SUBMISSION

FOR

MARY KAVANAGH

IN THE

INQUIRY INTO THE DEATHS OF

GARY LOUIS ARTHUR

ANTHONY LYNDON COLLINS

JOSEPH ROBERT CUSKER

COLIN GIBSON

ROBERT JAMES JENKINS

JOHN MCGARRIGLE

SAMUEL BELL MCGHEE

KIRSTY MARY NELIS

MARK EDWARD O'PREY

DAVID IAIN TRAILL

INTRODUCTION

This inquiry is being held as a result of the deaths of 10 people in the incident at the Clutha Bar, Glasgow on November 29th 2013. On this date, the police helicopter G-SPAO crashed onto the roof of the premises causing the roof to collapse into the premises.

The governing statute is the Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Act 2016 (2016 asp 2).

Mary Kavanagh was in the Clutha on the night of the incident in the company of her partner Robert Jenkins.

She escaped from the bar after the crash but her partner was killed.

Mary Kavanagh has never in any way been motivated by a desire to see blame attributed to anyone be they individual or organisation.

However, she does seek an answer to a simple but crucial question.

Why did she and her partner go out for a pleasant evening and yet she had to go home alone while the man she loved lay dead in the rubble of the Clutha?

It is submitted that this is a question she is entitled to have answered and that there is an obligation on the Inquiry to seek to provide that answer.

PRELIMINARY MATTERS

Two preliminary issues are raised on behalf of Mary Kavanagh.

The Inquiry first heard evidence at Hampden Park, Glasgow on 8th April 2019. This was five and a half years after the incident. This is a delay, which is unacceptable and unconscionable and would be regarded as such by any reasonable individual. The Report of the Air Accident Investigation Branch has been available since it was published on 23rd October 2015.

The families of those who died, and those who survived but were injured, have been kept waiting for this length of time and, so far, no explanation for the delay is known to have been forthcoming.

The Court is invited to comment adversely on delay of this length failing which to stress the desire for inquiries such as this to be commenced as soon as possible after the originating incident has occurred. If there appears to be a delay, which is not explained, the Court is invited to indicate that the Crown will be expected to provide a full and public explanation for any such delay.

Reference is made to the Act of Sederunt (Fatal Accident Inquiry) Rules 2017 rule 2.2 which sets out the principle that "An inquiry is to be progressed expeditiously and efficiently, with as few delays as possible."

The delay militates against the interests of the people who matter most, namely those who died, their families and those who were injured.

This group of people have hardly featured in the Inquiry.

At the start of the Inquiry, it was permitted that a statement might be read out containing reflections of and on behalf of the dead.

Thereafter, those who died have merited scarcely a mention.

It is of course accepted that Joint Minutes were read in open court dealing primarily with pathology.

However, no evidence has been led about the precise circumstances in which they as individuals came to die.

No evidence has been led to explain why they died while others survived.

No evidence has been led from the emergency services to explain what was done to try to save them, if anything.

No evidence has been led to show what more, if anything, could have been done to save them.

It is submitted that these are matters, which ought to be canvassed by evidence in a public inquiry such as this.

It is submitted that this is what people would wish to know and are entitled to know.

The onus of proof is on the Crown in an Inquiry such as this.

It is submitted that the 2016 Act is designed to prevent, or at least militates against, this happening and that this is a fundamental flaw in this piece of legislation.

Those who died are men and women who individually died alone and without the comfort of those who loved hem and cared for them.

The court is urged to comment on this matter in a way, which is supportive of the above narrated submissions.

SUBMISSIONS ARISING FROM THE EVIDENCE LED

On the evening Friday 29th November 2013, the helicopter G-SPAO was involved in police operations in central Scotland. The aircraft was a two-engined EC135 T2+ Eurocopter.

Its crew consisted of the pilot David Ian Traill and two police observers, Anthony Lyndon Collins and Kirsty Mary Nelis. Each of these three was well qualified and experienced in their respective roles.

