House of Commons

Defence Committee

Beyond endurance? Military exercises and the duty of care: Government Response to the Committee's Third Report of Session 2015–16

Second Special Report of Session 2016–17

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The Defence Committee

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The current staff of the Committee are James Davies (Clerk), Dr Anna Dickson (Second Clerk), Claire Cozens, John Curtis, Dr Megan Edwards, Eleanor Scarnell and Ian Thomson (Committee Specialists), David Nicholas (Senior Committee Assistant), and Carolyn Bowes and David Gardner (Committee Assistants).

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Second Special Report

The Defence Committee published its Third Report of Session 2015–16, entitled *Beyond endurance? Military exercises and the duty of care,* on 24 April 2016. The Government's response was received on 24 June 2016 and is appended to this report.

Appendix: Government Response

The Government notes the House of Commons Defence Committee's (HCDC) inquiry, 'Beyond endurance? Military exercises and the duty of care' and the findings set out in the Committee's report published on 24 April 2016.

The Government shares the Committee's view that military training is inherently hazardous. This is especially true where activities involve weapon systems, vehicles or strenuous physical activity. This risk is rendered as low as reasonably practicable (ALARP) during training by ensuring that its design and delivery are subject to strict safety procedures and rigorous risk analysis. This allows the Services to provide realistic and effective training which balances the risk and the need to provide a safe training environment with the provision of effective training to support operational output.

The Government also shares the Committee's view that every death is a tragedy. However, the deaths that have occurred in training need to be considered in the context of the tens of thousands of personnel who have participated in, and completed, training activity over the period in question. The key is ensuring we get the right culture surrounding training safety, including ensuring that policy is applied, trainers are appropriately trained, and the lessons process is robust to ensure we try to prevent such tragedies recurring.

The Government's responses to the Committee's specific recommendations and conclusions are detailed below.

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)**

The DSA has already begun work to derive useful measures of effectiveness (MoE) that can be used to assess its performance in its three roles of Defence Authority, Regulator and Accident Investigator. However, such MoE are notoriously difficult to develop and can, if not chosen carefully, be misleading. For example, an apparently obvious MoE might be a reduction in incidents/injuries, but the DSA does not necessarily hold all of the levers that drive a reduction in these numbers. A reduction in accident rates may be due to other factors such as a reduction in activity, or an increase in risk aversion to an inappropriate

level. Instead, the DSA will endeavour to develop a range of direct and indirect MoE, which together will provide a richer picture of effectiveness. This work is part of on-going continuous improvement so no end date has been set.

The MoD confirms that it intends to commence a programme of periodic audits of the DSA by an externally recruited team or organisation in the Financial Year 2017–18. The composition of the team has not yet been finalised but is likely to include representatives from the Health and Safety Executive (HSE) as well as external subject matter experts in each of the Defence regulatory domains. The DSA would welcome the involvement of the external auditing team in setting or at least agreeing the MoE to be used, and then reviewing and commenting on the progress against each MoE in their external audit report. Meanwhile, it should be noted that Defence's Land and Nuclear regulators have already been subject to external audit in 2015–16 by the HSE and the Defence Nuclear Safety Committee respectively. The report from this audit is published publicly and available on the gov.uk website.

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)**

Prior to, and after formation of the DSA, numerous communications activities were undertaken using specialist safety publications and online using the gov.uk website. This sought to inform stakeholders of the rationale for forming the DSA, its composition and roles. Since then senior members of the DSA have continued to undertake briefings to audiences across the country, addressing professional fora such as the Royal Aeronautical Society, Institute of Mechanical Engineers, Institute of Engineering and Technology and the HSE. Additionally, there have been a number of engagements with Industry, for example, the Director General (DG) DSA presented, along with Sir Charles Haddon-Cave QC, on 'Risk based assurance in the Defence environment' at the Transport for London Underground staff training day in April this year.

As the organisation continues to mature, the authority will develop a rolling programme of engagement activity for Industry and members of non-specialist communities (for example, legal groups and families' federations) and, as necessary, generate two-way conversation with these audiences. Furthermore, as a high-profile presence on the gov.uk website has very recently been secured, a continuous feed of news articles and information for the site will be established. This will further promote awareness and understanding across the broadest possible range of interested parties. Such a programme of engagement should strengthen both the MoD's and public's knowledge of the DSA as recommended by the Committee.

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)**

The establishment of a single DSA was a recommendation made by both Sir Charles Haddon-Cave and Lord Levene aimed at addressing deficiencies in the system as it was. The DSA was established on 1 April 2015 so is still a relatively new organisation, therefore the Government recognises it will take time for it to be fully embedded within the MoD.

DSA was established under a Charter from the Secretary of State for Defence. The Charter places the DSA outside of the military chain of command and ensures that the organisation has true independence for its three roles of Defence Authority, Regulator and Accident Investigator. Moreover, where instances of overlap or functional overlap between Regulator and delivery organisations have been discovered these are being systematically addressed to ensure that appropriate separation will exist in future. The DSA will be subject to external audit. The first of these is intended to be undertaken in 2017–18 by an externally appointed body. Its findings will be publicly released. We expect any external audit body to comment on the progress of this work in support of its assessment of the independence and effectiveness of the DSA.

