



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Simon Cooper, Coroner, having investigated a death of Milfred Keith Knight

Find, pursuant to Section 28(1) of the *Coroners Act 1995*, that

- a) The identity of the deceased is Milfred Keith Knight;
- b) Mr Knight died as a result of injuries sustained by him in an aircraft crash;
- c) The cause of Mr Knight's cause of death was multiple traumatic injuries; and
- d) Mr Knight died on 4 March 2017 at Devonport Airport, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Knight's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; the results of toxicological analysis of samples taken at autopsy; relevant police and witness affidavits; a report from an air crash investigator; and photographic and forensic evidence.

Mr Knight was aged 75 at the time of his death. He was killed when the ultralight Avid Flyer aircraft he was flying at Devonport Airport crashed shortly after take-off.

Just after 10.00am on 4 March 2017 Mr Knight arrived at the Devonport airport towing his aircraft on a trailer. He was given access "air side" to the General Aviation hangars and surrounds. Once there he parked the trailer on the north side of the General Aviation hangar and then parked his vehicle at the nearby Aero Club car park.

Mr Knight then unloaded the aircraft from the trailer and re-assembled it (it had amongst other things folding wings). The process took him some hours.

At about 3:30pm, having assembled the aircraft, Mr Knight was seen to commence to take-off on runway 32 (a runway facing essentially Bass Straight). Mr Luke Muir who saw the plane take-off, himself a pilot, described the aircraft as immediately unstable. He described the aircraft as going from a nose altitude of high to almost level and said that the aircraft was “moving around a lot” and that it “seemed very floppy”.

Mr Muir then saw Mr Knight’s aircraft with a steep nose down trajectory drop dramatically into a position with the nose down somewhere between 40° and 60°. He described seeing the aircraft plummet to the ground from a height of less than 150 feet.

Witnesses were quickly on the scene but found Mr Knight clearly deceased. Nothing could be done for him other than to cover his body with a blanket. Police and emergency services were quickly on the scene. Mr Knight’s body was photographed *in situ* as was the aircraft. His body was removed from the aircraft and, after formal identification, transported by mortuary ambulance to the mortuary at the Royal Hobart Hospital. At the Hospital experienced forensic pathologist, Dr Donald McGillivray Ritchey, carried out an autopsy upon Mr Knight’s body. He said in a report provided as part of the investigation that:

“The autopsy revealed a normally developed, probably obese (obesity defined as a body mass index of greater than or equal to 30 kg/m²) elderly Caucasian man whose post mortem length may not fully reflect his height in life and may therefore have affected the body mass index.

There was extensive trauma of the face, skull, brain, chest and arms and legs that would have resulted in near instantaneous death.”

Dr Ritchey expressed the opinion, which I accept, that the cause of Mr Knight’s death was multiple injuries. Samples were taken at autopsy from Mr Knight’s body and subsequently analysed at the laboratory of Forensic Science Service Tasmania. Aside from the presence of a small amount of aspirin, no drugs or alcohol were identified as having been present in Mr Knight’s body at the time of his crash. I am accordingly satisfied that neither drugs nor alcohol played a role in the happening of the crash.

Recreational Aviation Australia investigated the circumstances of the crash. The consultant involved in that investigation provided a report to me. The report described, *inter alia*, that the aircraft Mr Knight was flying at the time of his death was an amateur built one constructed from a kit. The aircraft was a so-called 3 Axis aircraft fitted with a single 100 horsepower 912 Rotax engine. I was advised that the aircraft is capable of cruising at 80 knots and has a range of 547 km. The aircraft in question had first been registered with what was then the Australian Ultralight Federation on 1 August 1999 and according to records had a total of 360 hours' time in service with some 820 landings.

The investigation by the consultant identified, as a result of his inspection of the wreckage of the aircraft, that a primary flight control (namely the left-hand flaperon) had not been connected prior to the flight. The investigation by the consultant indicates that all attachment points associated with that primary control were found to be in a both safe and appropriate condition. Everything else about the aircraft appears to have been also in a safe and appropriate condition for the flight other than the left hand flaperon.

The evidence is that Mr Knight had approximately 885 hours flying experience. I am satisfied that Mr Knight was an experienced pilot of aircraft of the type he was flying when he crashed, having commenced flying ultralight aircraft in about 1987 and obtaining a pilot's certificate in 2002. The certificate was valid at the time of the crash. It follows lack of experience can be excluded as a cause of the crash.

An examination of maintenance and servicing documentation contained within the aircraft logbook indicates that the aircraft was properly serviced and maintained.

No inappropriate, or indeed any, modifications of the aircraft were identified by the investigator. An examination of the propeller and the damage to it demonstrates that the engine was still running at the time of the crash. Accordingly engine failure can be excluded as a cause of the crash.

Evidence of witnesses along with records related to weather indicate that the weather conditions were benign at the time of the happening of the crash and certainly played no role in the crash.

There is no evidence whatsoever to suggest the involvement of a third party in Mr Knight's fatal crash.

I am satisfied to the requisite legal standard that the crash occurred as a consequence of a failure on the part of Mr Knight to properly attach a primary flight control. As a consequence, within a matter of seconds after taking off Mr Knight lost control of his aircraft and it plummeted into the ground causing his almost instantaneous death.

Comments and Recommendations

I extend my appreciation to investigating officer First Class Constable Gray for her investigation and report.

The circumstances of Mr Knight's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Knight.

Dated 21 May 2018 at Hobart in Tasmania.

Simon Cooper
Coroner