HOUSE OF COMMONS

Defence Committee

Oral evidence: Military exercises and the duty of care: further follow-up, HC 164

Tuesday 21 July 2020

Ordered by the House of Commons to be published on 21 July 2020.

Watch the meeting

Members present: Mr Tobias Ellwood (Chair); Stuart Anderson; Sarah Atherton; Martin Docherty-Hughes; Richard Drax; Mr Mark Francois; Mrs Emma Lewell-Buck; John Spellar; Derek Twigg.

Questions 1-55

Witnesses

I: Philip White, Director of Regulation, Health and Safety Executive, Samantha Peace, Director of Field Operations, Health and Safety Executive and Andrew Cayley, Director Service Prosecutions, Service Prosecuting Authority.

II: Baroness Annabel Goldie DL, Minister of State, Ministry of Defence, Isabel Letwin CBE, Director, Ministry of Defence Legal Advisers, Major General James Illingworth, Director of Land Warfare, British Army, and Air Marshal Susan Gray CB OBE MSc CEng FIET FREng RAF, Director General of the Defence Safety Authority.

Written evidence from witnesses:

- Health and Safety Executive
- Ministry of Defence

Examination of witnesses

Witnesses: Philip White, Samantha Peace and Andrew Cayley.

Q1 **Chair:** Welcome to the Defence Committee hearing on military exercises and the duty of care. This is a legacy study, the second follow-up session to the Committee's 2016 report, "Beyond endurance? Military exercises and the duty of care".

Q2 We have two panel groups today. I will introduce the first one: Philip White, who is the Director of Regulation at the Health and Safety Executive; Samantha Peace, who is the Director of Field Operations at the Health and Safety Executive; and Andrew Cayley, who is Director of Service Prosecutions at the Service Prosecuting Authority.

Q3 We are grateful for your time this afternoon as we explore this important issue. Naturally, we understand that the environment in which the armed forces operate is different from that of the civilian world. I ask Mark Francois to take us forward in opening up our study today. Mark, the floor is yours.

Q4 **Mr Francois:** I apologise to the witnesses as I have another defence-related engagement at 3pm, so I am going to have to "shoot and scoot", in military parlance. I am sorry about that; I mean no disrespect.

As the Chairman has already intimated, military operations can be extremely dangerous and therefore we have to train our personnel to be able to cope with highly stressful and challenging situations. Given that that is different to some aspects of civilian life, can you explain quickly how you organise to investigate, if and when things go wrong?

Chair: Philip White, do you want to open up with that?

Philip White: We will investigate any death or serious injury that comes to our attention from the military following, maybe, a training exercise, in the same way as we would investigate a death on a building site or in a factory. We have set procedures and protocols that we follow. They will be followed in relation to the military environment.

If we find that there is an immediate risk in a civilian environment, we will serve a prohibition notice. We can do the same in the military environment by serving a Crown notice. The real difference comes if we find that there is sufficient evidence, following the investigation, for us to take a matter to court. Clearly, we cannot do that because of Crown immunity, but what we do is take a Crown censure. We have to have the same level of evidence as if we were taking a matter to court to take a Crown censure, but all the processes leading up to that situation are no different than if we were investigating an accident in the civil environment—say on a building site, a factory, a farm or in some other setting.

Q5 **Mr Francois:** Thank you; that is helpful. Given that, have there been any notable changes relevant to this inquiry to the way the Health and Safety

Executive—or the Service Prosecuting Authority, Mr Cayley—operate since the Committee's report into these matters in 2016? Has anything effectively changed in your operating procedures in the intervening four years?

Philip White: In terms of HSE's procedures, other than tweaking here and there as one would normally do in response to those changes—in the way statements are taken or whatever—no, but one of the key things we did following the last inquiry was that we published a position statement on realistic training in the military. We wanted to be clear and open about the difficulty, as you outlined earlier, Mr Francois. This is a very challenging environment. We need to put people under stress, getting ready for combat or working in combat zones. That has to be balanced against a number of other factors.

