House of Commons

Defence Committee

Beyond endurance? Military exercises and the duty of care

Third Report of Session 2015–16

HC 598

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The Defence Committee

The Defence Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Ministry of Defence and its associated public bodies

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The Sub-Committee

For this inquiry, the Chair of the Sub-Committee was Mrs Madeleine Moon MP. The Members of the Sub-Committee were Richard Benyon MP, James Gray MP and Johnny Mercer MP.

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The Committee is one of the departmental select committees, the powers of which are set out in the House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

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Contacts

All correspondence should be addressed to the Clerk of the Defence Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 5857; the Committee's email address is defcom@parliament.uk. Media inquiries should be addressed to Alex Paterson on 020 7219 1589.

Contents

Summary

Military training is inherently hazardous. It is not possible completely to remove all risks, but we believe it is possible to manage these in such a way as to reduce the incidence of accidents and fatalities.

Between 1 January 2000 and 20 February 2016, 135 Armed Forces personnel have died whilst on training and exercise: 24 from the Royal Navy and Royal Marines, 89 from the Army and 22 from the Royal Air Force. Every death is a tragedy and we think that that steps should be taken to drive down these numbers.

While we have found no systemic failings, the Ministry of Defence (MoD) has not always got the correct balance between adequate training and reducing risk, resulting in life-changing injuries and deaths in training and selection events.

We believe the MoD and the Armed Forces take their "Duty of Care" responsibilities seriously. However, some members of the public do not. The MoD must take appropriate action to change this perception and reassure the public. Not to do so will continue to undermine confidence in the Armed Forces.

The level of acceptable risk will vary with the desired training outcomes. While Specialist Military Units will need more rigorous training and selection events because they are required to do "exceptional things", this should be coupled with more stringent risk assessments and preparations.

Of the total number of fatalities, 55 of these occurred overseas where current practice is for such deaths to be investigated by the Service Police and local police authorities. Arrangements must be made to allow the Health and Safety Executive (HSE) to carry out such investigations to ensure that death in training is treated the same, wherever it may occur.

There are a range of not very well known internal mechanisms and sanctions which can be used to hold the MoD, the Armed Forces, and individuals within them, to account for failings in the supervision of the safety of training events. However, it is essential that the MoD and the Armed Forces are seen to be accountable. There have been no civilian prosecutions, and since the establishment of the Service Prosecuting Authority in 2010, only seven Service prosecutions relating to training, exercises and selection events. While we accept that decisions on prosecutions are not a matter for the MoD, we recommend that the MoD conduct an analysis of whether Service Law is fit for the purpose of holding people accountable for training supervision.

Over the period of our investigation there have been 11 Crown Censures: the highest penalty that can be issued to the MoD by the HSE. However, at present the MoD and Armed Forces have exemptions where they cannot be prosecuted under the Corporate Manslaughter and Homicide Act 2007. This must change. Where a Crown Censure has been issued, it should be made possible to prosecute the MoD. The lives of serving personnel are worth no less than those of civilians and those responsible for their deaths must be equally liable under the law.

1 The Sub-Committee

1. On 8 September 2015, the Committee appointed a Sub-Committee to consider the matter of military exercises and the duty of care. This is the first in a series of inquires that will be considered by a Sub-Committee of the Defence Committee. For this inquiry, the Chair of the Sub-Committee was **Mrs Madeleine Moon MP**. The Members of the Sub-Committee were **Richard Benyon MP, James Gray MP** and **Johnny Mercer MP**.

2 Introduction

Background

2. Between 1 January 2000 and 20 February 2016, 135 Armed Forces personnel have died whilst on training and exercise, not on operations. Of these 115 were Regular personnel and 20 were 'on duty' Reserve personnel.[1] The number of fatalities by Service was as follows:

- Royal Navy and Royal Marines: 24 (Royal Marines: 15)
- Army: 89
- Royal Air Force: 22

A further breakdown of these fatalities is given in the following table:

		Navy & Marines (24)	Army (89)	RAF (22)	Totals (135)
Gender	Male	23	84	21	128
	Female	1	5	1	7
Training	Collective	7	34	21	62
	Individual	17	47	1	65
	Other	0	8	0	8
Service Type	Regular	23	72	20	115
	Reservist	1	17	2	20

Source: Ministry of Defence, *Ad Hoc Statistical Bulletin: Training and Exercise deaths in the UK Armed Forces, 1 January 2000–20 February 2016*, 2 March 2016

3. The Ministry of Defence (MoD) informed us that 100 of these fatalities occurred as a result of injuries and 25 were a consequence of disease-related conditions.[2] In respect of the remaining 10 deaths, the cause was either not yet known or no definitive cause of death could be found following a coroner's inquest. Of the 135 deaths, 122 were trained personnel and 13 were personnel in basic training (classified as personnel in Phase 1 or Phase 2 training).[3] Five of the untrained personnel were under the age of 18 at the time of their death, of which one was a Royal Marine and the remaining were Army personnel.

1 Ministry of Defence, *Ad Hoc Statistical Bulletin: Training and Exercise deaths in the UK Armed Forces, 1 January 2000—20 February 2016*, 2 March 2016. At the start of our inquiry, a Ministry of Defence Freedom of Information response stated there had been 125 deaths between 1 January 2000 and 18 July 2015 (MoD FoI response, *Number of Armed Forces personnel who died during training or exercises during each year from January 2000 to July 2015*, 21 July 2015).

2 Ministry of Defence, *Ad Hoc Statistical Bulletin: Training and Exercise deaths in the UK Armed Forces, 1 January 2000—20 February 2016*, 2 March 2016

3 Phase 1 training is all new entry training to provide basic military skills, Phase 2 training is initial individual specialisation and Phase 3 training is that undertaken throughout a career, often linked to progression in rank and which develops military knowledge, skills and attitude.

The Armed Forces Covenant

4. The Armed Forces Covenant is an agreement between the Armed Forces community, the nation and the Government which encapsulates the moral obligation to those who serve, have served, their families and the bereaved. The Covenant includes a "Responsibility of Care" (also referred to as the "Duty of Care"):

> The Government has a responsibility to promote the health, safety and resilience of Service men and women; and to ensure that they are appropriately prepared, in the judgement of the chain of command, for the requirements of any training activities or operations on which they are to be engaged.[4]

Our inquiry

5. The number of fatalities whilst on training exercises was of concern to us. As a result, in September 2015, we launched an inquiry into the overarching policies, practices and guidance of the MoD and the Armed Forces in respect of training, exercises and selection events. We wanted to examine whether effective processes exist for learning lessons from accidents and deaths that have occurred during such events and whether there was an appropriate level of accountability and sanction when failings occurred. We made clear at the outset that the inquiry would not examine or investigate individual cases.

6. The areas in which we were particularly interested were:

- whether the 135 Armed Forces' deaths indicated any systemic failings in the policies and practices of the MoD and the Armed Forces;
- the adequacy of health and safety and risk assessment processes, and the quality of training and available guidance in these processes, within the MoD and Armed Forces, and what changes might be required;
- how the MoD and the Armed Forces balanced potential risks in training, exercises and selection events with the need to maintain operational preparedness and effectiveness;
- whether the Armed Forces had consistent standards of supervision, responsibility and accountability for both individual and collective training of Regulars, Reserves and Specialist Military Units;
- the provision of medical services during training, exercises and selection events;
- the checks in place to manage the risk of Service personnel pushing themselves too hard;
- whether the MoD and Armed Forces had effective processes for capturing lessons from accidents and deaths during training, exercises and selection events;
- how the MoD and the Armed Forces implemented Coroners' recommendations following the deaths of Service personnel during training, exercises and selection events, monitored progress towards and measured the effectiveness of their implementation;

4 Ministry of Defence, *The Armed Forces Covenant*, May 2011, pp 7–8

- what the implications for future selection events for recruitment to Specialist Military Units were; and
- whether changes were required in the preparation of Regular and Reserve personnel for training, exercises and selection events.

7. We held a number of oral evidence sessions and heard from a range of witnesses, including the Minister of State for the Armed Forces, the Commander of Joint Forces Command, the Chief Coroner for England and Wales, the Director General of the Defence Safety Authority and other senior military officers, solicitors with a wide ranging experience in representing Service, and ex-Service personnel. We held a private evidence session with the Director of Specialist Military Units. We also received 14 pieces of written evidence. During our inquiry we visited the Commando Training Centre Royal Marines at Lympstone, where we saw at first-hand, Royal Marine recruits undertaking training, which included a 30 mile march across Dartmoor. We are extremely grateful to all those who have assisted our inquiry. We would like to particularly record our appreciation to the families of Service personnel who have died during training, exercises or selection events for their constructive contribution to our inquiry.

3 Training and governance structure

8. Military training is inherently hazardous. It is not possible to completely remove all risks, but it is possible to manage them in such a way as to reduce the incidence of accidents and fatalities. Throughout our inquiry we have sought to examine the balance between the military requirements and the Ministry of Defence's (MoD) duty to reduce the risks to its employees as far as reasonably practicable. In this section, we examine the MoD's governance structures for ensuring safety during training, exercises and selection events.

The Defence Safety Authority

9. The Defence Safety Authority (DSA) was established on 1 April 2015 as the over-arching body for the MoD's safety regulators bringing together the Military Aviation Authority and the other independent defence safety regulators.[5] The DSA is responsible for the regulation of Defence Health, Safety and Environmental Protection and as such it has, among other things, responsibility for the conduct of independent service inquiries into safety-related fatalities and major equipment loss or damage.[6]

10. The DSA also regulates all areas of the defence arena which have exemptions from relevant Acts with the remit to produce outcomes that are, so far as reasonably practical, at least as good as those required by law.[7] As part of providing the required assurances to the Secretary of State, the Director General of the DSA submits an Annual Assurance Report to him.[8]

11. The DSA is independent from the chain of command. Its Director General, Air Marshal Richard Garwood, has direct access to the Secretary of State for Defence to raise matters of concern and he has done so on two occasions since the establishment of the DSA.[9]

12. The role and remit of the DSA is still being developed. In parallel to its establishment, the MoD commissioned the Defence Safety Review of Regulation (DSRR) to make recommendations on how Defence should regulate safety in the future.[10] Specifically, the review considered the following questions:

- *How should the DSA perform its role as a Defence Authority?*
- *How should Defence regulate safety?*
- *How should Defence accident investigation be improved?*[11]

5 The Defence Safety Regulators within the DSA are: Military Aviation Authority; Defence Nuclear Safety Regulator; Defence Maritime Regulator; Defence Ordnance, Munitions and Explosives Safety Regulator; Defence Land Systems Safety Regulator comprising: Land Systems Safety Regulator; Defence Movement and Transport Safety Regulator; Defence Fuel and Gas Safety Regulator; Defence Fire Safety Regulator. In addition, the Military Air Accident Investigation Branch and Land Accident Prevention and Investigation Team have joined the DSA.

6 Ministry of Defence (MEX0003); see also "*New defence Safety Authority launched today*", Ministry of Defence, 1 April 2015

7 Ministry of Defence, *Defence Safety Authority Team Document*, (accessed 15 April), and Ministry of Defence (MEX0017)

8 Ministry of Defence, *Defence Safety Authority Annual Assurance Report April 2014–March 2015*, 1 December 2015

9 Ministry of Defence, *Charter for the Defence Safety Authority*, 24 March 2015, and Ministry of Defence (MEX0009)

10 Ministry of Defence (MEX0014)

11 Ministry of Defence (MEX0014)

13. Implementation of DSRR recommendations is being carried out by the Programme for Regulation and Investigation of Safety by the MoD (PRISM), under which, the DSA has initiated a number of workstreams. The MoD told us that "this work will improve the way in which independent regulation and investigation is undertaken across all domains".[12]

14. Witnesses were supportive of the establishment of the DSA. Air Commodore (retired) Stephen Anderton, former Commandant General of the RAF Regiment, saw it as a positive development and a great improvement.[13] Brigadier Matthew Porter, former Royal Marine and Commandant of CTC, told us:

> I cannot see anything not to like about that system. It seems to me to be a potent way of, in particular, taking the lessons learned from the mishaps that do happen and trying to ensure that there is a good understanding of what caused them and how they can be avoided in future, and then trying to promulgate the lessons learned.[14]

15. However, neither Hilary Meredith nor Philippa Tuckman, two solicitors with a large body of experience of dealing with military claims, had heard of the DSA.[15] Penny Mordaunt MP, Minister of State for the Armed Forces, was surprised by this:

> I find that incredible. It is a new organisation, but it is not in an ivory tower; it is out working not just with third parties outside the MoD that have responsibility and expertise but with other nations.[16]

16. Air Marshal Garwood told us that one aspect of the work of the DSRR was to establish procedures to measure the effectiveness of the DSA.[17] However, basic statistics were already being passed onto the Defence Board for consideration each month.[18] In her evidence, the Minister explained that in addition to oversight by the Defence Board, the DSA would also be subject to an external check on the quality of its work, for example by the Health and Safety Executive.[19] In supplementary evidence, the MoD stated that the DSRR would be recommending the requirement for periodic external audit of the DSA by an externally recruited team or organisation and if accepted, the first external audit would take place early in Financial Year 2017–18.[20]