The helicopter was returning to its base at Glasgow City Heliport. When it was approximately 2.7 nautical miles from this destination the left engine flamed out. Approximately 32 seconds later the right engine flamed out.

The fuel to power the engines was provided from a main fuel tank via supply tanks to the engines.

At the time of the flame outs, the supply tanks were deplete of fuel albeit there was 73kg of useable fuel out of a total of 76kg in the main tank.

In the event that there is a loss of power to the aircraft's engines as in the present circumstances, a procedure is available to the pilot to cause his aircraft to enter what is known as autorotation.

This could allow the aircraft to make a controlled and potentially safe landing.

In order to affect a successful autorotation, the pilot must maintain the aircraft's rotor speed (Nr) as near to 100% as possible.

If rotor speed falls below 75% then the aircraft will not recover and is doomed.

In the present case, the pilot attempted without success to enter autorotation.

Post-accident investigation revealed that the rotors were not turning at the point of impact.

Approximately 8 seconds after the second engine flamed out, G-SPAO crashed onto the roof of the Clutha bar killing the three crew members and seven customers in the bar, including Robert Jenkins the partner of Mary Kavanagh. A large number of other people were injured in a variety of ways and to varying degrees.

It is submitted that there are central questions for the Inquiry to seek to answer.

Firstly, why did the engines flame out when there was sufficient fuel on board to enable the aircraft to return safely to base?

Secondly, why were the engines allowed to flame out when there was sufficient fuel on board to enable the aircraft to return safely to its base?

It is submitted that on the basis of the AAIB Report (Production 327) and other available evidence, it is beyond a peradventure that there was sufficient fuel on board to enable the aircraft to reach base and land safely.

DISCUSSION OF LAST FLIGHT OF G-SPAO

Reference is made to the AAIB Report and the Submissions for the Crown which have been lodged with the Inquiry.

On the 29th November 2019, the helicopter was operational during the day and its pilot reported no abnormal or unusual issues.

It was handed over to the nightshift pilot (Captain Traill) with 400 kg of fuel on board. There is no reason to doubt the accuracy of this assertion.

It is clear, according to the evidence, that a reasonable figure to calculate fuel consumption would be a burn rate of 3.3kg per minute or 200kg per hour.

At the time of the accident the operator's Operations Manual stated that the Final Reserve Fuel was 85kg with a Minimum Land on Allowance of 40kg and that 'Company policy is that the aircraft should not land with less than 60kg of fuel in the tanks. If it appears to the aircraft Commander that the Final Reserve Fuel may be required, a Pan call should be made. If the Final Reserve fuel is then subsequently reached, this should be upgraded to a MAYDAY'.

Accordingly, the aircraft ought to have been able to fly safely for something in the region of 103 or thereby minutes before reaching the 60 kg threshold.

At the time of the crash, the aircraft had 76kg in the main tank, 73 of which was useable.

Again, this would mean that the aircraft could have flown for 100 or thereby minutes prior to reaching a useable fuel level of 73kg.

According to Chief Inspector MacAllister (day 6 and Production 81) and under reference to the Air Support Unit Standard operating Procedure, he would have expected a normal police flight to last 90 minutes although it could be extended (paragraph 6.2.)
(Day 6 page 48 line 21 and page 49 line 7)

In actual fact G-SPAO left its base at 2044 and crashed at 2222, a flight of 98 minutes.

There was ample fuel on board to enable the aircraft to complete its sortie in safety.

In practical terms the aircraft crashed because fuel was not transferred from the main tank to the supply tanks.

It is clear from the evidence that this was brought about because the transfer pumps, which were used to transfer fuel from the main tank to the supply tanks, had been switched off during a part of the flight and were still switched off at the time of the crash.

Had the transfer pumps been switched on and the main fuel tank fuel been made available, there is no reason to suppose that the accident would have occurred.

Only the pilot possessed the authority to decide if the transfer pumps were to be switched off.

As part of the fuel system on board the aircraft, cautions and alerts were available to assist the pilot. The avionics are dealt with in the AAIB Report at paragraph 1.11. et seq.

