cognitive impairment. The fact that Mr Hill wishes his own footage to be disclosed is of little weight in this context.

136. There is no public interest benefit against which to balance harm that would be caused by disclosure. The Coroner's application must accordingly fail.

137. For completeness, we should record that we do not accept that the law on standard of proof as articulated in *Maugham* and Mr Hill's acquittal make any difference to the approach to *Norfolk* issues, as argued by certain parties. At the level of principle, there should not be duplicative investigations whether or not there has been a criminal prosecution preceding an inquest. That fact does not dictate whether something less than credible evidence of deficiencies in an AAIB investigation should be required before such an investigation is reopened.

Mr Hill's submissions

138. As we have said above, aside from supporting the Coroner's application, Mr Hill seeks to make a broader attack in OPEN and CLOSED submissions on the AAIB investigation. He argues that the Coroner should have considered a wider range of issues. His evidence and that of Mr Verrall (both OPEN and CLOSED) go substantially beyond the narrow issue of hypoxia related cognitive impairment postulated in the Mitchell Paper and involve attacks on a number of broad fronts on the AAIB's approach and conclusions. They complain, for example, in relation to the AAIB's conduct of test flights and comparisons between its investigation on medical matters compared to that of the Rail Accident Investigation Branch in relation to the Croydon Tram Crash. We cannot entertain those challenges made under the cover of the Coroner's application which has a limited focus.

139. That is for three reasons. First, we are not an appeal court from the AAIB. Second, insofar as Mr Hill had any complaint about the narrowness of the Coroner's Ruling (and the limitations she determined as to the scope of the further investigations), it is not appropriate for this Court to entertain a collateral challenge to it on the back of submissions made by a defendant to the main application. Thirdly, in any event, we consider the Coroner's refusal to examine wider issues addressed by the AAIB was plainly correct for the reasons given in her Ruling which was (in that regard) consistent with *Norfolk*.

Conclusion

140. The application is dismissed.