17. During our inquiry, we also considered the possibility of creating an independent Training Commissioner along similar lines to the Service Complaints Ombudsman. This suggestion received mixed reactions. Air Commodore Anderton said that while it was an interesting proposition, it could create overlap with the responsibilities of the Director General of the DSA. He believed that the Director General was best placed to provide that oversight:

> The beauty of that position, I understand, is that although it is within the MoD, it is completely separate from the chain of command, so he exercises

12 Ministry of Defence (MEX0017)
13 Q311
14 Q311
15 Qq175–176
16 Q395
17 Q139
18 Q139
19 Qq390-391
20 Ministry of Defence (MEX0017)

> independence. The beauty of having it within the organisation is that he, rather than perhaps an outsider, understands what the concepts are and the context in which that is taking place.[21]

18. By contrast, Philippa Tuckman thought that the idea had merit. While she did not see it as the perfect solution she said that it would be a "very good step towards normalising or bringing the MoD back into civil society: making sure that people realise—that staff realise—that they have rights too".[22] Hilary Meredith was also in favour of independent oversight of the MoD and its planning for training but was not convinced that it could work in practice, as the office holder would require knowledge of the military and operations.[23]

19. The Minister also believed that it was vital that the oversight function was headed up by someone from the Armed Forces because he or she would need to fully understand the objective of training.[24] Humphrey Morrison, Head of Legislation at the MoD, also had reservations about an independent Commissioner saying that in addition to a well-defined remit it was important to have:

> A very clear definition of what this person's power were and how they fitted in with the other powers that exist, whether prosecution powers, powers of the chain of command to take administrative action, the powers of coroners to give Section 28 reports and so on. Otherwise legally, it could add to the confused messages. People apply different tests with different powers, almost adding to the fog of supervision that can quite easily be created if one simply adds another person who can interfere and cut across other decisions.[25]

20. ***We welcome the establishment of the Defence Safety Authority (DSA). However, the DSA will need clear methods to measure its effectiveness and we recommend that the MoD set these out in response to our report. We also support the requirement for periodic external audit of the DSA by an externally recruited team or organisation. We seek confirmation from the MoD that this process will begin at the start of Financial Year 2017–18 and of the composition of the external auditing team.***

21. ***Whilst we acknowledge that the DSA is a relatively new body, we are concerned that there appears to be a limited level of knowledge of it outside the MoD and Armed Forces. We recommend that the DSA engages with external interested parties and stakeholders to promote and explain its work, and to provide the opportunity for external comment and review.***

22. ***We also recommend that an assessment take place of the DSA by the end of 2018 to determine the extent of the independence and the effectiveness of the Authority. Should deficiencies continue to exist the MoD should consider alternative oversight mechanisms, perhaps based on the model of the Service Complaints Ombudsman. The Committee may choose to return to this issue in 2019 if it remains concerned about the independence and effectiveness of the DSA.***

21 Q324
22 Q214
23 Q214
24 Q412
25 Q412

Duty Holder Concept

23. A key element of the Defence Safety Governance Arrangements—overseen by the DSA—is the Duty Holder Concept. It is intended to be the means by which specific individuals are made personally accountable and responsible for potential 'Risk to Life' decisions.[26]

24. Air Marshal Garwood told us that the Duty Holder Concept was at differing levels of maturity in each Service:

> In aviation the duty holder concept has been around since early 2011, so it is very mature and very well defined, and people clearly understand their role. It's far, far newer in the land domain, where it has come in over the last year or so, so to be fair it's still settling down.[27]

25. He believed that the responsibility it placed on senior officers had had a positive effect; "if the two-star is interested in safety, then people around him and below him are interested in safety, and we are seeing that".[28] In conclusion he described it as "the jewel in the crown of safety".[29]

26. The Duty Holder Concept uses a three tiered approach which all three Services and the Joint Forces Command use.[30] For example the Army's Duty Holder Concept consists of:

- Senior Duty Holder, Chief of the General Staff;
- Operating Duty Holder, appointed for specific activities or groups of activities, normally at the 2* General Officer Commanding level; and
- Delivery Duty Holder, appointed for specific activities or groups of activities, normally at Unit Commanding Officer level.[31]

Across the Services, each Operating Duty Holder and Delivery Holder receives a letter from the Senior Duty Holder setting out their role and responsibilities as a Duty Holder.[32]

27. Overall, our witnesses were supportive of the Duty Holder Concept. Brigadier (retired) Matthew Porter, a former Royal Marine, said that it had provided "a much clearer articulation of who is responsible for any aspect of training", in particular at the higher levels of the chain of command.[33] However he was less convinced that it had made much difference at the lower levels:

> It had always been very clear that if you are running a bit of training, you are responsible for it and for the welfare of the people below you.[34]

26 Ministry of Defence (MEX0003)
27 Q95
28 Q95
29 Q95
30 Q95
31 Ministry of Defence (MEX0003)
32 See Ministry of Defence (MEX0009) for examples of such letters.
33 Q283
34 Q283

28. Ms Meredith and Ms Tuckman, in a similar response to their answers on the DSA, told us that they had not heard of the Duty Holder Concept.[35]

29. General Sir Richard Barrons, Commander, Joint Forces Command, saw both positive and negative impacts of the Duty Holder Concept. He believed that while it would establish a better culture and a more professional approach to safety and training, he was concerned about its impact on the middle and lower levels of the Armed Forces.[36] In particular, he saw the danger of a misinterpretation about how to bear down on risk in training which, in some areas has led to:

> A set of restrictions, on training in particular, which are making people operate their equipment in such a narrow way that they are not ready to go on operations.[37]

30. Brigadier Porter also highlighted the potential for difficulties where on the basis of safety in the chain of command, the operating duty holder effectively transfers risk on to the operational delivery of that capability to the commanding officer of any future operations:

> For parachuting for brigade recce and for specialist units, the operating duty holder is a two-star on the RAF chain, who has responsibility for the part of the RAF that delivers the capability for parachuting. The operational output of those capabilities sits more on a command chain that lies along the Royal Marines or specialist units. A decision may be taken by the operating duty holder—and it has been taken—that he is not happy about parachutists parachuting with night vision goggles attached to their helmets, because there is a snag risk. The user would say, "No, these things are designed to clip off, so they will just drop off", but that is the ruling: you cannot parachute with night vision goggles.
>
> That means that when those parachutists are approaching their drop zone they have a higher risk of not finding it, being surprised at the drop zone, or not being able to fight immediately on arrival.[38]

We see this as a powerful example of conflicting priorities.

31. ***The introduction of the Duty Holder Concept (DHC) across the Armed Forces should establish a systematic process of both managing risk and holding to account those responsible for the design and delivery of training. As we saw with the establishment of the DSA, there seems to be little or low awareness outside the MoD and the Armed Forces of this development. We recommend that the MoD undertakes to publicise this widely so that families can have confidence in knowing that while military training may be hard or dangerous, that the organisers of that training are known and accountable.***

32. ***We recommend that a systematic survey is undertaken by the DSA to establish where the DHC is yet to be applied or effectively applied and to identify the measures needed to ensure a comprehensive roll out of the scheme.***

35 Q177
36 Q408
37 Q408
38 Q312

33. ***We agree that the DHC simplifies accountability and responsibility to three levels in an effective manner. However, we are not yet convinced that this simplicity and clarity exists where there is the involvement of more than one Service or chain of command in the management and delivery of risk. We recommend that the DSA review those exercises where the Operating Duty Holder and the Delivery Duty Holder are not aligned in the chain of command, or where there are multiple Operating Duty Holders required to exercise judgement in support of activities which are not delivered within their chain of command. In response to our report the MoD should provide examples of measures and controls which can demonstrate that risk is not simply transferred between Duty Holders.***

4 MoD policy and guidance on training and selection events

Guidance and policy

34. The Ministry of Defence's (MoD) overarching policy on health and safety and risk assessments is set out in JSP 375, *The Management of Health and Safety in Defence*, and requires the MoD to comply with all applicable health and safety legislation, including that giving effect to the UK's international obligations.[39]

35. Under JSP 375 are a number of policy documents setting out the governance of training and education within the MoD and the Armed Forces and the health and safety and risk assessment requirements including:

- JSP 822, *Governance and Management of Defence Individual Training and Education;*
- JSP 898, *Defence Direction and Guidance on Training, Education and Skills*;
- JSP 419, *Joint Adventurous Training;* and
- JSP 539, *Climatic Illness and Injury.*[40]

36. These policy documents are constantly under review. For example, during the course of our inquiry, JSP 822 was revised and a new version published in December 2015 with a further revision published in March 2016.[41]

37. The MoD told us that the application of these policies depended on the individual nature of the activity and that each Service would contextualise these overarching polices within their own policy documents.[42] This was done through Service instructions, and below that level, possibly unit and establishment standing orders.[43]

38. During the course of our inquiry we heard that the range and complexity of the guidance presented significant issues. Brigadier (retired) Matthew Porter, a former Royal Marine, cited as an example JSP 898, *Defence Direction and Guidance on Training, Education and Skills*, which referenced over 25 other associated JSPs.[44] Brigadier Porter also said that this complexity was compounded by other guidance which sat below the JSPs:

> There are several hundred JSPs. They sit at the top, and underneath them you have single Service instructions, and below that there are probably unit and establishment standing orders. For example, when I was working at Lympstone, it had its own set of standing orders, and each wing would have its own specific guidance for what it was trying to train. That is just the governance instructions,

39 Ministry of Defence (MEX003)
40 Ministry of Defence (MEX003)
41 Ministry of Defence (MEX003)
42 Ministry of Defence (MEX003)
43 Q284
44 Q284

> let alone the subject knowledge of what you are trying to train people in. If you are training people in troop attacks that comes with its own doctrine that you have to understand and learn.[45]

39. Brigadier Porter continued by doubting that busy young leaders in the Services would have the time or inclination to read what he described as the "plethora of written stuff out there".[46] He added:

> There is a comfort in knowing that you have published instructions as a joint service publication, because now you can think, "I've done my bit; I've published a JSP and it's all in there". To my mind, that is less important than creating a culture within your organisation that follows the letter of the publications. It is not enough to publish something, you have to inculcate it into your training and into the way you do business at all levels of command.[47]

40. General Sir Richard Barrons, Commander Joint Forces Command, agreed that there was a large amount of guidance, but pointed out that not all of these would apply to each training event.[48] While he understood the need for the guidance to ensure safety in a complex, rigorous and demanding training environment he considered the guidance to be only part of the solution:

> The guidance must first be written and it must be appropriate, and I think that that is pretty much in place. Then it has to be read and people have to be trained in its application. If it is not read or if people are not trained in its application, we are likely to fall short in the training regime that we provide.[49]

41. General Barrons also highlighted the responsibility on commanding officers to ensure that this had been done.[50] However, he was concerned that if too much risk was removed from Armed Forces' training there was a possibility that Service personnel could be sent on operations "where they are working out how to use their equipment properly for the first time, or being presented with a physical challenge for the first time".[51] This, he added would not help the Armed Forces "win in the crucible of war" and that it was the duty of senior leaders in the Armed Forces to ensure that the balance between reducing the risks that could be reduced and maintaining Service personnel who are fit for operations was preserved.[52]

42. On 2–3 February 2016, we visited the Commando Training Centre Royal Marines (CTCRM) at Lympstone to see for ourselves how training exercises were run. In evidence, Brigadier Porter told us that Lympstone was a good example of how to instil a culture of putting the guidance into the chain of command.[53] He told us that this had been achieved through an induction process which enabled a new instructor to observe how training was delivered. Videos were also used to highlight what could go wrong in a training scenario

45 Q284
46 Q284
47 Q284
48 Q341
49 Q341
50 Q341
51 Q341
52 Q341
53 Q285

and to show correct and incorrect ways to undertake their tasks as instructors. There was also constant engagement by senior officers in that organisation with training in order to ensure that the culture continued.[54]

43. In contrast to concerns regarding the amount and complexity of guidance, Philippa Tuckman, a solicitor with Bolt Burdon Kemp, told us that mistakes were repeated even though the requirements in the MoD's policy were straightforward.[55] She gave us the following examples in relation to "cold injuries"[56] and referenced the relevant parts of JSP 539, *Climatic Injury and Illness in the Armed Forces*:

- failure to make risk assessments before exercises begin;
- failure to call off exercises in extreme weather conditions;
- failure to take account of wind chill;
- forbidding the use of protective equipment such as gloves;
- providing inadequate equipment (e.g. cold weather boots);
- failing to evacuate immediately on report of symptoms of Non-Freezing Cold Injury (e.g. numbness, lack of feeling in a limb, "can't feel my feet", feels like I'm wearing someone else's");
- relying on training materials that stress extreme injuries (e.g. gangrene), so that soldiers do not consider milder symptoms should be reported, and the chain of command does not realise they should be acted on;
- encouraging the soldier to "man up", and/or stressing the fact that reporting injury will result in his or her failing the exercise;
- failing to take account of the fact that after one NCFI in a group the other participants are likely to be at risk also; and
- prescribing or advising rapid re-warming of the affected part which causes further injury.[57]