Following consultation and engagement with the MoD and with different services branches, we published on our website that high-level statement to show and outline the sort of balances that we bring into our work in this area. As you say, this is a different environment than a farm, building site or factory, say. That is the one thing we have published.

Q6 **Mr Francois:** For the record, in what year did you publish that statement?

Philip White: I would need to check that out. I think it was about two years ago, but I wouldn't want to guarantee that. We can let the Committee know at a later date.[1]

Q7 **Mr Francois:** Mr Cayley, any changes in the last four years?

Andrew Cayley: I cannot say that we changed policy. As you know, I can only consider, at the SPA, cases that have been referred to me by the service police, so an investigation has to have commenced and been completed before I can consider charges.

What I can say is that certainly since my last attendance at the Committee, when we do have these cases, that is at the forefront of my mind. I certainly tell my staff who are considering these cases that we must give these particular cases a degree of scrutiny that is adequate.

I think we were doing that before, but certainly since the last meeting with the Committee, we have had two cases, both involving deaths in training. I won't go into detail, because I know time is limited, but what I can tell you, in respect of one particular case, which was the unlawful killing of a soldier on a range, is that it was a case that took place in the United Kingdom and the civilian justice system led on it. It was considered twice by the CPS, and the decision was made for no further action.

The case came to me eventually, through the service police, for consideration of service disciplinary offences, as opposed to a civilian offence—gross negligence manslaughter. In the end, we took external counsel's opinion. The advice that we were given was to charge one

[1] The Health and Safety Executive later confirmed that it was 2018.

individual with gross negligence manslaughter and then two other individuals with service disciplinary offences—neglect of duty. We got convictions for all of it, so that was actually quite an important milestone. We convicted somebody of gross negligence manslaughter for the death of a soldier on a range.

We had another case—it took place in the Brecon Beacons—involving training of special forces. Three reservists died during a very hot period of weather while running. You are nodding, Mr Francois: you know the case. That is actually a case where I decided not to prosecute, because I felt that there were intervening factors that had certainly affected causation in terms of the responsibility of the two accused in the case and the very sad deaths of these three individuals.

The families of the three victims asked for a review of the case. We had it reviewed, again by external counsel. The decision was made to prosecute for service disciplinary offences—neglect of duty. The case was dismissed at half-time by the judge. It never went into a defence case; at the end of the prosecution case, the judge essentially dismissed the case on the basis that there were systemic failures for which the two individuals were not responsible.

Q8 **Mr Francois:** In other words, your procedures have not really changed.

Andrew Cayley: Correct.

Q9 **Mr Francois:** But by the sound of it, in some ways you are paying even more attention to these cases than perhaps you did a few years ago.

Andrew Cayley: I think—to be fair to us—we did pay attention, but obviously the concern expressed by the Committee last time has been at the forefront of my mind when these cases come across my desk.

Q10 **Richard Drax:** Following our predecessor's inquiry, the HSE carried out a programme of work to assess the adequacy of the MoD's risk control measures for centrally delivered training exercises. Can you talk the Committee through your findings, concerns and recommendations? Samantha, could you kindly answer that question?

Samantha Peace: We conducted a series of inspections, over a period of three years, tri-service. It gave us an opportunity to benchmark, and we actually homed in on arduous training and live firing as the two areas of real concern within the huge range of training that the military carry out.

We conducted, at frontline commands, those inspections and, broadly speaking, we were satisfied, on all the visits that we made, that those managing those activities actually understood the risks associated with live firing and arduous training, and that they had adequately managed it and were competent, in line with the guidance that they are supposed to follow for those training activities.

We also found sufficient evidence that the MoD has acted on recommendations from previous censures and investigations, and indeed the Defence Committee report "Beyond endurance?", which was

mentioned earlier. We did not find any cases where we had to take formal enforcement action.