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)**

The Government acknowledges that there is more to do in publicising how the DHC works in practice—both externally and internally within the MoD. The requirement for Duty Holding arrangements to be put in place for managing Risk-to-Life activities is set out in the Secretary of State's policy for health, safety and environmental protection. The details of how Duty Holding is to be implemented are currently set out in Defence's Joint Service Publication (JSP) 815 (Defence Health, Safety and Environmental Protection). Both of these documents are already available on the Internet and can be accessed by members of the public. However, it is acknowledged that more could be done to raise awareness of these documents. These two important documents are currently being reviewed and are scheduled to be reissued later in 2016, together with an illustrated guide to Duty Holding in practice. This will provide a key opportunity to deliver an effective engagement and awareness campaign especially with the families of Service and Civilian personnel. Such a campaign should strengthen both the MoD's and public's knowledge of the DHC.

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)**

The degree to which the DHC has been effectively applied across Defence is currently being assessed with a view to ensuring the universal adoption of a number of key principles that all parts of Defence must follow when managing Risk-to-Life (RtL) activities. Potential changes to the existing arrangements and measures to ensure a fully comprehensive roll out of the scheme will be the subject of discussion at the next Defence Safety Committee (DSC) meeting in June 2016. The DSC is the highest level forum in the MoD dedicated to safety and is chaired by the DG DSA. Its membership is drawn from across Defence with

representation at 2-star/3-star level. Following discussion and consideration at the DSC, it is the intention that any changes to the DHC will be implemented across Defence during the remainder of 2016.

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)**

The MoD agrees that it is essential for there to be clarity with regard to Duty Holding accountabilities and responsibilities in all situations, and in particular where there is the involvement of more than one Service or chain of command. It is not the intent to review individual exercises as work is being undertaken more widely on the topic of Duty Holding. Work continues to define a revised set of Duty Holding principles and these will be fundamental to ensuring consistency in the application of Duty Holding across Defence, including circumstances where Operating Duty Holders and Delivery Duty Holders may not be aligned. Furthermore, it is the MoD's intention to produce an illustrated guide to Duty Holding to provide real, situational examples in order to improve understanding of how the principles should be applied in practice. A better understanding of the relationship between Operational Commanders and Duty Holders will improve the management of safety in such circumstances. Duty Holding across Defence is being considered by the DSC in June. This will add further clarity to the pan-Defence approach to Duty Holding across all our activity. Defence Duty Holding training has already been updated to ensure a common understanding is achieved.

In general, for 'routine' activities where capability is generated or assets are deployed by one of the Services, then the parent Service will retain Duty Holding responsibilities for the activities. For example, aviation or aircraft-related Risks-to-Life will remain with the appropriate Air Duty Holder. Any RtL activity that cannot be maintained ALARP must be highlighted to the Duty Holding chain. Duty Holder arrangements have been developed along these lines between the single Services and Joint Forces Command (JFC) to clarify Duty Holding responsibilities on joint operations. This includes a mandated requirement to hold a formal meeting with relevant stakeholders prior to the start of each joint operation to agree and formally document Duty Holding responsibilities. This meeting is crucial to ensuring Duty Holding responsibilities are clearly articulated and managed effectively. Where any excursions from routine operating are planned, the JFC Operational Commander, appropriate Duty Holder and SME's will discuss the circumstances to establish if the risks associated with the excursion are still ALARP or if additional controls can be introduced to achieve it. If an agreement cannot be reached but the Operational Commander requires the excursion to continue, the discussion will be formally elevated up the Duty Holder chain to see if agreement can be reached at higher

level. Agreed changes to normal operating or transfer of Duty Holding responsibilities must be formally recorded, implemented and reviewed on a regular basis and records maintained for scrutiny.

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)**

The Government welcomes the Committee's acknowledgement that detailed policy and guidance should exist for governance and safety of those being trained and agrees that such guidance should never reduce the risk to such an extent that it would undermine operational effectiveness through inadequate training.

As part of its normal internal assurance processes, the Army has commissioned a Defence Internal Audit (DIA) review into Army training later this year and this is one of the topics that it will be considered.

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)**

The Government accepts that this is an area which needs to be monitored more closely and further action taken to prevent and reduce such injuries. Over the last year DG DSA has issued two advice notes to Top Level Budgets (TLBs) and Duty Holders reminding them of the need to ensure that the requirements of JSP 539 (Climatic Illness and Injury in the Armed Forces: Force Protection and Initial Medical Treatment) are being applied to all military training activities.

Consideration is currently being given to rewriting the policy on this subject and one of the options proposed is that there would need to be Annual Mandatory Climatic Injury Prevention Training (although some areas of the Armed Forces already incorporate this element into their training).

Examples of steps the individual Services within the MoD are taking are provided below:

Joint Forces Command (JFC)

The JFC Chief Environment and Safety Officer (CESO) followed up the DSA issued notes with an initial letter asking for confirmation that appropriate risk assessments were in place, which referred to the controls in JSP 539 and that those controls were being applied. This was confirmed by all sections of JFC, including the Permanent Joint Operating Bases. In addition CESO also monitors this requirement during safety audits and all accident and incidents involving heat or cold injuries are investigated. Initially reporting and

investigation would be undertaken at Unit level. If required the investigating manager may call upon the assistance of subject matter experts including the Site Safety Adviser of TLB CESO.

Investigation should be proportional to the severity/potential severity of the incident and may range from short interviews with the individuals concerned, to formal inquiries. In JFC this is initially captured on the JFC Incident Notification Form (JINF) but follow up investigations will be recorded separately. All accident data recorded on the JINF is reported to CESO (JFC) on a monthly basis; the data is reviewed and any accident or incident specifically involving heat or cold injuries is highlighted and followed up by CESO to ensure that an investigation has been undertaken and to discuss the lessons learned. CESO can conduct additional investigations of any accident or incident affecting JFC personnel if required.