44. Penny Mordaunt MP, Minister of State for the Armed Forces, said that it was important to have detailed guidance, but acknowledged that it must be understood and applied in a practical way.[58] In order to meet that challenge, the Minister told us the MoD had introduced:

> Potted, easily understandable versions, which can be used in practice and which translate the policy into how it actually should be applied on the day and disseminate the core information in a few pages that are of direct practical

54 Q285
55 Ms Philippa Tuckman (MEX0005)
56 Ms Philippa Tuckman (MEX0005); Cold injuries can be either 'freezing', where body water reaches 0°C or below and tissue dies, or 'non-freezing' where temperatures are no lower than 4°C but continue for hours or days. For further information see: Ministry of Defence, *JSP 539 Climatic Injury and Illness in the Armed Forces: Force Protection and Initial Medical Treatment version 2.4* (August 2014), para 303, accessed 19 April 2016.
57 Ms Philippa Tuckman (MEX0005)
58 Q341

> benefit. You do need the substance behind that because exercises are often complex and you have to cover off every aspect of safety. The policy is no good in a drawer. It has to be applied.[59]

45. There will always be risk in training events and the MoD's approach to Health and Safety and Risk Assessment is to reduce risk to 'As Low As Reasonably Practicable (ALARP)'.[60] Major General Christopher Tickell, Army Recruiting and Training Division, argued that the collective training environment was a good example of the risk being reduced to ALARP as it also included climate factors where ambient temperatures were often above the guidelines within the appropriate JSP.[61] Major General Tickell said that if the JSP was applied strictly it would result in "very little training". Therefore, a process was undertaken to reduce the risk to the ALARP standard:

> The requirement is then for us to look at what is in the JSP and adjust it, and adjust it so much that I, as the two-star ODH [Operating Duty Holder], am prepared to sign off that waiver. The way we adjust it, in theory, is that you have two-hours work, one-hour rest. We reverse that to one-hour work, two-hours rest. We stop in the middle of live firing and allow soldiers to ventilate—that is, take their helmet and body armour off in order to cool down. That is all after the acclimatisation process, which takes quite a lot of time anyway.
>
> That and a number of other measures allow us to conduct live firing at an ALARP standard. There is clearly still a risk, which is why it sits with me rather than the commander in Kenya or Canada or wherever it happens to be. As a consequence of that activity, we then sent out a multidisciplinary team to all those locations to make recommendations back into the JSP, in order to amend it.[62]

46. **Given the wide range and varied nature of Armed Forces' training we regard it as essential that detailed policy and guidance exists for its governance and the safety of those being trained. However, that guidance should never reduce the risk to such an extent that it would undermine the operational effectiveness of Service personnel through inadequate training.**

47. **The high number of cold weather related injuries and the severe long term consequences of such injuries could not be ignored by the Committee. The failure to follow the clear JSPs in place, which should prevent such injuries, is worrying. The MoD must advise us of the steps it will take to monitor, prevent and to reduce the number of these injuries.**

48. ***The use of "potted" guides (aides-memoire), which translate policy to core and relevant information are a welcome practice and their widespread use would mean no training supervisor could ever claim ignorance on the basis of too much information. We recommend the DSA measure their use and ensure comprehensive coverage accordingly.***

59 Q341

60 Ministry of Defence (MEX0003); A risk is ALARP when it has been demonstrated that the cost of any further Risk Reduction, where the cost includes the loss of defence capability as well as financial or other resource costs, is disproportionate to the benefit obtained from the risk reduction.

61 Q99

62 Q99

Risk Assessments

49. All training activities, wherever they take place, require a risk assessment which are a vital element of ensuring the safety of Service personnel while participating in training, exercises and selection events. The MoD's approach to when and how risk assessments should be carried out are set out in JSP 375 and is based on the Health and Safety Executive's (HSE) recommended "5 Steps to Risk Assessment" which satisfies the requirements for risk assessments as set out in the Management of Health and Safety at Work Regulations 1999.[63]

50. JSP 375 describes risk assessments as 'live documents' that should updated and reviewed on a regular basis.[64] The JSP adds that:

> If an assessment needs to be amended it is not necessary nor desirable to wait until the review date, it should be reviewed at the earliest opportunity as accidents can easily result from last minute changes to activities (especially dynamic activities such as military training exercises) where the consequences of change have not been fully considered.[65]

51. The JSP also recognises that "it is not possible to foresee all hazards and that on occasion it may be necessary to conduct a dynamic risk assessment when confronted with an unexpected hazard".[66] The MoD told us that:

> Dynamic risk assessments form a vital part of the risk assessment process which is laid out in JSP 375. Personnel at all levels are able to raise concerns over any activity. As part of the formal risk assessment process additional dynamic risk assessments can be conducted if it is felt that something has changed that will affect the activity or adversely affect the safety of participants such as climatic extremes.[67]

52. Major General Tickell saw dynamic risk assessments as playing a key role:

> Once you have absolutely nailed the risk assessment before an activity happens, there is a requirement to dynamically risk assess during that activity. Therefore that means that it is beholden on the commander, the DDH—duty delivery holder—to reduce the risk if he feels that either the training audience or the environmental conditions are taking it outwith the boundaries that are safe. That absolutely plays into the duty holder construct, which we now enjoy.[68]

53. In written evidence, the MoD provided a number of examples for each of the Services of exercises, training and selection events that had been cancelled following a dynamic risk assessment.[69] These can be found in Appendix 1.

63 Ministry of Defence (MEX0003)
64 Ministry of Defence, JSP 375 Management of Health and Safety in Defence, Part 2 Vol 1, Chapter 8, Risk Assessments, (January 2016) para 8.2.5
65 Ministry of Defence, *JSP 375 Management of Health and Safety in Defence, Part 2 Vol 1, Chapter 8, Risk Assessments*, (January 2016) para 8.2.5
66 Ministry of Defence, JSP 375 Management of Health and Safety in Defence, Part 2 Vol 1, Chapter 8, Risk Assessments, (January 2016) para 8.2.6
67 Ministry of Defence (MEX0017)
68 Q86
69 Ministry of Defence (MEX0017)

54. Air Marshal Garwood, Director General, Defence Safety Authority, acknowledged that different types of training had differing degrees of severity but thought it correct that the guidance was in one document.[70] In his opinion the risk assessment undertaken by commanders was the important element and this should look at the type of activity and put mitigation in place accordingly:

> If you have arduous training conducted by a Specialist Military Unit, you are clearly pushing people a lot further than you would, for instance, on an Air Training Corps or Army Cadet hike. The risk assessment would therefore look at better mitigation. If […] you are sending people over the top of a mountain range, you would not rely on mobile phone coverage; you would use proper radios and have proper medical cover, et cetera. For me, it is down to the risk assessments, stemming from the common document. I can see no reason why, in the total force concept, we would have a series of documents especially for Reserves.[71]

55. Air Commodore Warren James, Head of Training, Education, Skills, Recruiting and Resettlement, added:

> The design of the training policy covers Reserves and Regulars, regardless of whether it is a specialist military unit. What changes is how the course is designed for that particular cohort. Your framework documents actually allow for the ability to do that and then introduce more robust training, with an increased risk appetite and the increased risk mitigation that goes with it—you tailor accordingly. The JSP enables anything across that range.[72]

56. Air Marshal Paul Evans, then Surgeon General, explained how environmental factors were taken into consideration:

> Obviously heat is one, cold is another and noise is another. These elements are all things that are covered very well in policy. […] JSP 539 […] is a very comprehensive document that covers, from both the commander's and the medical officer's perspective, the sort of questions that one should be asking in order to formulate that risk assessment that was mentioned earlier.[73]

57. In oral evidence, Philippa Tuckman asserted that the risk assessments she had seen were templates and just "tick boxes".[74] In respect of "cold injuries"[75] she thought that the assessments contained very generic risks and were limited in scope.[76] Ms Tuckman believed that it was "the dynamic risk assessment on the ground" that made the difference.[77] She felt this was only possible if there was the correct information "coming up from the bottom as well".[78]

70 Q77
71 Q77
72 Q78
73 Q88
74 Q184
75 Ms Philippa Tuckman (MEX0005); Cold injuries can be either 'freezing', where body water reaches 0°C or below and tissue dies, or 'non-freezing' where temperatures are no lower than 4°C but continue for hours or days. For further information see: Ministry of Defence, *JSP 539 Climatic Injury and Illness in the Armed Forces: Force Protection and Initial Medical Treatment version 2.4* (August 2014), para 303, accessed 19 April 2016.
76 Q184
77 Q186
78 Q186

58. Brigadier Porter highlighted the need for risk assessments to be 'live' documents. He described the bad application of risk assessments as "rerunning the risk assessment that you ran for that exercise last year—pulling it off the printer, changing the dates and going with it without really thinking about it".[79] He said that it was crucial that those undertaking risk assessments had an "openness of mind to adjust on the day" if something unexpected occurred, for example the weather deteriorated or became too hot. He added:

> It is about that flexibility, that rolling risk assessment, which should be natural to military personnel because at the end of the day war is chaos and operations never go the way we expected. […] We always have to adapt our plans all the way through the conduct of our operations, so it really should be part of good leadership.[80]

59. General Barrons said that everyone was clear about the requirement to conduct a risk assessment prior to undertaking training activities.[81] He also thought everyone was clear that that process must be supervised by the company commander and his commanding officer. However, he cautioned that common sense had to be applied. There were some activities which he believed required "slightly cursory" risk assessments, because the risks were self-evident and small. By contrast, conducting arduous, rigorous training, with or without live firing, would require a far higher level of assessment to which the chain of command would "be held to account".[82]

60. Despite these requirements for detailed risk assessments, Hilary Meredith, a solicitor with experience of representing Service personnel in claims against the MoD, expressed concern that there remained "a higher rate of injury and fatalities whilst practising for war than in combat".[83] She added:

> This has to be addressed. As with any responsible "employer" the MoD should be no exception to this requirement and the need to effectively risk assess activities to provide as safe a system as possible to reduce attrition rates need to be instilled as part of military training.[84]

61. The Minister told us that from her experience of observing training courses, the audits that are carried out and the oversight of the DSA, that risk assessments were done well. In her opinion when things went wrong this would generally be for four reasons: "the processes were not followed; the right person was not doing it; or there was something awry with the environment or with the equipment".[85]

62. **Robust and detailed risk assessments are a vital part of ensuring the MoD correctly exercises its duty of care to Service personnel during training, exercises and selection events. We accept that it is not possible to mitigate against all risks and therefore dynamic risk assessments are a critical part of the process—they can be the difference between life and death or serious injury. We were concerned to hear from our witnesses that there are variations in how effectively risk assessments are carried out. While training is extremely varied and some events will always require more**

79 Q289
80 Q289
81 Q350
82 Q350
83 Ms Hilary Meredith (MEX0001)
84 Ms Hilary Meredith (MEX0001)
85 Q349

detailed assessments, they should not become be a tick box exercise. ***We expect the MoD to review both the education in, and delivery of, risk assessments and identify what measures they intend to take to address shortfalls in their application.***

Other risks

Reservists

63. Of the 135 Service Personnel fatalities recorded during training or exercises, 20 were Reservists.[86] In written evidence at the start of our inquiry, the MoD told us that in the Army and RAF there were no additional measures specifically in place for Reservist training, while some aspects of training for Royal Navy Reserves was currently under review or had recently been reviewed.[87] Air Commodore James told us that the reason for this was that the MoD treated the "whole force as the same whole force".[88] However, he highlighted a number of adaptations which reflected the difference in the "start state" between Reservists and Regulars. If Reservists required more pre-training prior to the main training, it would be incorporated in "the design phase, so the Reservist might get a different course and treatment, but the policy that governs it would be identical."[89] In subsequent evidence the MoD stated that "not all [Army] Reserve training has been revised in the period since the White Paper on Reserves as it falls outside of the mandated programme and the resource and requirement have not meant this is possible".[90]

64. Brigadier Porter acknowledged that running training events for Reserves was a particular area of risk:

> If you had the Regulars running that […] then those Regular staff do not know those candidates very well. [The Reservists] have done all their preparation back in their home Reserve units.[91]

65. He said that at Lympstone, Reservist staff were involved in the commando tests to ensure that "somebody who knows them" was involved in the course.[92] However, in the wider training of Reserves he was not convinced that there was a similar level of consistency.