However, we did also make a number of recommendations that went beyond any single frontline command. These were that the risk control policies and procedures in place are reviewed to make sure that, rather than trying to deal with all risk, they actually focus on what is significant and direct the efforts into those areas that are significant, and that the methodology for explaining and delivering those policies and procedures is also reviewed and they really ensure that it reaches all the people who need to know it and it is understood.

Quite a lot of activity has gone on, to learn lessons. That is important. It happens in pockets, it happens in different areas, it happens in different parts of military service: an effective mechanism for making sure that that is spread more widely and, indeed, that it isn't just about learning lessons after things have gone wrong, but there is more that could be done for a very simple way of actually showing good practice. The fastest way for people to achieve compliance here is to be shown what good looks like, and what it looks like when these risks are really managed well.

Peer review should be carried out across the services, at both tactical and strategic level, and a strategy be put in place to benchmark against external organisations, because while we have those differences with military there is also an awful lot that can be learned about the management of risk with training activities, from others too; and there should be a method to ensure continuity—a kind of corporate memory. Often changes are made in response to things, and they unravel a little later on, and are undone, potentially, if there is not the corporate memory there.

We also recommended that at an appropriate governance level a decision on the visibility of the Defence Safety Authority to provide third-party assurance for high-risk training activity should be agreed; and, finally, that the MoD should ensure that their internal monitoring provides assurance about the training that isn't centrally delivered. This was focused on centrally-delivered training, and not all the training is delivered in that way. They would need to check whether the standards being applied to training that isn't centrally governed are equally robust. Indeed, that is an area that the Health and Safety Executive may decide to probe into with further inspection in future.

Q11 **Richard Drax:** Can I just dig into that little area a bit more? Being a former infantry soldier myself, we went through some very tough training on live firing, as officers, to qualify to run a range, I recall, and to learn how to manage them properly. Do you look at that, so far as what the Army is doing to teach officers and senior warrant officers how to run ranges safely, or do you leave that entirely to the Army or armed forces to deal with internally?

Samantha Peace: What we can do is assess the provision laid out to ensure that somebody is competent. That means that they have been

through the relevant training courses, and have been assessed at those training courses, but have also acquired the right level of experience. That is a judgment that the military make themselves.

Indeed, we have had instances and scenarios in the past where somebody who has been through the training has been deemed as having not quite enough experience, and requiring some more supervision, before they are allowed to design certain live-firing ranges, or do certain things. In some of the incidents, sadly, that supervision has not then been put in place.

What we will do is check that that supervision is going into place. So we are not there to second-guess the standards of training that should be applied to equip somebody to do that and manage that live-firing activity. We expect the military to set out those standards and train people to them. What we can do is test whether that is actually happening in practice and whether, then, the findings of that training, and any other measures to ensure that somebody is competent, are happening in practice. That is what we examine when we go in on inspection.

Q12 **Richard Drax:** Just leading on from that, do you think the agency is too reactive, rather than being proactive, especially in areas where lessons are not being learned?

Samantha Peace: I think that we have a balance. Philip has described that we apply the same selection criteria to looking at issues like incidents or concerns where we are reacting to what is happening, but on a broader front we have risk-based intelligence-led inspection activities and we include MoD premises in those activities. That may be when we are looking at construction activities, or looking at Legionella, or topic-based issues. It enables us also to gain an insight into how the management of risk is functioning across the MoD more broadly and in different areas.

We also have specialists that go in and inspect in certain areas—so explosives storage, mines, diving. We actually have quite an active programme that isn't just us reacting to things across the piece, together with things like major hazards. If there is storage of fuels that reaches a certain point, our major hazards colleagues will go in and look at that.

So periodically within our organisation—we did so some time ago—we sit and bring all of those people together to actually look at what we are learning and look at the body of our regulatory work across the MoD, to share that and to make sure that we are also going in and then looking to see whether the lessons are being learned in different areas of the MoD's activity—it is a huge range of risks that they are managing. We are working hard to be not simply reacting, but taking very much a risk-based and intelligence-led approach to what we examine.

Chair: Thank you. Can we turn to hazardous training? Stuart Anderson.