Naval Service

The Flag Officer Sea Training (FOST) organisation has robust procedures in place to mitigate the risk of cold weather injuries (CWIs) and all Phase 1 establishments are fully compliant with Joint Policy. As an example the risk mitigation for Royal Marine Recruits includes a Health and Hygiene brief delivered to all recruits by the Medical staff during foundation period which refers to foot care and all instructors are issued the 'Climatic Injury Aide Memoire.'

Navy Command monitoring of cold weather injuries can be conducted through interrogation of the Navy Lessons Identified Management System (NLIMS). NLIMS can be reviewed at Unit and/or Operational Duty Holder (ODH) levels and has in the past identified trends in CWIs which have been referred to units for action. The Navy Safety Centre does sample compliance with UK legislation and MoD policy in its safety assurance audits, the results of which are provided to the unit Commanding Officer and the ODH.

Royal Air Force

Of the CWIs that have occurred in the RAF over the last four years, two specific exercises accounted for over half of these. It is worth noting that it was because the RAF followed the JSPs that these injuries were caught and dealt with at the earliest opportunity, for example, during a twice daily Commander's foot inspection.

With respect to arduous training, the RAF Regiment Training Wing does not experience a significant occurrence of cold injuries. Moreover all formal training courses are conducted in compliance with the respective JSP for the management of cold injuries. The RAF is currently seeking to enhance the cold weather equipment issued to Phase 2 students such as cold weather socks and cold and inclement weather hats.

Army

Where risk is apparent, Commanders must implement controls to minimise the risk, particularly to vulnerable personnel. The Army also include specific modules on Climatic Injuries—including the cold—in the Military Annual Training Tests that all soldiers are required to complete annually. CESO(Army) will include the subject in its Safety publication and raise it at the Army Safety Working Group. This issue will be considered as part of the DIA review into Army training later this year.

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)**

A number of guides or aides-memoire already exist, produced by the Front Line Commands for staff, particularly in overseas operational areas, and they remain best placed to address shortcomings that arise due to ignorance, poor culture or lack of training. However, the DSA is well placed to support action by the Commands where there is a common need. For example, the provision of improved guidance on the application of the DHC to real situations is one example where the DSA is already seeking to introduce a common guide. Also, organisations across the MoD release specific advice ahead of the summer months relating to heat illness and draw attention to JSP539 which includes a number of checklists and aide-memoire for commanders and medical personnel. In the ordnance domain, the Defence regulator has disseminated an 'Out of Area' Live Firing aide memoire for use by all MoD personnel when planning Live Firing activities overseas. In other areas, such as the nuclear domain, the regulator has adopted a less prescriptive approach, in accordance with its partner statutory body, and the guides it has produced serve to assist the regulated community in producing their compliance arrangements. Work by the HSE represents good practice in the area of aides-memoire and the MoD undertakes to continually improve by learning from such examples.

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)**

The Government views the risk assessment process as more than a tick box exercise and agrees that risk assessments should not become such. Whilst there is a form to fill in, which is a useful guide to identifying potential risks, it is the way in which personnel manage these risks that is the important element of this process. This includes conducting dynamic risk assessments where necessary and acting upon the outcome of these assessments.

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)**

Risk assessments will be the focus topic of the DSC in December and the working groups running up to this. Examples of steps the individual Services within the MoD are taking are provided below.

Joint Forces Command

Risk Assessment awareness training has been delivered across the MoD for some time, either by training units such as RAF Halton or by the unit safety staff. Recently CESO (JFC) has developed a bespoke Risk Assessment training course, which will shortly be accredited by the Institute of Occupational Safety and Health. Once accredited (mid 2016) the course will be rolled out across JFC to those with high risk activities and will be specifically tailored to those activities including military training in Specialist Military Units (SMU). CESO already monitors risk assessments during audit and will continue to do so. A specific review of SMU military training will commence in 2016 and will also review the risk assessments.

Naval Service

The Navy Safety Centre has established a Training and Education Committee to ensure safety training provided to Navy Command personnel is suitable and sufficient to ensure compliance with safety legislation and help in the improvement of safety performance. The delivery of risk assessment training is included in this package of work and, where training improvements are required, the deficiencies and/or improvements are being raised with the appropriate responsible persons.

Royal Air Force

Risk management lies at the heart of the Duty Holder construct and overall is a well understood requirement and activity in the RAF. Work has been done over the last 12 months to allow a comparison of risks across differing Safety Domains. This work has identified that whilst risk assessments are being conducted across all domains, there is not necessarily consistency in the process of assessment and capture of risk information. A draft AP8000 (the RAF Safety Management Plan) leaflet has been produced to address this shortfall, which should go live within three months.

All personnel responsible for the delivery of arduous training, as instructors or exercise conducting officers, receive formal training at the RAF Regiment Training Wing or through interactive learning to teach them how to conduct specific tasks. This training includes the Risk Assessment process as laid out in the respective tri-Service policies. Therefore, risk assessments are produced by Suitably Qualified and Experienced Person (SQEP) individuals who, within their professional boundaries, understand the process and are well versed in the tasks the Risk Assessment covers.