66. When she gave evidence to us, the Minister said that changes had been implemented for Reservist training:

> Reservists will spend a week with their instructors prior to those particular courses or selections. They will have met them during the course of other training, but that is so that, particularly when they are building up to arduous training, they get to know them better. At the same time, […] we have adapted

86 Ministry of Defence, *Ad Hoc Statistical Bulletin: Training and Exercise deaths in the UK Armed Forces, 1 January 2000—20 February 2016*, 2 March 2016.
87 Ministry of Defence (MEX0009)
88 Q121
89 Q121
90 Ministry of Defence (MEX0017)
91 Q294
92 Q294

> how we monitor individual candidates on those courses to ensure that any of the signs are picked up early. Where we can build it in so that they get to know them on an individual basis beforehand, we have done that.[93]

67. **While we accept the principle of the "whole force" in respect of Reservist and Regular training, the different circumstances of Reservists must be taken into account in the design and delivery of that training. The MoD recognise this and are implementing changes to Reservist training. However, we are not convinced that there is sufficient assessment of training circumstances for Reservists, and there is a tendency to apply the Regular design and delivery template too readily. In particular, we were not reassured by the MoD 's statement that "not all [Army] Reserve training has been revised in the period as it falls outside of the mandated programme and the resource and requirement have not meant this is possible". It is nearly three years since the White Paper on Reserves was published which promised to ensure that the individual would become an integral part of the 'Whole Force' made up of both Regulars and Reservists.**

Specialist Military Units

68. The training and exercises undertaken by Specialist Military Units are understandably more arduous and hazardous in nature than all other military training. These Units, which are part of Joint Forces Command (JFC), employ the same three level risk management structure for the Duty Holder Concept with the rest of the JFC.[94]

69. Due to security considerations, the evidence we took on Specialist Military Units was taken in private and is not published. However, General Barrons gave us an assessment of the balance which needed to be struck between the risk attached to arduous or hazardous training and the importance of not undermining those Units' "must win" mindset:

> It is in the nature of specialist military units that they must be obsessively, aggressively and mercurially determined to win. That is the point of Specialist Military Units. To some degree, you have to protect them from themselves. I would distinguish between the regime for selection—as a result of catastrophic events, a whole range of changes in that regime are now in place that moderate that risk, but the fact is that you will still have individuals operating […] in extreme circumstances.[95]

70. He went on to explain that collective training for those in Specialist Military Units, involves "exercising at the edge of what is humanly possible, in the most extreme climate and terrain and with some unique and complex equipment."[96] This was done to prepare them for operational conditions where the margin for success or failure was "tiny and comes down to seconds and the very last edge of physical advantage".[97] Therefore he argued that it would be "a disaster if we tried to not make them think and feel that way".[98]

93 Q358
94 Q103
95 Q387
96 Q387
97 Q387
98 Q387

71. General Barrons concluded that the key to success lay in the balance of risk and safety:

> In making sure that we can train effectively and, indeed, operate effectively, it is a combination of: do people understand the law and regulations; are they trained in it; does the chain of command make sure that is implemented; and are they held to account for it?[99]

72. The Minister understood the importance of the "must win" mindset but believed that it was incumbent on those designing the training to have established appropriate safeguards:

> I think that because of candidates, quite understandably, not wishing to not complete a particular exercise, the onus has to be on the instructors and the safety team on those events. That, in my view, is very clearly understood. The onus must be on them; the responsibility has to sit with them. The changes I have mentioned in technology—how you monitor those individuals and how you understand what an individual is capable of prior to those exercises—are recent changes that have been made, and they help that.[100]

73. ***Whilst recognising the special security considerations for Specialist Military Units, we are disappointed that we are unable to put the reports and evidence we have received in respect of Specialist Military Units into the public domain, even in a redacted format. To do so would help clarify and identify changes and improvements that have been made to the training of Specialist Military Units. In the absence of this material being put in the public domain, we recommend that this information, in some format, should be shared on a confidential basis with the families of those who have died or been injured.***

Must succeed culture

74. Our witnesses have acknowledged that a 'must succeed' culture exists within Service personnel. While this is to be expected, even applauded, it is also acknowledged that this can lead to the non-reporting of illness or injury which enhances the risk to them when participating in training, exercises and selection events. Air Marshal Paul Evans, then Surgeon General, told us that a cultural shift was required:

> I think you have to create a culture where you get a level of responsibility from the individual, so that they are confident enough to report against a training background that, as you have heard, could be very arduous, including where they are keen to complete the course as best they can.[101]

75. Air Marshal Evans thought there had been a change in recent years with the introduction of the Duty Holder Concept.[102] However, it was also important to create a culture in which individuals were confident enough to come forward and say they had an

99 Q387
100 Q386
101 Q107
102 Q107

injury or illness. He accepted that this was a challenge because ultimately it could be the "pass or fail of their staying at the level of activity they are in, whether it is in the military or another field of activity".[103]

76. Both Hilary Meredith and Philippa Tuckman agreed that the culture needed to change. They had both seen examples of individuals failing to report a seemingly minor injury or illness which had subsequently become serious.[104] Major General Tickell, however, said that there had been a cultural shift from "selecting out" to "training in":

> That is the mantra we use in the Army and in the other Services as well. It is absolutely in our interest to get everybody to pass whatever course it is, because it is a waste of individual time and, frankly, collective resources for them not to pass it.[105]

He concluded that it was "beholden on the individual, but it is absolutely beholden on the training staff to have a duty of care to the individual, to make sure he or she can continue to get to the end state."[106]

77. We saw this culture in operation during our visit to the Commando Training Centre Royal Marines at Lympstone where we were impressed by the relationship between the instructors and students. The instructors knew those in their charge well and told us they would recognise quite quickly if a student had a problem.

78. However, we are aware that this level of relationship between instructor and student is not always possible. We asked the Minister what safeguards were in place for events where candidates were not known to instructors. She saw this as a critical issue with the instructors having a vital role because it was not always possible to rely on the individual trainee to disclose a problem:

> We should be ensuring that they know individual candidates and what they are capable of when they are showing signs of duress. We have adapted some of the training and selection pipeline to ensure that that happens.[107]

79. ***It is important for the Armed Forces to balance the individual's desire to succeed and the need for them to self-declare injury and illness and not see it as a sign of failure. We saw good examples of this in practice at the Commando Training Centre Royal Marines in Lympstone where the instructors follow trainees through from the beginning to end of their course. However, this relationship between students and instructors is not replicated across the Services. We recommend the MoD set out what further action it proposes to ensure that instructors are proactive in identifying those at risk and to instil a culture within the Armed Forces where individuals are encouraged to self-report injuries or illnesses.***

103 Q107
104 Qq191–195
105 Q107
106 Q107
107 Q358

Investigations and learning lessons

80. There are a number of ways that the MoD investigates and learns lessons from accidents and fatalities during training, exercises and selection events.

Service Inquiries

81. On the establishment of the Defence Safety Authority (DSA) on 1 April 2015, its Director General became the primary convening authority for all safety-related Service Inquiries (SIs).[108] The purpose of a SI is to determine the facts of an incident and identify any lessons to ensure that it is not repeated. It is mandated by statute that a SI is to be held in the event of the death of a Service person,[109] unless in the opinion of the Convening Authority there is nothing of consequence to be learnt by the Regular or Reserve forces that was not apparent from the death. A SI panel must comprise of a president and at least two other members.[110]

82. The DSA is also responsible for managing recommendations emanating from SIs to ensure an audit trail exists of action taken.[111] Each recommendation is assigned to a lead official within the Defence Accident Investigation Branch (Defence AIB) and this lead works closely with an appointee from the Authority to agree how to take the recommendation forward. An update is required on progress every quarter with a formal report submitted to the Director General (DG) of the DSA bi-annually detailing the plan, actions to date and evidence of progress. Where appropriate the Defence AIB official can make a recommendation for closure or, if insufficient progress has been made, recommend engagement by DG DSA directly with the action authority. The DG DSA is the only person who is empowered to close a recommendation arising from a safety–related SI.

83. Air Marshal Garwood, Director General of the DSA, thought that the new processes for SIs had resulted in improvements.[112] He highlighted that in the past a SI might have delayed commencing its investigation to await other reports. He now intended to run SIs in parallel with other investigations, such as those of the coroner, as the DSA was "only interested in safety and preventing recurrence" and so timeliness was essential.[113] In addition to SIs he also described non-statutory inquiries which might, for example, be into a life-changing injury. The process for these types of inquiries was as follows:

> If they are led by the accident investigation branch, they will follow the same process in monitoring. If they are led by the commands—we often delegate this down into the commands, to, say, a duty holder, or the command chain rather than the duty holder—then their lessons would go into their own lesson management system […]. Those are all information management systems that look after those lessons accounts. As we further grow this branch, I would like to take in all of those lessons, even at the lower level, as one central lessons bank.[114]

108 Ministry of Defence (MEX0003)
109 The Armed Forces (Service Inquiries) Regulations 2008 (SI2008/1651)
110 The Armed Forces (Service Inquiries) Regulations 2008: Regulation 6 (SI2008/1651)
111 Ministry of Defence (MEX0003)
112 Q134
113 Q134
114 Q134

Coroner's investigations and inquests

84. Where a Coroner's Inquest (Fatal Accident Inquiries in Scotland) is convened, the Defence Inquests Unit (DIU) acts as the Departmental focus within the MoD.[115]

85. The Coroners and Justice Act 2009 requires coroners to make reports to a person, organisation, local authority, government department or agency where the coroner believes that action should be taken to prevent future deaths.[116] Such recommendations are issued by coroners in the form of a formal "Report to Prevent Future Deaths" (also known as a Regulation 28 report). For Defence inquests this is usually issued by the coroner to the Secretary of State or another Defence Minister. The MoD then has 56 days from the date of the letter to respond to the coroner. If it is not possible to provide the coroner with an answer within the timeframe for response (56 days), the coroner has the power to grant an extension on application.

86. On receipt, the Regulation 28 report is passed to the DIU to coordinate a response on behalf of the Department.[117] Having attended the inquest, and therefore being aware of the background to the coroners concerns, DIU tasks the relevant business areas with providing subject matter and policy advice on the matters raised. Business units are advised to address the coroner's concerns or give sound reasons as to the basis on which they are not accepted. The DIU scrutinises the advice received from the relevant business areas, then brings together all relevant advice to provide a draft response of the Department's position which is circulated to relevant parties for review. Once a final draft is agreed, it is submitted to the appropriate Defence Minister for final approval and onward transmission to the coroner.

The role of coroners

87. We took evidence from the Chief Coroner of England and Wales on the effectiveness of the coroner's system for dealing with Service deaths. Under section 17 of the Coroners and Justice Act 2009, the Chief Coroner must monitor and train for investigations into the deaths of Service personnel.[118] The Chief Coroner requires senior coroners to notify him of all such investigations and update him upon their progress and outcome. In respect of his duty to train coroners, in 2013 the Chief Coroner created a specialist cadre of coroners, at present 10, for Service deaths in England and Wales.[119]

88. The purpose of the Service deaths cadre is to provide a specialist well-trained, experienced group of coroners to conduct where necessary investigations and inquests into Service deaths.[120] Initial training focused on Service death investigations and inquests under the 2009 Act and the associated rules and regulations and the Chief Coroner told us that further specific training from the DIU would be provided on request.[121] Furthermore, a number from the cadre had visited the Land Warfare Centre, Warminster, to receive training about equipment, vehicles and medical issues in theatre.[122]

115 Ministry of Defence (MEX0003)
116 Ministry of Defence (MEX0003)
117 Ministry of Defence (MEX0003)
118 Coroners and Justice Act 2009, section 17
119 Q221 and Q229
120 Q229
121 Q239
122 Q240

89. Following the evidence session, the Chief Coroner wrote to us about possible further training:

> I have considered all the training issues you have raised and will continue to do so. I am grateful to you for having raised them. For example I have discussed with the Defence Inquests Unit (DIU) of the Ministry of Defence (MoD) whether there might be an opportunity for the cadre to learn about the treatment and care pathways available to Service men and women, particularly after discharge from the Armed Forces. This is a matter the MoD are considering.[123]

The Minister also committed herself and other relevant ministers to meeting regularly with the Chief Coroner in order to accommodate requests for further training.[124]

90. We also asked the Chief Coroner about Regulation 28 reports to prevent future deaths and whether coroners took into account the unique nature of military service. He was sure that coroners did so, but emphasised that "the focus is on the evidence received in court, in writing or from witnesses, and if they have a concern—the word in the Act—about something that has or has not happened that could lead to a future death arising in similar circumstances, they have a duty to report".[125] He added that coroners were only allowed to make general recommendations, for example a request for the MoD to review a policy, but they could not make recommendations about a particular piece of equipment.[126] The lessons identified in the Regulation 28 Report are captured by the relevant MoD and Armed Forces lessons management systems.[127]

91. We were also keen to establish the Chief Coroner's role in monitoring and taking forward the recommendations of Regulation 28 reports. He told us:

> I have not taken anything further forward from the MoD. […] I think it is a matter for Government whether the implementation of those proposals in that response are carried out.[128]

92. However, he added that:

> If anything was brought to my attention and anyone—any family—said, "Please follow this up or do something about it", I would look at it and take it up.[129]

93. When we asked the Minister whether the DSA should include in its annual report an update on the responses to, and implementation of, recommendations from Service Inquiries and Coroner's Regulation 28 reports she gave us a positive response, although she thought the final decision rested with the DSA.[130]

94. **We welcome the DSA becoming the convening authority for all safety-related Service Inquiries and the management of recommendations emanating from them. We**

123 The Chief Coroner of England and Wales (MEX0016)
124 Q415
125 Q260
126 Q260
127 Ministry of Defence (MEX0009)
128 Q263
129 Q263
130 Qq401-403

also welcome the decision to run Service Inquiries in parallel with other investigations. This will help to ensure that potential safety hazards are identified and dealt with quickly and so lessen the chances of further deaths or injuries.