Having departed its base, G-SPAO conducted operations in the Glasgow area and at 2121 the pilot requested clearance to route towards Dalkeith.

It arrived at Dalkeith at 2141 and left the area at 2145 heading back towards Glasgow.

At 2159 it was heading towards Bothwell arriving at 2206 to carry out a routine task.

It carried out a routine task at Uddingston for three minutes.

It then diverted to Bargeddie to carry out a further routine surveillance.

At 2219 the pilot informed Air Traffic Control that the Bothwell area tasks were complete and the aircraft was returning to Glasgow.

At 2222 it crashed.

No evidence has been led which would establish, or tend to establish, that there was a fault with the aircraft or that there was any water or other contamination of fuel or the fuel management system.

The AAIB Report indicates that prior to G-SPAO reaching Bothwell, the pilot was presented with a Low Fuel warning caption together with an aural attention getter. This was acknowledged by the pilot.

The evidence led makes it clear that the attention getter ought to have been heard by all members of the crew.

The AAIB Report sets out (electronic page 18) a series of warnings issued and acknowledged by the pilot. It indicates that a point was reached when Low Fuel 1 and low Fuel 2 were illuminated and remained so for the rest of the flight.

It is submitted that it is not possible to determine the time scale of neither these warnings nor the precise point in time from when the two warnings remained on. (AAIB Report electronic page 18).

What is clearly established is that there is a set procedure for a pilot to follow in the event of a Low Fuel Warning.

This is contained in Production 66 the Pilot's Checklist and also in the evidence of Captain Mark Prior (day 30 page 80 et seq).

It is submitted that the actions of the crew from Bothwell onwards are highly significant.

As already indicated, Captain traill was a highly experienced pilot.

The evidence would suggest that he was not a man who would ignore procedures and was a stickler for detail.
(Niall McLaren Day 6 page 95 line 21 et seq).

The importance of Crew Resource Management has been stressed by a number of witnesses.

Chief Inspector Colin MacAllister, PC Niall McLaren and PC Alan Graham (all day 6).

The import of this evidence is that the police observers are expected and encouraged to be pro-active during a flight. While the pilot is ultimately responsible for safety, the observers are entitled to express concerns about the flight or a proposed mission. If either of the observers were concerned enough to wish to land the aircraft, then it would be landed at the first safe opportunity.

Pilots would brief observers before the start of their shift.
(MacAllister day 6 page 46 line 4)

Towards the end of the last flight of G-SPAO, it is submitted that the behaviour of the crew as a whole was not consistent with an aircraft, which was operating under Low Fuel warnings.

Throughout its last sortie, there was nothing to suggest that the crew was involved in any operations which were particularly stressful or out of the ordinary.

CONDUCT OF CAPTAIN TRAILL

In communication with Air Traffic Control, there was no indication from Captain Traill that he had any issues with his aircraft or with the members of the crew.

It does not appear that the Bargeddie task was a matter of any great urgency or involved a life, which was at risk. However, he must have undertaken the task at Bargeddie in the full knowledge that he was operating under a Low Fuel Warning.

Five times he acknowledged a Low Fuel Warning but, putting it bluntly, appeared to do nothing about it.

He did not issue a Pan Call let alone a Mayday.

He could not have followed the checklist following the Low Fuel Warning. Had he done so, he would have checked his fuel levels and that the transfer pumps were on. It is not conceivable that he would have failed to notice that he had fuel in the main tank and that the transfer pumps were off.

CONDUCT OF THE POLICE AIR OBSERVERS

There was no communication from the Air Observers via the police system to suggest that there was any issue or unusual event at any point during the last flight of G-SPAO.
(Andrew Campbell day 6 pages 18, 22, 25-26).

There is nothing to suggest that Anthony Collins and Kirsty Nelis were doing other than going about their duties in a calm and professional manner.

If the evidence already referred to is to be accepted as correct, then one would have expected that the crew would have raised with the pilot the matter of the Low Fuel warnings and the fact that it must have been clear that he was unconcerned by them and not reacting to them. It might be thought that concern for their own safety would have been a natural human reaction.