Army

General career courses include training on aspects of risk. For example:

- Different stages of officer training include aspects of risk: the Royal Military Academy Sandhurst syllabus includes risk assessment in support of Adventure Training and with respect to exercise conduct (specifically the production of a Range Action and Safety Plan to support the qualification required for range-based marksmanship Live Fire training 'under safe practice' and the production of a similar risk assessment in support of an Exercise Action and Safety Plan to

support the qualification required for blank-firing exercises). The professional training for risk and risk management delivered during Intermediate Command and Staff Course (Land) is based upon JSP 892 (Risk Management).

- Similarly, the theory of risk management and the ability to conduct risk assessment, as underpinned by JSP 375 (Management of Health and Safety in Defence), is delivered during the Junior Non-Commissioned Officer (JNCO) and Senior NCO (SNCO) Command Leadership and Management syllabuses as well as on specialist logistic courses such as the Quartermasters' course. The JNCO CLM Part 1 Safety Health Environment and Fire (SHEF) includes an introduction to risk assessment and its practice, while the SNCO CLM Part 1 SHEF module covers risk assessment strategy in detail together with the underlying theory of how and why it is used. JNCO and SNCO CLM Part 3 includes risk assessment training delivered at Army Education Centres by a Unit Safety Advisor or Manager.

Specialist courses also have risk assessment at the heart of their activities. For example:

- The All Arms Unit Safety Advisor course and the All Arms Unit Safety Manager course, both of which are geared towards unit-level Health and Safety management, include training on risk management and risk assessment in line with JSP 375 and extant Health and Safety at Work legislation.

- The Army School of Physical Training regards the delivery of training on the production of risk assessments (founded on JSP 375) as fundamental and are therefore considered critical pass/criteria for their All Arms Physical Training Instructor and Unit Fitness Training Officers courses on safety grounds.

- Live Fire Tactical Training (LFTT) qualification courses including Range Management Qualifications, All Arms LFTT, and the Platoon Commanders' and Platoon Sergeants' Battle Courses all incorporate risk assessment in accordance with JSP 375.

- The ARTD Staff Leadership School courses refer to risk and risk assessment.

Some online risk assessment training is also available via the Defence Learning Environment. For example, the Food Services Wing of The Defence College for Logistics and Personnel Administration provide online risk assessment training that includes a variety of risk assessment requirements including for field catering equipment, manual handling, fuel and environmental considerations, and for kitchens and infrastructure.

Individual risk assessments are covered by CESO (Army) audits (annual for high risk units, every 2 years for medium and 3 years for low risk) with the appropriate rectification required. This issue will also be considered in the DIA review into Army Training later this year.

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 recognises 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)

The Government acknowledges that there are sometimes different requirements that exist between the design and delivery of Regular and Reserve training. The individual Services continue to implement changes that take into account the specific training circumstances of Reservists, as well as ensuring they continue to meet their duty of care in all aspects of training delivered. Below are examples of how single Services within the MoD are taking this forward:

Naval Service

Royal Naval Reserve Phase 1 Training has been completely updated with Reservists circumstances taken into consideration. A blend of Royal Navy and Royal Navy Reserves (RNR) Instructors deliver the variety of training, in RNR Units, at weekends and on the two week confirmation courses. RNR training provided through HMS RALEIGH and Britannia Royal Naval College is identified on the Statement of Training Requirements (SOTR) and where appropriate are included in the Commander's Risk Assessments and Supervisory Care Polices which also includes Instructor/Trainee ratios. A separate Reserve focused Supervisory Care Policy covers the area beyond the responsibility of Royal Navy Training establishments and OFSTED's inspection last September gave a 'Good' for RNR Initial Training.

Royal Air Force

Royal Auxiliary Air Force Phase 1 Training is kept under constant review and is delivered through bespoke, modularised training that fully accounts for the special requirements of Reservists. Phase 2 professional training is also bespoke to this cadre and while it varies by role has robust risk assessments built in. Beyond these first 2 levels of training, Reservists participate in more integrated activities with other capability areas, other Services and other nations. In all cases risk assessments are conducted during the design of training and prior to training commencing.

Army

The Army delivers a high number of courses and has undertaken a great deal of work to remove the unnecessary distinctions between Regular and Reserve training as appropriate. The Army aims to achieve consistency in standards to provide assurance that the correct training has been delivered and also that soldiers (be they Reserve or Regular) are trained to the same standard as they will usually do the same job on operations. Although the methods of delivering training and material used can differ, where possible common training is used for both cohorts and many Reservists enjoy training alongside their Regular counterparts and certainly like being trained by Regulars. We are increasingly designing training that better suits the Reserve lifestyle and fits in with their civilian work life balance.

The resources for the development of courses are limited so both Regular and Reserve courses are developed as the resources allow. A review of Collective Training has confirmed that the existing model is still appropriate in that the Reserve unit follows the same Formation readiness Cycle as their paired unit. Each sub unit completes collective training at level 1 and every third year undertakes level 2 training. Some specialists do participate in level 3 training in order to support their paired units on exercises, but this is not mandated. All Army training activity is reviewed in accordance with JSP 822 (Defence Systems Approach to Training—Direction and Guidance for Individual and Collective Training) which specifies that, "This should be regularly such as annually, or when changes are made to the training need or requirement; or as an absolute minimum, every 5 years", but also within resource. Planned evaluation focuses on the validity and efficiency of all training. Courses are reprioritised annually against directed criteria so that highest priority courses are reviewed first. It should be noted that while it has not been possible to review all Reserve courses due to the requirement to prioritise, risk assessments undertaken for training activity should take account of the level of training and competence of all those partaking including Reservists.