95. ***Service Inquiry reports and Coroners' Regulation 28 Reports to Prevent Future Deaths provide an invaluable mechanism for learning lessons from training-related fatalities and injuries. We recommend that the DSA, in addition to its responsibility for managing recommendations emanating from Service Inquiries, also be responsible for oversight of the finding of Coroners' Regulation 28 reports. We expect the DSA to report on the progress of how it will take forward each of these recommendations in its Annual Report.***

96. ***We welcome the creation of a special cadre of coroners for military inquests and the training provided by the Chief Coroner. We also welcome Minister's offer of providing additional training and we look to both parties to ensure that it is provided.***

5 Support for families

97. Support to the families of Service personnel who have died or been injured is an essential element of the 'duty of care' owed by the nation to its Armed Forces. **We are extremely grateful to the families of Service personnel who have died during training for their willingness to share their experiences with us and also their observations on our inquiry as it progressed.**

98. During our inquiry we received evidence detailing concerns regarding the support for families. These centred predominately on the information that families received regarding the circumstances of the incident. Hilary Meredith, a solicitor with Hilary Meredith Solicitors, highlighted the fact that the details of an incident reported to the family by the MoD often changed by the time of the conclusion of the inquest:

> Among the families I have come into contact with, the original approach from the MoD and liaison officers is usually quite good, but without a doubt, in every incident I have been involved in, the picture of the fatality that has been given to the families at the beginning and that they have set in their minds is not the picture they have after the inquest.[131]

99. Ms Meredith suggested that while this could have been caused by the natural filtering of facts over time she also believed that negligence may have been a factor.[132] She said that a military inquest was "difficult enough for a civilian family to deal with" without having to find out in evidence that "what actually happened is different from the story they were told at the beginning".[133] Ms Meredith said that this had happened at every inquest in which she had been involved and the result was that closure for families was delayed and prolonged.[134]

100. Philippa Tuckman, a solicitor at Bolt Burden Kemp, shared these concerns.[135] She said that in a number of cases there was a complete breakdown in communications and that families might not even receive a copy of the Service Inquiry Report. Although she accepted that she had heard good stories, in the main she considered the approach of the MoD as "very unsatisfactory". In her experience there was "kindness [from the MoD] to begin with and then the inquiry process seems to take over, at which point the shutters come down because you can only assume that the MoD does not want to prospectively incriminate itself".[136]

101. MoD guidance and direction on casualty management is contained in Joint Service Publication 751, *Joint Casualty and Compassionate Policy and Procedures*.[137] JSP 751 sets out immediate and subsequent procedures to be followed after an incident. Each Service uses this as the framework on which to develop and deliver their support for bereaved families and each will have different organisations involved in supporting families.

131 Q200
132 Q201
133 Q201
134 Q202
135 Q202
136 Q202
137 Ministry of Defence (MEX0009)

102. Air Marshal Garwood, Director General of the DSA, saw family engagement with the Service Inquiry process as essential and said that he has requested that Service Inquiries make early contact with the families—if they wish to have contact—to explain the process.[138] He found that families were normally receptive and that during the inquiry, updates would be provided to the families. When the inquiry was completed an unredacted copy of the report would be provided to them, followed by a briefing from the head of the inquiry. As Director General of the DSA, he saw himself as having a key role "in making sure the family is looked after".[139]

103. In a similar vein the Chief Coroner told us that they put the families at the heart of the process and tried to ensure they were looked after.[140] However, he was aware that the way in which families received information was not ideal and that many of the sources of information were outside the remit of the coroner; for example the visiting officer, the Royal Military Police and other inquiries, including the Service Inquiry. He added:

> Ultimately, the information is not all there, it is not all put together, until the final inquest. It may be that what is given sometimes piecemeal to a family does not reflect the final picture.[141]

He stressed the importance of getting this right because "first impressions will be huge for them" and would "stick in their mind and will be the explanation that they are living with for all that time until the inquest comes".[142]

104. Andrew Cayley, the Director of Service Prosecutions, told us that the Service Prosecuting Authority liaised with families to explain decisions on whether or not to prosecute and that a right of review existed for those decisions.[143]

105. Despite these assurances, Penny Mordaunt MP, Minister for the Armed Forces, had concerns regarding some of the treatment that families have had to endure following a tragedy.[144] Following one such incident, she commissioned a non-statutory inquiry into this matter which is ongoing. The inquiry has two key aims:

- investigate and comment upon the notification process and after care of the families of the deceased;
- investigate and comment upon the welfare management of the personnel responsible for running [that particular] selection course.[145]

At the time of this report there was no estimated completion date for the inquiry. However, the Minister anticipated "probably about 25 to 30" recommendations on how the MoD could improve its support.[146]

106. While the Minister believed that many parts of the Armed Forces conducted support for families "incredibly well", she conceded that it did not happen every time. Failures,

138 Q136
139 Q136
140 Qq241-242
141 Q252
142 Q252
143 Q47
144 Q416
145 Ministry of Defence (MEX0017)
146 Q416

she believed, were down to a combination of factors including, "responsibilities for doing particular things were not clear"; "the quality of support that has been provided"; and "lack of support for the individuals who are supposed to be providing that support."[147]

107. The MoD acknowledged that "the policy and processes supporting the delivery of Casualty and Compassionate procedures cannot be seen to fail as the risk is considered too great."[148] Therefore, in addition, to the above inquiry, it had also commissioned an audit of Casualty and Compassionate policy to provide an independent and objective opinion as to its adequacy and effectiveness. The audit will review the process and procedures from the point of incident to the period post inquest.[149]

108. ***The families of Service personnel are entitled to the highest possible level of support and care. This is especially important in cases of fatalities and serious injuries suffered during training or other aspects of military service. We acknowledge that this is the MoD's intention. However, it is clear to us that the MoD does not always meet the high standards that it has set itself. We welcome both the Minister's decision to establish a non-statutory inquiry into the treatment of families following a fatality and the MoD's audit into its Casualty and Compassionate policy in recognition that changes are required. We expect the MoD to share with us the outcomes of these reviews together with an action plan for taking forwarding their recommendations.***

109. ***We are deeply concerned to hear that in some cases families do not receive full disclosure of information relating to a fatality or that the facts they are given immediately following the incident are not compatible, or are different, from those that are disclosed at the subsequent coroner's inquest. Given the length of time it takes to complete inquests, it is vital that that families are supported with as much information as possible and on a regular basis. We welcome the fact that the DSA will fully involve families in the Service Inquiry process from a very early stage, and the commitment that presidents of such inquiries will engage fully with families. In its response to this Report we expect to receive a detailed account of how this will work in practice.***

147 Q416
148 Ministry of Defence (MEX0017)
149 Ministry of Defence (MEX0017)

6 Accountability

Introduction

110. Some of our witnesses expressed concern at what they saw as the Ministry of Defence's (MoD) and Armed Forces' lack of accountability for fatalities and injuries during training, exercises and selection events and questioned the adequacy of the mechanisms that existed to hold them to account.

111. Hilary Meredith told us that "historically the MoD has enjoyed no accountability or ownership for accidents resulting in injury or death on manoeuvres or whilst practising for war".[150] She suggested that a lack of intervention in the Armed Forces, for example from the Health and Safety Executive, and Crown censorship had resulted in a "blasé attitude" towards accidents and attrition rates.[151] As a result, she concluded that the MoD and the Armed Forces "police themselves".[152]

112. We also heard concerns regarding accountability from Mr and Mrs Maher whose son died during a selection event for a Specialist Military Unit. They were particularly concerned that a lack of accountability for such units engendered risk within them and a resistance to change to make training and selection events safer.[153]

113. However our witnesses from the military did not recognise this. Brigadier Porter a former Royal Marine, could not recall a time when the "approach to training was lackadaisical or blasé", and that the focus of training was on "being as successful as possible and to get as many people through as possible".[154] Air Commodore (retired) Stephen Anderton, former Commandant General of the RAF Regiment, agreed. He said that the aim was "to get the maximum amount of training done to get these young men through intellectually and physically demanding courses". He regarded this as having worked "quite well" and he did not believe that he, or those responsible for training, had ever compromised safety by cutting corners.[155]

114. Penny Mordaunt MP, Minister of State for the Armed Forces, accepted that there would always be an element of risk in training events but argued that while it was not possible to mitigate against everything, there was not a "blasé attitude" and that in her experience, the safety culture was "extremely good".[156]

115. In her opinion, the establishment of the Defence Safety Authority was a "massive step forward" in providing quality control and consistency between the Services but she added that "clearly we [the MoD] want to learn lessons where things have gone wrong".[157]

116. The Minister also refuted the suggestion that the MoD policed themselves. She told us that the DSA was the "internal governance that holds the services to account", but that it

150 Ms Hilary Meredith (MEX0001)
151 Ms Hilary Meredith (MEX0001)
152 Q171
153 Mr and Mrs Maher (MEX0004)
154 Q297
155 Q297
156 Q338
157 Q338

"does not mark its own homework." She explained that while the DSA reports to the single Service Boards and the Defence Board, it will be audited externally through statutory bodies including the Health and Safety Executive and the Civil Aviation Authority.[158]

117. **We are concerned by the suggestions that the MoD and the Armed Forces police themselves and are perceived to be unaccountable in respect of injuries and deaths during training, exercises and selection events. While we do not consider there to be a "blasé attitude" towards accidents and attrition rates, it essential that Ministers and the Armed Forces seek to change this perception where it exists, as a matter of priority. If they do not, it will continue to undermine confidence in the Armed Forces.**

Legal Accountability

118. During the course of this inquiry we explored the mechanisms which exist to hold the MoD and the Armed Forces to account; in particular the role of the Health and Safety at Work etc Act 1974, Service Law and the military exemptions contained in Section 4 of the Corporate Manslaughter and Homicide Act 2007.

Health and Safety at Work Act etc. 1974

119. The Health and Safety at Work Act 1974 is the primary piece of legislation covering occupational health and safety in Great Britain. In evidence, the Health and Safety Executive (HSE) set out the key differences in how the law applies to the MoD. Unlike civilian employers, the MoD (like all other Crown bodies) has Crown Immunity, which means that formal enforcement is not applicable.[159] Furthermore, the Secretary of State has the power to exempt the Crown from any or all of the provisions that bind the Crown "in the interests of the safety of the State".[160] Different mechanisms have therefore been established for dealing with significant breaches of the legislation.[161]

120. The HSE and the MoD have a formal written agreement, the "General Agreement", signed by the MoD's Permanent Under-Secretary and the HSE's Chief Executive.[162] This agreement defines the relationship between the two in discharging their respective responsibilities and roles for health and safety in defence activities in Great Britain. Under the agreement, the MoD recognises its duties to comply with the 1974 Act while the HSE commits to take into account the operational context in which defence activities are conducted.[163] The HSE investigates incidents or complaints involving the MoD as they would with any other duty holder. Any decision to investigate an individual case is made by applying HSE's Incident Selection Criteria, and HSE field inspectors, supported by specialists as required, carry out investigations.[164]

121. There are, however, a number of limitations. The 1974 Act applies to Great Britain and extends a further 12 nautical miles out to sea to cover defined work activities such as

158 Q359
159 Health and Safety Executive (MEX0006)
160 Health and Safety Executive (MEX0006)
161 Health and Safety Executive (MEX0006)
162 Health and Safety Executive (MEX0006); Ministry of Defence and Health and Safety Executive, *General Agreement between Health and Safety Executive and Ministry of Defence* (December 2014) accessed 19 April 2016
163 Health and Safety Executive (MEX0006)
164 Health and Safety Executive (MEX0006)

loading and unloading of vessels.[165] An analysis of the locations of the 135 deaths which had occurred during training, exercises or selection events revealed that 55 of these were outside of that jurisdiction and therefore could not be investigated by the HSE.[166] Philippa Tuckman, a solicitor at Bolt Burdon Kemp Solicitors, questioned this: "I don't see why the HSE should not be allowed to investigate training exercises overseas, because a great deal of work is done there".[167]

122. Between 1 January 2000 and 18 July 2015, the HSE carried out 190 investigations into defence-related activities, the outcomes of which are summarised below:

- Out of 190 investigations, 36 related to training, exercise and selection activities of which 23 involved fatalities;
- The HSE issued four Crown Prohibition Notices and 43 Crown Improvement Notices. Of these, two Crown Prohibition Notices and 13 Crown Improvement Notices related to training, exercise and selection activities; and
- There were 15 Crown Censures of the MoD and its agencies, 10 of which related to training, exercise and selection activities.[168]

We note that during our inquiry an additional Crown Censure was issued to the MoD in April 2016 in respect of the deaths of three Reservists on Brecon Beacons in 2013.