From the standpoint of the crew alone, a Low Fuel Warning must have been an unusual event. (See for example Day 6, PC Niall McLaren page 94 et seq)

INFERENCES TO BE DRAWN

It is submitted that the following inferences may reasonably be drawn and should be drawn.

That Captain Traill must have been aware of the Low Fuel Warnings.

That Captain Traill would not deliberately put his aircraft and lives at risk.

That Captain Traill did not wilfully or recklessly ignore the warnings.

That Captain Traill was not cavalier as to the existence of the warnings.

That Captain Traill believed that he would land the aircraft safely.

That the Police Air Observers must have been aware of the warnings.

That the Police Air Observers would not knowingly allow Captain Traill to put the aircraft or their lives at risk.

That the Police Air Observers must have sought an explanation from Captain Traill as to why he was not taking positive steps in light of the five warnings.

That the Police Air Observers must have been satisfied by the explanation given.

That said, and given what ultimately occurred, how can this possibly be the case?

The evidence disclosed that, over a number of years, there had been issues relating to the fuel systems and false fuel readings on the CAD.

This is set out in detail in the Crown submission.

It is submitted that it is for the Court to indicate whether it considers that the available evidence is sufficient to provide a basis for understanding why such an experienced pilot may not have reacted to the Low Fuel Warnings as prescribed.

The court will wish to consider whether such an experienced pilot believed that the Low Fuel Warnings were in some way false or illusory and accordingly he felt he could, with impunity, ignore them.

It is submitted that for the court to come to this conclusion, it would have to be able to identify evidence which it could accept as supporting this contention on balance of probabilities.

In the event that the Court is of the view that the Police Air Observers must have been satisfied by the explanations given by the pilot or that they were not fully aware of the significance of the Low Fuel Warnings, then the Court is invited to consider whether the training of Police Air Observers requires to be reviewed.

The police helicopter is a professional emergency service. By definition it should not create a danger or cause harm.

It is submitted that consideration ought to be given to at least one of the Police Air Observers having a level of training in piloting the helicopter in order to better understand the actions being taken by the pilot.

OTHER ISSUES

It may be that it will not be possible to reach a definitive view as to what did happen in the helicopter during the last minutes of G-SPAO.

Undoubtedly, cockpit voice recorders would have provided invaluable additional information.

It is submitted that all emergency services helicopters should be fitted with such recorders as soon as practicably possible and that cost should not be a relevant factor.

It is one of the sad ironies of this case that G-SPAO was in fact fitted with Test-Fuchs transfer pumps which did not require to be switched off during the flight.

So far as the evidence disclosed, no attempt was made to bring this information to the attention of the pilots of G-SPAO.

Reference is made to the Crown submission paragraph 5.3 and especially paragraph 5.3.3. It is asserted that there was no clear evidence before the court on whether it would be possible to design different avionics for aircraft with different transfer pumps. It may be said with equal force that there was no evidence before the court to suggest that it would be impossible.

It is submitted that it is an inescapable fact that a major cause of the deaths of ten people is the fact that transfer pumps were switched off and not switched back on again, transfer pumps which did not require to be switched off in the first place but no one told the pilot.

It is for the Court to resolve what to make of this.

CONCLUSION

This has been an Inquiry conducted by the Crown in which Mary Kavanagh has been a participant.

Sight must never be lost of the fact that the only reason for the Inquiry to be held is the fact that ten human being lost their lives.

The AAIB has prepared a full Report; evidence has been led by the Crown before the Inquiry and an opportunity given for that to be cross-examined; the Crown has presented a detailed Submission, as indeed it should.

The Submission for Mary Kavanagh seeks to highlight specific questions, which require an answer.

Most importantly of all, it is submitted that the Court is under an obligation to seek to find an answer to the questions she has to live with every day – why on a night out did Robert Jenkins die alone in the Clutha Bar and she has to live without the man she loved and who's company she expected to enjoy for the rest of their days?

DONALD R. FINDLAY QC