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)**

The decision not to put the reports and evidence the Committee received with respect to SMU into the public domain is in accordance with Her Majesty's Government's long standing policies on these matters. However, that decision does not reflect the approach taken to sharing information with the families of those who have died. In this case it is the policy of Director SMU to give families, as a matter of course, redacted copies of all relevant reports and evidence and to provide them with an opportunity to see the un-redacted versions to provide further assurance as to what information has been removed. In the case of the deaths in Brecon Beacons in 2013 significant amounts of information has been provided to the families since the incident and throughout the inquest and investigation process.

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)**

This is for individual Service organisations to deliver and is being taken forward as follows:

Joint Forces Command

Training risk assessments are required to consider that appropriate medical arrangements are in place, which are reviewed at audit/inspection by CESO and others. CESO is responsible for collating accident and incident records in JFC. Raising awareness of the importance and need for individuals to self-report injuries and illnesses is managed through Higher Level Budget and Site Focal Points and also through internal publicity, including the JFC intranet page. CESO continues to consider how awareness of this issue can be improved. CESO has also recently launched a campaign across JFC to encourage individuals to report 'near misses' for health and safety incidents.

Naval Service

The MoD is pleased that CTCRM has been recognised by the HCDC as an example of good practice. CTCRM and all other Naval Service establishments are continuously looking to improve this culture that encourages students to report medical conditions early on and seek the necessary assistance. As part of this each establishment has the necessary support in place to allow recruits and trainees access to medical advice and assistance if and when they need it. All recruits and trainees are informed about the procedures for reporting sick or injured and processes are in place for this.

Additionally, all training exercises are subject to a risk assessment which includes the assessment of any medical risks. Trainers are required to have access to these risk assessments and risks, including medical, are briefed before any training serial. Trainers are also trained during their 'Defence Train The Trainer' version 2 course to understand the need for risk assessment training and their requirement to inform the recruits and trainees of the risks and mitigating factors in place to reduce the risk as far as is reasonably practicable. Trainer Continuous Professional Development programme and training documentation is reviewed as part of the HQ-led second party assurance process.

The topic of encouraging students to report injuries and illnesses has been added as a discussion point at the Care and Welfare Continuous Improvement Group meeting, which can create an action for establishments to review their process and identify if they need to do more. Where good practice has been identified Navy Command, through FOST, should encourage adoption of these practices across other areas of training and share the process with other TLBs. The Navy Safety Centre is in the process of improving safety culture across the Navy Command. This includes improving accident reporting frequency and accuracy through training in the use and interrogation of the accident reporting process (NLIMS).

Royal Air Force

Students are encouraged to be open and honest about their medical situation during all formal training courses, including the Pre-Para Selection Course, to enable the staff to manage minor injuries and enhance student chances of graduating and to preserve their personal wellbeing. Physical Education and tactical training instructors form strong bonds with their students and discuss the management of injury and illness with them. The subsequent provision of appropriate formal medical care is a high priority that is

mandated in RAF Regiment Training Wing policy, and it is well supported by the Station Medical Centre. Medical chits have been refined to ensure students are able to conduct as much activity as possible, without risking further injury, to reduce the impact of reporting sick to be as small as possible, further reducing pressure on individuals to cover up injuries.

Culturally, students are taught that the hiding of injuries, however small, is a negative trait and this perspective is positively reinforced through the timely treatment of injuries, and by the great lengths that the training staff go to in order to appropriately keep students on course for as long as possible.

Army

The good practice seen by the Committee at CTCRM is also mirrored in Army training (Infantry training at the School of Infantry as a like for like example). Phase 1 training at Initial Training Group and the Combat Infantryman Course delivered at the Infantry Training Centre (Catterick) are consistent with this practice, although a number of Phase 2 establishments are unable to conform to the extent seen at CTCRM for structural reasons. For many of the Army's Phase 2 training Operations Groups, the nature of the diverse subject matter being delivered requires greater levels of technical competence and knowledge, skills and experience on the part of the instructors, thereby making it unreasonable for the burden of instruction to lie with just one individual. For example, the training delivered by the civilian instructors at the Armour Centre, whose competence and experience is fundamental to delivering safe training in the correct operation of dangerous mechanical equipment, could not reasonably be delivered to similar depth by the military instructors; consequently a degree of continuity has to be sacrificed in order to attain the necessary training outputs.

In terms of encouraging recruits and trainees to declare injury early, the recent review of medical injuries sustained during a Phase 1 course would indicate that recruits do not seem to be reluctant to visit their medical centre; any perception of reluctance is countered by the Phase 1 instructors and early presentation with injuries is encouraged (drop-in physiotherapy clinics are an example). As opposed to increasing the 'First Time Pass Rate', the ARTD Operations Groups have been set wastage reduction targets that seek to reduce overall wastage. Such direction to the Operations Groups further promotes that culture within each training organisation that encourages recruits/trainees to seek medical care as and when required, thereby attaining the highest overall output from training whilst also safeguarding the personal well-being of the individuals concerned.

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)**

The Government welcomes the Committee's view on the DSA becoming the primary Convening Authority for all safety related Service Inquiry (SIs) and associated recommendations. Additionally, it is worth noting that the single Services still retain the option of convening their own SI into specific aspects of an incident in circumstances where the DSA chooses not to hold an SI, or after the DSA has completed its SI.