123. Dr David Snowball, Director of Field Operations, Health and Safety Executive, explained that a Crown Censure would be the equivalent of a prosecution but for Crown Immunity.[169] However, the censure was normally directed at the organisation, not at an individual:

> We would never […] prosecute an individual, either in the civilian or the military world, if we thought that the primary, underlying reason for failure lay at organisational level. [170]

However, he emphasised that military staff were still subject to individual responsibility under the Health and Safety at Work etc. Act, even though they were not exposed to Crown Notices or Crown Censures.[171] When asked if it should be possible to censure individuals, Dr Snowball responded that achieving parity between the civilian and the military role would be "a worthwhile thing to look at".[172]

124. Dr Snowball told us he had delivered three Censures to the military during the last 10 years but in his opinion the failure in each case was corporate, not individual. He told us it was clear to him that the interface between the conception, the planning and the implementation pointed very strongly towards corporate failings which amplified the failings of individuals in the system.[173]

165 Health and Safety Executive (MEX0006)
166 Ministry of Defence, Ad Hoc Statistical Bulletin: Training and Exercise deaths in the UK Armed Forces, 1 January 2000—20 February 2016, 2 March 2016.
167 Q 160
168 Health and Safety Executive (MEX0006)
169 Q6
170 Q6
171 Q6
172 Q13
173 Q58

Service Law

125. The Service Prosecuting Authority (SPA) was established in 2010. Its main role is to review cases referred to it by the Service Police or chain of command and to prosecute appropriate cases at court martial. There are two types of case that are prosecuted: "Criminal Conduct" and "Discipline" offences. When the SPA concludes that an individual is culpable for accidents or deaths during training the level of available sanction will depend upon the level of culpability or wrongdoing.[174]

126. Under "Criminal Conduct" offences, Section 42 of the Armed Forces Act 2006 makes those subject to Service law liable to be charged with any criminal offence that could be charged in England and Wales. The SPA applies the same charging standards that apply in the civilian courts in England and Wales. In the most serious cases, an individual could be charged with manslaughter with a maximum sanction of life imprisonment. "Discipline" offences are levelled where conduct falls short of criminal in the civilian sense but amounts to negligence in a military sense. Such offences carry a maximum sentence of two years' imprisonment.[175]

127. The SPA regard Service law as complementing other provisions such as health and safety legislation.[176] Unlike health and safety legislation, Service law is not confined territorially to Great Britain.[177] Primacy, under health and safety legislation, for any prosecution rests with the Health and Safety Executive as it does in a civilian case. If required, the SPA would assist the HSE with any prosecution that it brought. All those subject to Service law are subject to the criminal law of England and Wales wherever they are based. Therefore, if the gross negligence of an individual subject to Service law caused the death of another during training, an exercise or selection event, the SPA believed the Service justice system was well equipped to prosecute that individual for manslaughter.[178]

128. If a case which involved the death or injury of military personnel in such circumstances, is referred to the SPA, all relevant criminal offences would be considered together with all military offences.[179] Since its creation in 2010, the SPA had charged seven cases of negligence in performing a duty[180]. Andrew Cayley, Director of Service Prosecutions, told us that all of those cases had been referred, but resulted in different actions:

> There was a conviction for dangerous flying—three service personnel were killed and a number were injured. For all the other cases, the Service Prosecuting Authority charged negligently performing a duty, which is a military offence with a maximum penalty of two years' imprisonment. In other words, when the service police had referred manslaughter gross negligence, the determination was made at the time that the evidence was not sufficient for that charge, so the military offence was charged instead.[181]

174 Service Prosecuting Authority (MEX0007)
175 Service Prosecuting Authority (MEX0007)
176 Service Prosecuting Authority (MEX0007)
177 Service Prosecuting Authority (MEX0007)
178 Service Prosecuting Authority (MEX0007)
179 Service Prosecuting Authority (MEX0007)
180 Q21
181 Q22

Administrative Action

129. The SPA described a further avenue open to the chain of command, "Administrative Action". This is essentially an employment sanction carried out by the chain of command in cases of misconduct or inefficiency.[182] There are a full range of sanctions available under this action, including dismissal. The process is separate from any court proceedings and not something that the SPA would advise on, but the chain of command could obtain legal advice from other Service lawyers.[183]

130. We questioned Mr Andrew Cayley, Director of Service Prosecutions, on the safeguards in place to stop the chain of command applying Administrative Action when the case should be referred to him as Director of Service Prosecutions. He explained the rules:

> In essence, when the service police investigate an alleged offence and it is what is called a Schedule 2 offence within the Armed Forces Act—Schedule 2 offences are all serious matters, including manslaughter—that has to come to me. It is a statutory obligation on the service police: they have to send that case to me.
>
> If it is a non-Schedule 2 offence […] it would go to the commanding officer of the individual who had allegedly committed the offence. The commanding officer will get legal advice from a [relevant] military lawyer. […] The commanding officer will be advised and that legal adviser will advise the commanding officer that he might deal with the offence summarily—summary dealing. […] A commanding officer has the authority to deal with lesser offences, but if the lawyer who is advising says, "Look, even though this is not a Schedule 2 offence, it is sufficiently serious that I think you should go to the director of the Service Prosecuting Authority," that is what happens.[184]

131. As a result Mr Cayley was assured that the safety mechanisms worked correctly, and added, "that is why the Armed Forces Act and the SPA were created—to make sure that things were being properly dealt with".[185]

132. During our evidence, we heard that under this process, Service personnel had been removed from command for failings in the supervision of safety of training events. Major General Tickell told us:

> Every incident is investigated […] during my time, I have removed one independent sub-unit commander from command as a result of a safety incident.[186]

133. Notwithstanding that example, we encountered difficulties in obtaining information on the use of Administrative Actions in respect of training, exercises and selection events. Air Marshal Garwood, Director General of the Defence Safety Authority, told us that the Single Services, not the DSA, monitored its use.[187] The Minister accepted that there was a problem with the fact that the information historically had been held by the single

182 Service Prosecuting Authority (MEX0007)
183 Service Prosecuting Authority (MEX0007)
184 Q32
185 Q32
186 Q85
187 Q129

Services and was in favour of that information being routinely forwarded to the DSA.[188] General Barrons also agreed that transparency would be helpful. He did not consider it to be "wrong or a challenge" to be able to say that, as a result of a failing, that a commanding officer was removed or that some other sanction had been applied.[189]

134. Following our evidence session with the Minister and General Barrons, we made a further attempt to ascertain the level of use of Administrative Action in respect of deaths and accidents during training, exercises and selection events. We requested the information on the number of people removed from post since 2000, by Service, for failures relating to the supervision of training or selection events and also details of any other sanctions that had been applied for such failures. The MoD told us that it was not possible to provide a full response "as it would require a recall and search of a large volume of individual records over a number of years".[190] The single Services did, however, provide the following information:

- **Army:** Out of eight cases which have been found from a search of Army records there have been four letters of censure and four formal warnings linked to training incidents.
- **RAF:** RAF records indicate that no Major Administrative Action has been actioned over at least the past five years in relation to a death in training.
- **Royal Navy:** No Administrative Action or disciplinary investigation initiated in the last year as a result of training safety incidents.[191]

135. The MoD also pointed out that:

> Administrative Action is very much like the action any employer can take. It may be used to improve a person's performance, but where that is not going to work, it can used to remove the person from his or her job, or from the Armed Forces. It is flexible and can be used to great effect but, as with similar action by other employers, it is an internal matter and not one for achieving public accountability.
>
> It is worth highlighting that where an incident does happen it is investigated by the necessary bodies (for example, Civilian Police, HSE or Service Police) and their conclusions, independent of the chain of command are sent to the CPS or the Service Prosecuting Authority for action as required.[192]

Civilian prosecutions

136. We asked the Minister why there had been no civilian prosecutions and why there appeared to be a relatively low number of Service prosecutions. The Minister responded that while it was important that people were held to account for their actions, criminality was not a matter for the MoD, and that it was inappropriate to criticise the Department

188 Q406
189 Q381
190 Ministry of Defence (MEX0017)
191 Ministry of Defence (MEX0017)
192 Ministry of Defence (MEX0017)

for the level of prosecutions.[193] However, she emphasised the importance of the chain of command understanding the need for transparency so that "people understand who is responsible for what and that people are held to account for their actions".[194] She added:

> I absolutely agree that even if that criminal bar is not met, clearly there has to be accountability and a consequence if someone does not do what was required of them. There is no question about that.[195]

137. Humphrey Morrison, Head of Legislation at the MoD, suggested that it was important to look at the range of ways that the MoD and the Armed Forces could be held to account:

> One has to look at the regime as what is available as a whole: civilian claims; Crown censure as far as the Health and Safety at Work etc. Act 1974 is concerned; prosecution under the Corporate Manslaughter and Corporate Homicide Act 2007 where training that should not be dangerous becomes dangerous through negligence—such prosecution is available against the MoD under that Act—prosecution of individuals, whether by the civilian authorities or the military authorities, for criminal or disciplinary offences; and, last but not least, the ability of individuals who seek to air issues of negligence publicly to bring civil claims. Beyond that whole area of public accountability is the internal processes of administrative action. Those are not primarily a mechanism of public accountability, but they are one of the mechanisms available to seek improvement and, if necessary, to remove people from posts or even the Armed Forces as a whole if they are not able to meet the standards required.[196]

138. ***There are a range of mechanisms and sanctions which can be used to hold the MoD, the Armed Forces, and individuals within them, to account for failings in the supervision of the safety of training events. However, it is essential that the MoD and the Armed Forces are also seen to be accountable. There have been no civilian prosecutions, and since the establishment of the SPA in 2010, only seven Service prosecutions relating to training, exercises and selection events. While we accept that decisions on prosecutions are not a matter for the MoD, we recommend that the MoD conduct an analysis of whether Service law is fit for the purpose of holding people accountable for training supervision.***

139. ***We are also concerned that 55 of the 135 deaths during training, exercises or selection events occurred overseas and were therefore not subject of HSE investigations. While such cases can be investigated by Service Police and the authorities in the host country, we do not consider this to be adequate. Therefore, we recommend that the MoD identify with the HSE, mechanisms to allow the HSE to investigate service deaths overseas.***

140. ***We note that the Armed Forces can use Administrative Action in respect of failings in the supervision of training, exercises and selection activities. This is an appropriate response to cases where minor failings are identified. However, it is unacceptable that there is extremely limited information the level of the use of such measures. In respect***

193 Q360
194 Q360
195 Q367
196 Q378

of safety infringements, this information should be routinely communicated to the Defence Safety Authority (DSA) and the collated information included in the DSA's Annual Report.

Corporate Manslaughter and Homicide Act 2007

141. The Corporate Manslaughter and Homicide Act 2007 allows a corporate body to be prosecuted where serious management failings result in a fatality.[197] The Act provides a number of exemptions for the MoD, including the duty of care owed by it during defined military activities. Section 4 of the Act states:

4 Military activities

(1) Any duty of care owed by the Ministry of Defence in respect of—

(a) operations within subsection (2),

(b) activities carried on in preparation for, or directly in support of, such operations,

or

(c) training of a hazardous nature, or training carried out in a hazardous way, which it is considered needs to be carried out, or carried out in that way, in order to improve or maintain the effectiveness of the armed forces with respect to such operations,

is not a "relevant duty of care".

(2) The operations within this subsection are operations, including peacekeeping operations and operations for dealing with terrorism, civil unrest or serious public disorder, in the course of which members of the armed forces come under attack or face the threat of attack or violent resistance.

(3) Any duty of care owed by the Ministry of Defence in respect of activities carried on by members of the special forces is not a "relevant duty of care".

(4) In this section "the special forces" means those units of the armed forces the maintenance of whose capabilities is the responsibility of the Director of Special Forces or which are for the time being subject to the operational command of that Director.