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)**

While the strengths of the DSA SI Recommendations process are well understood within the Department, it is also worth recognising the full span of Regulation 28 recommendations that Coroners may wish to raise in the future. These will, unfortunately, likely extend beyond pure safety and training related fatalities and injuries. In 2008 the Defence Inquest Unit (DIU) was established to provide a single point of contact and expertise for MoD's interface with HM Coroners. One part of its role is to prepare coordinated, Defence-wide, responses to all Coroners Reports To Prevent Future Deaths (Regulation 28 reports) issued to the MoD (which may or may not be safety related). Currently, it is envisaged that the DIU will remain responsible for coordinating the MoD response to Regulation 28 reports, having engaged appropriately with the relevant areas of Defence, and the coroner where necessary. One of the strengths of the current DSA SI process is that it ensures that recommendations are only considered closed once they have been personally reviewed by a 3-star military officer who has a detailed knowledge of the circumstances of the accident in question, by virtue of his Convening Authority role. A similar arrangement will be challenging to replicate across all the areas that Coroners report on. However, in order to address the Committee's concern, the MoD will undertake further work to identify how best it can track safety-related Coroner's recommendations from receipt through to completion.

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)**

The Government welcomes the opportunity to assist coroners who may be conducting inquests into deaths of Service personnel. The DIU are currently engaged with the Chief Coroner's Office to establish the most appropriate form and content of training for the military cadre of coroners. The Government looks forward to progressing this in due course and will update the Committee when a way forward has been agreed.

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)**

The Government acknowledges the view of the Committee.

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 forward their recommendations. (Paragraph 108)

Since 2003 Casualty and Compassionate policy has changed significantly, as has the support offered to families of the injured and the bereaved. In 2003 MoD directed that the three single Services casualty and compassionate policies should be brought together under a single MoD owned and endorsed policy. Part of this process led to the formation of the Joint Casualty and Compassionate Centre which was to produce and manage a common and equitable standard of support. The single MoD policy was published as JSP 751 (Joint Casualty and Compassionate Policy and Procedures). This JSP remains under constant review, with monthly meetings between MoD and the single Services.

Some of the changes that the MoD has made were implemented as a direct result of considering the views and requirements of families of deceased personnel. For example directing that deceased personnel returning from operations were recovered via an OP PABBAY repatriation ceremony which ensured the deceased were treated with the appropriate level of respect and honour. Furthermore, to take account of changing family dynamics, the number of family members supported in attending repatriations has been increased from 5 to 7. The MoD also changed the policy that required bereaved families to vacate Service Families Accommodation (SFA) after 93 days. This was changed to extend the period to two years before the case would be reviewed. As noted by the Committee, on-going work includes a review of the casualty and compassionate process from point of incident to post inquiry. This review is being conducted by Defence Internal Audit and the report's findings are due in the autumn. The Government will share the findings of the report with the Committee.

The Government has already shared the terms of reference for the Non-Statutory Inquiry (NSI) with the Committee. The NSI is still underway but is expected to complete later this year. It is currently the MoD's intention to make public the report for the NSI after internal activity, including the briefing of those families who are affected, has been completed. The Government will pass a copy to the Committee at this time.

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)**

The Department carefully considers how to ensure families are supported including through the provision of appropriate information and had already started to change the process to ensure that the concerns highlighted by the HCDC do not recur. When DG DSA convenes an SI into a safety-related death, the President of that inquiry will establish

contact with the Next of Kin (NOK) via the single-Service aftercare support cell and the Visiting Officer (VO), and offer the NOK a personal visit to introduce himself and explain the SI process. This offer is normally made early in the SI process but a few weeks after an event so as not to impinge on the family in the immediate aftermath of the tragedy. The VO will coordinate the visit and accompany the President to make the introductions and facilitate the engagement with family members. The President will explain the SI process and its purpose, stressing the independence, thoroughness, expertise, no blame and the focus on recommendations to prevent recurrence. The President may be able to explain some of the factual information about the circumstances of the accident but will not at that stage offer any insight into the on-going analysis. He will give the NOK an appreciation of likely timescales for completion and explain how they will be informed of the findings.

The SI President will, periodically throughout the inquiry, provide brief updates to the VO so that the NOK are kept informed on progress and timescales. As soon as the report has been finalised, and in advance of any wider distribution, the DG DSA will provide the NOK with a full un-redacted copy of the SI report; it will be hand-delivered by the VO together with a letter from the DG DSA offering a further visit from the President to explain the findings and answer any questions the NOK may have on the contents of the report. Hence, the NOK not only have full disclosure, they are by design the first to see the finalised SI report and have privileged access to the SI President.

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)**

The Department welcomes the HCDC view that there is not a "blasé attitude" towards accidents and attrition rates within the MoD. We hope that the full engagement of the MoD with this HCDC inquiry has gone some way to changing such perceptions where they exist. We also hope the lessons that have been learned from tragic incidents which have resulted in changes to policy and processes, some of which are outlined elsewhere in this response, provide further reassurance on how seriously the Department takes such issues.