142. Hilary Meredith noted that in the past, the MoD had sought to Court Martial individuals in charge of training and selection where fatalities occur. However, she did not consider this an appropriate sanction:

> The MoD need to accept vicarious responsibility for the actions or failings of their personnel and look to their own systems and procedures for lessons learnt. Rather than seek to Court Martial individuals it may be considered appropriate, in circumstances where there is such a disregard for human safety and life, that actions become reckless or criminal, to remove the current immunity enjoyed by MoD and Special Forces from The Crown Immunity to Corporate Manslaughter and Corporate Homicide Act 2007. [198]

197 Corporate Manslaughter and Homicide Act 2007
198 Ms Hilary Meredith (MEX0001)

She believed that if the MoD police were subject to the Corporate Manslaughter Act, "it might make people sit up and take notice".[199]

143. Humphrey Morrison, Head of Legislation at the MoD, emphasised that the MoD could be held corporately responsible. In respect of the Military Exemptions in the Act, Mr Morrison explained that:

> To summarise, the Corporate Manslaughter Act applies to the MoD. There are areas where the circumstances of what is having to be done do not allow for an exemption for the MoD and therefore the Armed Forces from corporate criminal liability. That is the area of normal training, normal selection—all that sort of thing. But there is another area where you have to do things that are dangerous. Where you know it is inherently dangerous and you have to do it that way, or where you have to conduct operations that are inherently dangerous, to be told, "If you make a mistake, you will be criminally liable", was thought at the time to be the wrong approach.[200]

Specialist Military Units

144. In their written evidence Mr and Mrs Maher accepted that Specialist Military Units should be exempt from prosecution during operations and training. However, they believed that such Units should not be exempt from the Corporate Manslaughter and Homicide Act where fatalities occurred due to "gross neglect":

> We understand fully why [Specialist Military Units] must be exempt from prosecution whilst undergoing operations. The nature of their work and the environments in which they do it means that it would be inappropriate to subject them to this law. We can even accept exemption from prosecution for activities carried out during training. The training must be 'fit for purpose' and, even with a calculated risk assessment, it may lead to injury and even death.
>
> But we cannot accept that [Specialist Military Units] should not be answerable in law in cases where people die as a result of their gross neglect. This effectively makes them unique amongst all UK citizens and puts them above the law.[201]

145. When questioned on the complete exemption for Specialist Military Units, Mr Morrison told us it was related to:

> The hazardous side and, more generally, the view that was taken that as far as Special Forces training, Special Forces selection and the way they do things was concerned, the issue of security and confidentiality was more important, or as important as the issue of the hazardous nature of it.[202]

199 Q171
200 Q370
201 Mr and Mrs Maher (MEX0004)
202 Q372

He added that the arguments were much more about:

> Security of information, which led to the conclusion at the time that all their activities should not be subject to public scrutiny in the criminal courts in respect of a corporate liability.[203]

146. General Barrons argued against the removal of the specific exemption for Specialist Military Units. He told us that if there was a training accident within Specialist Military Units, the civil police would decide whether or not to investigate it.[204] If that was the case, the normal law would apply, and if it were to be found that the training had been done so catastrophically badly that the test of criminal negligence was passed, that individual would be prosecuted. Mr Morrison added that this would equally apply under Service law:

> As far as individuals are concerned, there is no exemption for members of Special Forces from either disciplinary offences or criminal law manslaughter. They can be prosecuted under the military system or under the civilian system.[205]

Mr Morrison went on to argue that the military system was better in so far as an individual could be charged with either a criminal offence such as manslaughter, or a disciplinary offence such as neglect of duty, which was treated and proceeded with as if it were a crime.[206]

147. However, the Director of Specialist Military Units did not believe from his own experiences that the removal of the exemption for Special Forces would necessarily affect the practical delivery of training:

> Strictly speaking, I struggle to see why it would affect the practical delivery, because we are already seeking to conduct this training with as low a risk as possible. Whether we are subject to the Corporate Manslaughter Act or not will not change how I or my people conduct training—it does not mean that we will be more risk-averse, because for all the right reasons we are trying to do things correctly.[207]

The witness also agreed that the removal of the exemption would not necessarily reduce the effectiveness of the training at the tactical level, or reduce the capability to carry out training to the level his personnel required. Though he did note that the ubiquitous nature and pace of special forces operations mean that it is particularly challenging to disentangle the standards and challenges posed during training and selection activity from the demands of the ultimate operational output, which is covered by combat immunity, and so it is hard to predict with certainty what changes removal of the exemption may lead to.[208]

148. By contrast Brigadier Porter, told us that he was unaware of "any instances where anyone has been prosecuted for corporate manslaughter".[209] However, he was aware of people being "disciplined for mistakes and people being moved on from employment

203 Q372
204 Q377
205 Q377
206 Q377
207 Evidence 11 January 2016
208 Evidence 11 January 2016
209 Q315

or administrative action being taken against individuals" and said that there had been occasions where the mistakes made were "so inexcusable that possibly there could be a higher level of action being taken".[210]

149. Air Commodore (retd) Stephen Anderton, former Commandant General of the RAF Regiment, went further:

> I would have no difficulty with the MoD being held corporately responsible. I do not see why there should be any difference between the Ministry of Defence and a civilian organisation. If there is culpable negligence at a corporate level because of the corporate structure, I do not see why the organisation should not be held responsible.[211]

150. ***We fully accept that the Corporate Manslaughter and Homicide Act 2007 should not apply in any respect to military operations. However, we are not persuaded that the military should be exempt in respect of hazardous training in preparation for operations or that Specialist Military Units should enjoy a complete exemption where gross neglect has occurred. Furthermore, it cannot be right that an individual can be prosecuted while the corporate body cannot. Any individual member of a Specialist Military Unit can be prosecuted under law, and with the same risk to be managed there of operational security and confidentiality. We do not see how this risk increases should the corporate responsibility exemption be removed. We recommend that the military exemptions in the Act be amended so that the MoD can be prosecuted if it has been subject to a Crown Censure from the Health and Safety Executive for a particular incident.***

151. ***We believe this strikes the correct balance between ensuring the Armed Forces are able to train effectively but at the same time be corporately accountable for failings in the supervision of training, exercises and selection events.*** **Given the fact that there have been 11 Crown Censures since 2000 in relation to training, exercise and selection activities, we do not envisage that this would open the MoD to a significant number of prosecutions.**

152. ***We are not convinced that the Special Forces exemption is required on the basis of security and confidentiality. We consider that sensible precautions can be taken at any judicial proceedings to ensure the appropriate level of security and confidentiality for Specialist Military Units.***

210 Q315
211 Q315

7 Conclusions

153. **Our Report has focused on the importance of getting the right balance between the need to put Service men and women, be they full time or Reservists, operating in the UK, or abroad, through the best possible training to equip them to do the arduous and often dangerous tasks that we expect them to do, while at the same time assessing, managing and mitigating the risks associated with such training so that accidents and fatalities are kept to a minimum.**

154. **We have examined the adequacy of the MoD's policy on the health and safety risk assessment process, the quality of training and whether Service personnel are properly prepared and monitored throughout their training and selection events. While we have found no systemic failings, the MoD has not always got the correct balance between adequate training and reducing risk resulting in life-changing injuries and deaths in training and selection events.**

155. **Evidence of this can be seen in the 135 fatalities during training and selection events over the past 15 years. While we accept that military training is inherently hazardous, we believe that some of these deaths could have been avoided if the risk assessment process had been followed correctly.**

156. **A key focus of our Report has been on the accountability measures which can be used from Service Inquiries to coroner-led investigations and inquests. While it is important that the MoD and the Armed Services are accountable for all accidents and fatalities on training exercises and selection events for all the Services, it is equally important that they are seen to be so. The families and friends of those who have died whilst on training exercises need to have confidence that that lessons have been learned for the future.**

157. **We believe the MoD is in fact moving in the right direction. Evidence of this can be found in the creation of the Defence Safety Authority in 2015 which has, among other things, responsibility for the conduct of independent service inquiries into safety-related fatalities and the roll out of the Duty Holder Concept.**

158. **We were impressed by the training we saw at the Commando Training Centre (CTC) in Lympstone, in particular the practical application of the concept of 'training in' rather than 'selecting out'. Although we were only there for the final assessment, it was clear to us that there was a good relationship between trainers and trainees, that facilities for medical and rehabilitation care were excellent and accessible, and that duty holder concept was fully integrated into their processes.**

159. **However, there is no room for complacency. Every such death is a tragedy. Our recommendations point out areas where we think the MoD can go further and areas which we would like them to explore in more detail.**

Conclusions and recommendations

Training and governance structure

1. *We welcome the establishment of the Defence Safety Authority (DSA). However, the DSA will need clear methods to measure its effectiveness and we recommend that the MoD set these out in response to our report. We also support the requirement for periodic external audit of the DSA by an externally recruited team or organisation. We seek confirmation from the MoD that this process will begin at the start of Financial Year 2017–18 and of the composition of the external auditing team.* (Paragraph 20)

2. *Whilst we acknowledge that the DSA is a relatively new body, we are concerned that there appears to be a limited level of knowledge of it outside the MoD and Armed Forces. We recommend that the DSA engages with external interested parties and stakeholders to promote and explain its work, and to provide the opportunity for external comment and review.* (Paragraph 21)

3. *We also recommend that an assessment take place of the DSA by the end of 2018 to determine the extent of the independence and the effectiveness of the Authority. Should deficiencies continue to exist the MoD should consider alternative oversight mechanisms, perhaps based on the model of the Service Complaints Ombudsman. The Committee may choose to return to this issue in 2019 if it remains concerned about the independence and effectiveness of the DSA.* (Paragraph 22)

4. *The introduction of the Duty Holder Concept (DHC) across the Armed Forces should establish a systematic process of both managing risk and holding to account those responsible for the design and delivery of training. As we saw with the establishment of the DSA, there seems to be little or low awareness outside the MoD and the Armed Forces of this development. We recommend that the MoD undertakes to publicise this widely so that families can have confidence in knowing that while military training may be hard or dangerous, that the organisers of that training are known and accountable.* (Paragraph 31)

5. *We recommend that a systematic survey is undertaken by the DSA to establish where the DHC is yet to be applied or effectively applied and to identify the measures needed to ensure a comprehensive roll out of the scheme.* (Paragraph 32)

6. *We agree that the DHC simplifies accountability and responsibility to three levels in an effective manner. However, we are not yet convinced that this simplicity and clarity exists where there is the involvement of more than one Service or chain of command in the management and delivery of risk. We recommend that the DSA review those exercises where the Operating Duty Holder and the Delivery Duty Holder are not aligned in the chain of command, or where there are multiple Operating Duty Holders required to exercise judgement in support of activities which are not delivered within their chain of command. In response to our report the MoD should provide examples of measures and controls which can demonstrate that risk is not simply transferred between Duty Holders.* (Paragraph 33)

MoD policy and guidance on training and selection events

7. Given the wide range and varied nature of Armed Forces' training we regard it as essential that detailed policy and guidance exists for its governance and the safety of those being trained. However, that guidance should never reduce the risk to such an extent that it would undermine the operational effectiveness of Service personnel through inadequate training. (Paragraph 46)

8. The high number of cold weather related injuries and the severe long term consequences of such injuries could not be ignored by the Committee. The failure to follow the clear JSPs in place, which should prevent such injuries, is worrying. The MoD must advise us of the steps it will take to monitor, prevent and to reduce the number of these injuries. (Paragraph 47)

9. *The use of "potted" guides (aides-memoire), which translate policy to core and relevant information are a welcome practice and their widespread use would mean no training supervisor could ever claim ignorance on the basis of too much information. We recommend the DSA measure their use and ensure comprehensive coverage accordingly.* (Paragraph 48)

10. Robust and detailed risk assessments are a vital part of ensuring the MoD correctly exercises its duty of care to Service personnel during training, exercises and selection events. We accept that it is not possible to mitigate against all risks and therefore dynamic risk assessments are critical part of the process—they can be the difference between life and death or serious injury. We are concerned to hear from our witnesses that there are variations in how effectively risk assessments are carried out. While training is extremely varied and some events will always require more detailed assessments, they should not become be a tick box exercise. (Paragraph 62)

11. *We expect the MoD to review both the education in, and delivery of, risk assessment and identify what measures they intend to take to address shortfalls in their application.* (Paragraph 62)

12. While we accept the principle of the "whole force" in respect of Reservist and Regular training, the different circumstances of Reservists must be taken into account in the design and delivery of that training. The MoD recognise this and are implementing changes to Reservist training. However, we are not convinced that there is sufficient assessment of training circumstances for Reservists, and there is a tendency to apply the Regular design and delivery template too readily. In particular, we were not reassured by the MoD 's statement that "not all [Army] Reserve training has been revised in the period as it falls outside of the mandated programme and the resource and requirement have not meant this is possible". It is nearly three years since the White Paper on Reserves was published which promised to ensure that the individual would become an integral part of the 'Whole Force' made up of both Regulars and Reservists. (Paragraph 67)

13. *Whilst recognising the special security considerations for Specialist Military Units, we are disappointed that we are unable to put the reports and evidence we have received in respect of Specialist Military Units into the public domain, even in a redacted format. To do so would help clarify and identify changes and improvements that have been made to the training of Specialist Military Units. In the absence of this material*

being put in the public domain, we recommend that this information, in some format, should be shared on a confidential basis with the families of those who have died or been injured. (Paragraph 73)

14. *It is important for the Armed Forces to balance the individual's desire to succeed and the need for them to self-declare injury and illness and not see it as a sign of failure. We saw good examples of this in practice at the CTCRM in Lympstone where the instructors follow trainees through from the beginning to end of their course. However, this relationship between students and instructors is not replicated across the Services. We recommend the MoD set out what further action it proposes to ensure that instructors are proactive in identifying those at risk and to instil a culture within the Armed Forces where individuals are encouraged to self-report injuries or illnesses.* (Paragraph 79)

15. We welcome the DSA becoming the convening authority for all safety-related Service Inquiries and the management of recommendations emanating from them. We also welcome the decision to run Service Inquiries in parallel with other investigations. This will help to ensure that potential safety hazards are identified and dealt with quickly and so lessen the chances of further deaths or injuries. (Paragraph 94)