It is worth noting that while the MoD has a system of robust internal assurance and investigations in the event that an incident occurs we also have strong relationships with external organisations such as the HSE and Coroners. There are well established procedures in place for the MoD's interaction with such agencies in the event of a death or accident in training. Our interaction with both of these bodies may generate lessons which are captured by the relevant area of the MoD's lessons management system and we believe there is a culture of openness to understand where things have gone wrong and learn lessons. External agencies increase the objectivity of inquiries and contribute significantly to the command and management of the organisation. We have outlined elsewhere in this

response some of the reports and audits which will be published which should also help to address this perception where it exists. The lessons process is something which we have much improved since 1 April 2015 and the establishment of the DSA.

Finally if there is evidence of serious wrongdoing, the Service Police and the Director of Service Prosecutions act independently in deciding whether prosecutions should be brought.

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)**

The MoD remains of the view that the range of criminal, disciplinary and administrative powers available provides a sufficient means of holding individuals accountable for training supervision. The Armed Forces' jurisdiction for all these powers is worldwide, and there is also a civilian criminal jurisdiction to investigate suspected manslaughter both within the United Kingdom and abroad.

At the same time, the MoD recognises, and believes that it is right, that the criminal law does not impose criminal liability lightly. When a tragedy occurs, there is sometimes a demand that someone should be prosecuted. In fact the criminal law demands both gross negligence for the crime of manslaughter and that there is evidence of such negligence beyond reasonable doubt. The figures referred to by the Committee may suggest the fairness of the Service Justice System to those responsible for training rather than that it is not fit for purpose. A failure to meet the requirements of the Health and Safety at Work Act 1974 so as to result in a Crown Censure is substantially less than the gross negligence required for manslaughter.

What is important is that those organisations responsible (within both the civilian and the Service jurisdiction) for investigation and charging are robust, professional and independent. The MoD has in place statutory and non-statutory safeguards for these standards. It does not at present consider that there is evidence justifying additional analysis of whether those organisations and the law which supports them, and defines their powers and duties, are fit for purpose. Recognising the importance of this subject, the MoD will continue to monitor it.

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)**

Since 1 April 2015, the Director General of the DSA has been the primary Convening Authority for all safety-related Service Inquiries whether they relate to accidents and incidents in the UK or overseas (with the exception of operational deaths). In support of the Service Inquiry Panel established to investigate any such event, the Defence Accident Investigation Branch now provides a 24/7, worldwide, deployable accident investigation capability. Through this mechanism, all deaths that occur during training, exercises or selection events overseas will be thoroughly investigated. While the jurisdiction of the HSE may not currently extend to investigate Service deaths overseas, they are represented at a senior level on the DSA Executive Board, enabling close communication and sharing of information to occur on all safety issues, including accident investigation.

The MoD view remains that the existing provisions, such as the ability to bring a civil claim against the Department where there is a breach of its duty of care, the availability in most cases of an inquest, the scope for individual criminal, disciplinary and Administrative Action, the role of the DSA in carrying out Service inquiries, and the link at executive board level between the DSA and HSE, provide a realistic and effective package of safeguards outside the UK. The 1974 Act is focussed on the conduct of employers within Great Britain (There is a separate but equivalent safety regulator for Northern Ireland), and for a British regulator to have responsibility for investigating and prosecuting employers for their conduct abroad would raise major legal, organisational and practical issues.

Finally, Front Line Commands will continue to endeavour to apply the same level of training oversight between training within the UK and overseas.

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 on 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)**

The purpose of taking Administrative Action is to safeguard or restore the operational effectiveness and efficiency of the Armed Forces. The effect of particular conduct and performance that may damage operational effectiveness is assessed by applying the Service Test. Administrative Action must always be considered subsequent to any disciplinary action, whether that is summary, Court Martial or a prosecution in a civil court. The Armed Forces will also consider taking Administrative Action where there is evidence of a personal or professional failing which indicates an apparent breach of the Service Test resulting from other proceedings such as a Public Inquiry, Coroner's Inquest or a Service Inquiry. In circumstances where Administrative Action is initiated, the most severe sanction is termination of service.

Records of Minor Administrative Action are kept by the MoD, however, as such action is dealt with at a local unit level by Commanding Officers the information is not recorded centrally. Current regulations require that records of Minor Administrative Action are to be retained by the unit and in the individual's service documents for at least 2 years or 'until the posting of the subject, whichever is the earlier' (this is laid down in JSP 833 'Minor Administrative Action'). To identify those cases where Minor Administrative Action has been taken in respect of failings in supervision of training, exercises and selection activities

would require a manual search of all individual personnel records. The MoD does use the tri-service Joint Personnel Administrative System but the primary function of this is the timely progression of Disciplinary casework and Major Administrative Action rather than collating reports and statistics; there is no link on it to identifying those cases which are a result of failings in the supervision of training, exercise and selection activities.

The Government view is that it is vital that the focus of the DSA remains on safety occurrence reporting and tracking in order to support a Just Culture within Defence. The aim of trying to instil a Just Culture promotes honest and open reporting and leads to more information being forthcoming during subsequent investigations. Administrative Action is related to the maintenance of discipline and should not be the responsibility of the DSA to track. The safety imperative is to understand root causes (which invariably lie with organisational factors rather than individual failings) and put in place measures to prevent recurrence. It is for good, evidenced-based reason that space is maintained between those responsible for conducting safety investigations and making safety recommendations to prevent recurrence, and those who conduct investigations for other purposes such as to determine whether an offence has been committed or to determine liability and culpability. They are two very different frames of reference and protocols exist to ensure that in the rare cases where an offence is suspected, this is handed over to the proper authorities to deal with separately. The Government feels that if DSA were required to track and report Administrative Action taken by the chain of command it would detract from the DSA's primary focus which should be on safety. However, the Government will explore the feasibility of collating and communicating such data.

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)**

The MoD welcomes the Committee's acceptance that the Corporate Manslaughter and Corporate Homicide Act 2007 should not apply to military operations. It has considered carefully the Committee's recommendation, and hopes that it will be helpful to respond first to their recommendation as it would apply to "hazardous training in preparation for operations", and secondly in relation to SMU.

As to hazardous training in preparation for operations, the MoD observes that the evidence given to the Committee by the Chief Coroner and the HSE's Field Operations Director indicates that, in their view, existing arrangements in respect of military training fatalities work effectively as a means of ensuring lessons are learnt so that, to the extent possible, the same mistakes are not repeated. The MoD invariably implements any corrective measures identified by the HSE and treats Crown Censure as a matter of the utmost seriousness. It is not therefore clear how the proposed amendments to the Act, which would only take effect

once MoD has been subject to a Crown Censure, would result in any tangible improvement to the safety of military training. These safeguards (to learn lessons, implement corrective measures identified by the HSE and the seriousness with which we treat Crown Censure), together with the ability to bring civil claims for negligence against the MoD, where a breach of a duty of care occurs within the UK or abroad, provide a strong system both for discouraging failure by the MoD and for learning lessons where things go wrong.

The MoD has considered carefully the particular question whether it can be right that an individual can be prosecuted while the corporate body cannot. First, it should be remembered that it is the Department which will be the focus of any civil claim, and meet a civil liability for a breach of its duty of care, whether the breach was at the highest levels of the MoD or at the immediate level at which training was carried out. Second, while a gross failure by an individual carrying out training and resulting in death can feasibly be assessed, it would be extremely difficult, perhaps impossible, to apply the concept of manslaughter (even in its very special form under the 2007 Act) to the role of the senior management of the MoD in permitting and setting parameters for training which is essential and which is by its nature hazardous.

In addition, even where training takes place within the UK, and so comes within the application of Health and Safety requirements, it is not always easy to distinguish between a training activity and operations; the connection between training and the carrying out of an operation is often a seamless one.

In relation to SMU, very similar points apply. Because of the exceptionally short response times needed to deliver SMU operations, it is particularly difficult to distinguish between training activity linked to operations and operations themselves. The role of Crown Censure, inquests, civil claims, and (against individuals) criminal, disciplinary and administrative action are the primary and most effective legal safeguards. The issues surrounding attempting to judge the criminal liability of an organisation in respect of units whose role demands selection and preparation to provide the highest level of response to the highest levels of risk are, if anything, even greater than those which would apply to judging such liability in relation to hazardous training for operations. The further issues as to SMU relating to secrecy are referred to in response to recommendation 28. The MoD recognises the importance of this subject and will keep it under review.

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)**

The Government's response is provided under recommendation 25.

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)**

The Government's response is provided under recommendation 25.

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)**

The MoD accepts that it may be able to take precautions in the context of individual prosecutions to ensure the appropriate level of security and confidentiality for SMU. Even in such a trial, there may nonetheless be difficulties, especially in the event of a trial before a civilian court, with a jury.

A prosecution under an amended Corporate Manslaughter Act for alleged gross negligence of the organisation would have to consider "the way its activities are managed or organised by its senior management" (section 1(3) of the 2007 Act). As a result, it would seem almost inevitable that the units, their organisation and practices would be identifiable and come under scrutiny. Moreover, while there is scope for evidence to be given in camera, the trial would have to be in a civilian court with a jury (the Service Justice System has no jurisdiction over the MoD or Armed Forces as a body, but only over individuals) and this would add to the difficulties of maintaining the necessary degree of secrecy.

The importance of secrecy as to all these aspects has been recognised by Parliament; for example by the absolute exemption under the Freedom of Information Act 2000 as to information relating to or supplied by Special Forces. The SMU exist to deliver operations that are beyond the reach, capability or profile of other parts of the Armed Forces. In order to meet that aim it is critical that the capabilities and identities of their units and personnel are protected. Any disclosure, no matter how innocuous it may appear in isolation, will be used by potential adversaries to build a picture or corroborate other sources of information and undermine this strategic capability.

Furthermore, the nature of SMU is that from the moment they complete selection they will be either training for operations, deployed on operations or on standby (usually at very short notice to move) to deploy on operations. Therefore the nature of selection itself is designed to 'train in' rather than 'select out' candidates. This means that the totality of SMU training and selection activity is directly linked to preparing for operations and a line cannot realistically be drawn between selection and training. It is important that this remains recognised in legislation.

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)**

The Government agrees with this conclusion.

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)**

The Government's response is covered in the main body of this response.

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)**

The Government's response is covered in the main body of this response.

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 lessons have been learned for the future. (Paragraph 156)**

The Government agrees that support to families of those who have died is an extremely important area to get right. The Government response is covered in the main body of this response.

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)**

The Government is pleased that the Committee feels the MoD is moving in the right direction as is evidenced by steps such as the creation of the DSA.

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)**

The Government is pleased that the Committee were impressed by the training they witnessed at the CTCRM in Lympstone. It should be noted that similar approaches are in place across Defence.

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)**

The Government agrees that each death is a tragedy. Our responses to the Committee's recommendations on areas where they think the MoD can go further and to explore in more detail are covered in the main body of the Government's response.

24 June 2016