16. *Service Inquiry reports and Coroners' Regulation 28 Reports to Prevent Future Deaths provide an invaluable mechanism for learning lessons from training-related fatalities and injuries. We recommend that the DSA, in addition to its responsibility for managing recommendations emanating from Service Inquiries, also be responsible for oversight of the finding of Coroners' Regulation 28 reports. We expect the DSA to report on the progress of how it will take forward each of these recommendations in its Annual Report.* (Paragraph 95)

17. *We welcome the creation of a special cadre of coroners for military inquests and the training provided by the Chief Coroner. We also welcome Minister's offer of providing additional training and we look to both parties to ensure that it is provided.* (Paragraph 96)

Support for families

18. We are extremely grateful to the families of Service personnel who have died during training for their willingness to share their experiences with us and also their observations on our inquiry as it progressed. (Paragraph 97)

19. *The families of Service personnel are entitled to the highest possible level of support and care. This is especially important in cases of fatalities and serious injuries suffered during training or other aspects of military service. We acknowledge that this is the MoD's intention. However, it is clear to us that the MoD does not always meet the high standards that it has set itself. We welcome both the Minister's decision to establish a non-statutory inquiry into the treatment of families following a fatality and the MoD's audit into its Casualty and Compassionate policy in recognition that changes are required. We expect the MoD to share with us the outcomes of these reviews together with an action plan for taking forwarding their recommendations.* (Paragraph 108)

20. *We are deeply concerned to hear that in some cases families do not receive full disclosure of information relating to a fatality or that the facts they are given immediately following the incident are not compatible, or are different, from those that are disclosed at the subsequent coroner's inquest. Given the length of time it takes to complete inquests, it is vital that that families are supported with as much information as possible and on a regular basis. We welcome the fact that the DSA will fully involve families in the Service Inquiry process from a very early stage, and the commitment that presidents of such inquiries will engage fully with families. In its response to this Report we expect to receive a detailed account of how this will work in practice.* (Paragraph 109)

Accountability

21. We are concerned by the suggestions that the MoD and the Armed Forces police themselves and are perceived to be unaccountable in respect of injuries and deaths during training, exercises and selection events. While we do not consider there to be a "blasé attitude" towards accidents and attrition rates, it essential that Ministers and the Armed Forces seek to change this perception where it exists, as a matter of priority. If they do not, it will continue to undermine confidence in the Armed Forces. (Paragraph 117)

22. *There are a range of mechanisms and sanctions which can be used to hold the MoD, the Armed Forces, and individuals within them, to account for failings in the supervision of the safety of training events. However, it is essential that the MoD and the Armed Forces are also seen to be accountable. There have been no civilian prosecutions, and since the establishment of the SPA in 2010, only seven Service prosecutions relating to training, exercises and selection events. While we accept that decisions on prosecutions are not a matter for the MoD, we recommend that the MoD conduct an analysis of whether Service law is fit for the purpose of holding people accountable for training supervision.* (Paragraph 138)

23. *We are also concerned that 55 of the 135 deaths during training, exercises or selection events occurred overseas and were therefore not subject of HSE investigations. While such cases can be investigated by Service Police and the authorities in the host country, we do not consider this to be adequate. Therefore, we recommend that the MoD identify with the HSE, mechanisms to allow the HSE to investigate service deaths overseas.* (Paragraph 139)

24. *We note that the Armed Forces can use Administrative Action in respect of failings in the supervision of training, exercises and selection activities. This is an appropriate response to cases where minor failings are identified. However, it is unacceptable that there is extremely limited information the level of the use of such measures. In respect of safety infringements, this information should be routinely communicated to the Defence Safety Authority (DSA) and the collated information included in the DSA's Annual Report.* (Paragraph 140)

25. *We fully accept that the Corporate Manslaughter and Homicide Act 2007 should not apply in any respect to military operations. However, we are not persuaded that the military should be exempt in respect of hazardous training in preparation for operations or that Specialist Military Units should enjoy a complete exemption where gross neglect has occurred. Furthermore, it cannot be right that an individual can be*

prosecuted while the corporate body cannot. Any individual member of a Specialist Military Unit can be prosecuted under law, and with the same risk to be managed there of operational security and confidentiality. We do not see how this risk increases should the corporate responsibility exemption be removed. We recommend that the military exemptions in the Act be amended so that the MoD can be prosecuted if it has been subject to a Crown Censure from the Health and Safety Executive for a particular incident. (Paragraph 150)

26. *We believe this strikes the correct balance between ensuring the Armed Forces are able to train effectively but at the same time be corporately accountable for failings in the supervision of training, exercises and selection events.* (Paragraph 151)

27. Given the fact that there have been 11 Crown Censures since 2000 in relation to training, exercise and selection activities, we do not envisage that this would open the MoD to a significant number of prosecutions. (Paragraph 151)

28. *We are not convinced that the Special Forces exemption is required on the basis of security and confidentiality. We consider that sensible precautions can be taken at any judicial proceedings to ensure the appropriate level of security and confidentiality for Specialist Military Units.* (Paragraph 152)

Conclusions

29. Our Report has focused on the importance of getting the right balance between the need to put Service men and women, be they full time or Reservists, operating in the UK, or abroad, through the best possible training to equip them to do the arduous and often dangerous tasks that we expect them to do, while at the same time assessing, managing and mitigating the risks associated with such training so that accidents and fatalities are kept to a minimum. (Paragraph 153)

30. We have examined the adequacy of the MoD's policy on the health and safety risk assessment process, the quality of training and whether Service personnel are properly prepared and monitored throughout their training and selection events. While we have found no systemic failings, the MoD has not always got the correct balance between adequate training and reducing risk resulting in life-changing injuries and deaths in training and selection events. (Paragraph 154)

31. Evidence of this can be seen in the 135 fatalities during training and selection events over the past 15 years. While we accept that military training is inherently hazardous, we believe that some of these deaths could have been avoided if the risk assessment process had been followed correctly. (Paragraph 155)

32. A key focus of our Report has been on the accountability measures which can be used from Service Inquiries to coroner-led investigations and inquests. While it is important that the MoD and the Armed Services are accountable for all accidents and fatalities on training exercises and selection events for all the Services, it is equally important that they are seen to be so. The families and friends of those who have died whilst on training exercises need to have confidence that that lessons have been learned for the future. (Paragraph 156)

33. We believe the MoD is in fact moving in the right direction. Evidence of this can be found in the creation of the Defence Safety Authority in 2015 which has, among other things, responsibility for the conduct of independent service inquiries into safety-related fatalities and the roll out of the Duty Holder Concept. (Paragraph 157)

34. We were impressed by the training we saw at the Commando Training Centre (CTC) in Lympstone, in particular the practical application of the concept of 'training in' rather than 'selecting out'. Although we were only there for the final assessment, it was clear to us that there was a good relationship between trainers and trainees, that facilities for medical and rehabilitation care were excellent and accessible, and that duty holder concept was fully integrated into their processes. (Paragraph 158)

35. However, there is no room for complacency. Every such death is a tragedy. Our recommendations point out areas where we think the MoD can go further and areas which we would like them to explore in more detail. (Paragraph 159)

Appendix 1: Training and selection events cancelled following a dynamic risk assessment

- **Army.** The Army provided the following examples:
    - On 21 January 2016 a 6-mile loaded march retest was cancelled as there was no water available.
    - On 29 January 2016 a Trainasium (aerial assault course) session was cancelled due to weather conditions being too windy.
    - In the past Exercise FAN DANCE has been cancelled due to adverse weather conditions.
- **RAF.** The RAF provided the following examples:
    - Exercise TELEMARK EAGLE 2 was an RAF sponsored expedition organised in order to expose RAF personnel to training and working in a winter environment using the medium of parachuting and Nordic ski touring, thereby, meeting the aims of AT. It took place between 20 February–9 March 2014. On 1 March 2014, low level cloud made it too difficult for the aircraft to land at the landing site to collect the parachute team. Therefore, the parachute jump was cancelled.
    - During the Pre-Parachute Selection Course (PPSC) Instructors will hold a daily meeting to discuss the climatic conditions and whether the assessment timings need to be altered; Physical education staff will conduct a wet bulb globe thermometer test (in accordance with JSP 539). The outcome of the daily meeting is recorded by exception (in accordance with JSP 375). Examples of amendments to avoid climatic conditions were:
        - **PPSC 3/08 (March 2009).** The 3 Peaks event was moved to another location due to adverse weather conditions in Yorkshire when snow and ice made the route dangerous and inaccessible.
        - **PPSC 1/09 (June 2009).** The increased midday temperatures caused events to be planned for 0900–1000 and then from 1500–1800.
        - **PPSC 1/15 (April 2015).** Due to the potential of increased daytime temperatures the 14 mile endurance event was moved to early morning.
- **Royal Navy.** A 30 mile speed march was cancelled in 2015 when it was assessed that two separate medical incidents resulted in an unacceptable level of medical risk remaining to those that remained.

Sub-Committee Formal Minutes

Monday 18 April 2016

Members present:

Mrs Madeleine Moon, in the Chair

Richard Benyon
Mr James Gray
Johnny Mercer

Draft Report (*Beyond endurance? Military exercises and the duty of care*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 159 read and agreed to.

Summary agreed to.

A Paper was appended to the Report as Appendix 1.

Resolved, That the Report be the First Report of the Sub-Committee to the Committee.

Ordered, That the Chair make the Report to the Committee

[Adjourned till a date to be confirmed.

Committee Formal Minutes

Wednesday 20 April 2016

Members present:

Rt Hon Dr Julian Lewis, in the Chair

Richard Benyon	Mrs Madeleine Moon
Mr James Gray	Rt Hon John Spellar
Johnny Mercer	

Draft Report (*Beyond endurance? Military exercises and the duty of care*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 159 read and agreed to.

Summary agreed to.

A paper was appended to the Report as Appendix 1.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 4 May 2016 at 10.45am.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

	Question number
Wednesday 25 November 2015	
Andrew Cayley CMG QC, Director of Service Prosecutions, **Dr David Snowball,** Director of Field Operations, Health and Safety Executive	Q1–72
Air Marshal Richard Garwood CB CBE DFC RAF, Director General, Defence Safety Authority, **Air Marshal Paul Evans CB RAF,** Surgeon General, **Major General Christopher Tickell CBE,** Army Recruiting and Training Division, **Air Commodore Warren James CBE RAF**, Head of Training, Education, Skills, Recruiting and Resettlement, and **Major General Simon Brooks-Ward CVO OBE TD VR,** Deputy Commander Field Army	Q73–139
Wednesday 9 December 2015	
Hilary Meredith, Hilary Meredith Solicitors**,** and **Philippa Tuckman,** Bolt Burdon Kemp Solicitors	Q140–218
Monday 1 February 2016	
Judge Peter Thornton QC, Chief Coroner of England and Wales	Q220–277
Wednesday 10 February 2016	
Air Commodore (Retd) Stephen Anderton, former Commandant-General, RAF Regiment, and **Brigadier (Retd) Matthew Porter,** Royal Marines	Q278–326*
Wednesday 2 March 2016	
Penny Mordaunt MP, Minister of State for the Armed Forces, **General Sir Richard Barrons KCB CBE ADC Gen,** Commander of Joint Forces Command, **Adrian McDonald,** Senior Lawyer, Government Legal Department, Ministry of Defence, and **Humphrey Morrison,** Head of Legislation, Ministry of Defence	Q337–422

* Asterisks denote that a part of the oral evidence, for security reasons, has not been reported at the request of the witness and with the agreement of the Committee.

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

MEX numbers are generated by the evidence processing system and so may not be complete.

1 Child Soldiers International (MEX0002)
2 Health and Safety Executive (MEX0012)
3 Health And Safety Executive (MEX0006)
4 HH Judge Peter Thornton (QC) (MEX0016)
5 Hilary Meredith Solicitors Ltd (MEX0001)
6 Ministry of Defence (MEX0014)
7 Ministry of Defence (MEX0015)
8 Ministry of Defence (MEX0003)
9 Ministry of Defence (MEX0009)
10 Ministry of Defence (MEX0017)
11 Mr and Mrs Edward and Marie Maher (MEX0004)
12 Ms Philippa Tuckman (MEX0005)
13 Service Prosecuting Authority (MEX0007)
14 Service Prosecuting Authority (MEX0010)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2015–16

First Report	Flexible response? An SDSR checklist of potential threats and vulnerabilities	HC 493 (HC 794)
Second Report	Shifting the goalposts? Defence expenditure and the 2% pledge	HC 494
First Special Report	Ministry of Defence Annual Report and Accounts 2013-14: Government response to the Committee's Eights Report of Session 2014–15	HC 365
Second Special Report	Re-thinking defence to meet new threats: Government response to the Committee's Tenth Report of Session 2014–15	HC 366
Third Special Report	Decision-making in Defence Policy: Government response to the Committee's Eleventh Report of Session 2014–15	HC 367