Q13 **Stuart Anderson:** Thank you, Chair, and thank you to all the witnesses for your time today.

First, I have to declare what is probably quite an unusual interest: I was

shot on a training exercise when I was a serving soldier, undertaking what my colleague Mr Drax has just described as "hazardous training". The MoD later admitted liability.

I was also in an unrelated incident, which was in "Beyond endurance?"—the tragic deaths of three servicemen on the SF selection. I was on the ground at that time, doing something separate, but I was there when the casualties were found. I had to declare that prior to starting.

My first question is for Philip and Andrew. Should the MoD have Crown immunity for hazardous training?

Philip White: Thank you for that question, and for letting us know about your background. Obviously, it is quite a sobering experience when you have experienced what you have experienced. It brings everything to real life for us today.

The question of Crown immunity is quite an interesting one, which comes up from time to time. Everyone thinks that it is something that should be looked at, but it is never really addressed. There are strong arguments for; there are also arguments against. I think it is something that should be looked at, but looked at more seriously than just saying, "We should be lifting it." I do not think that we really understand all the pros and cons of keeping it or removing it.

It has implications elsewhere. You talked about hazardous training standards and just lifting it for that. That could be quite a difficult boundary on which to curtail it. I think we would want to look from a broader perspective. We have taken Crown censures against a number of other bodies, like the UK Border Agency, the Prison Service and the Historic Buildings and Monuments Commission, so there are quite a few organisations that we have taken Crown censures against.

From our perspective, certainly with our experience with the MoD and the work that we have done over the last 10 years or so, particularly in the area of hazardous training, Crown immunity has not stopped us investigating matters. It has not stopped us taking matters to censure. It has not stopped us then getting publicity on the back of those censures. We put a press notice out and make it public. It is kept on our database of "enforcement", and we would expect matters to be brought to the attention of the Secretary of State within the MoD.

One of the things about Crown immunity and taking Crown censures is that there is a slightly different dynamic, we have found, compared with where there is no Crown immunity. We have not had too many arguments in terms of taking the process forward and accepting the Crown censure at the end of the day. It has not stopped us taking that action, and it has actually smoothed things over at one level, on the back end of the process.

When bringing prosecutions, there tend to be a lot more arguments and a lot more lawyers involved. Summing up, I think it is something that we

should be looking at, but we really need to understand both the pros and cons of it in terms of lifting the Crown immunity for these areas.

Andrew Cayley: Good afternoon, Mr Anderson. I am going to consider this for you principally under the Corporate Manslaughter and Corporate Homicide Act 2007, because obviously I am a criminal lawyer, and that is how I look at these things.

The first thing that I would say is that the Service Prosecuting Authority would never have jurisdiction to prosecute under that Act, because under the Armed Forces Act my jurisdiction is principally over members of the regular armed forces. I tell you that because any case that would be brought potentially against the Ministry of Defence would have to be brought by the Crown Prosecution Service. Indeed, if you look at the legislation, the Director of Public Prosecutions has to give consent.

Then the question arises that you specifically asked me, and I can give you a personal opinion as to whether or not there should be immunity for prosecution where it is hazardous training. In the end, that would have to be a matter for the Director of Public Prosecutions to consider.

To give a concrete example, in the case that you mentioned—the Brecon Beacons case of the three reservists who died in training—whether or not the exemption would apply would be for the Crown Prosecution Service to consider whether the level of that training was sufficiently serious to be hazardous or whether it was merely arduous. If it was less than hazardous, then they could indeed bring a prosecution.

I suppose, if you want my opinion, I think that probably for hazardous training the exemption should still apply, for all the reasons that the Chairman gave at the beginning. I think Mr Drax referred to this—training has to be realistic. I am an independent prosecutor within the system, but we expect members of the armed forces to use lethal force under the control of the Government. In order to do that, they have to train properly, so my view is that hazardous training should be exempt and they should not be prosecuted under the Act. Perhaps conduct that falls short of that—that would not be for the DSP to consider; it would be for the DPP—for training that was perhaps arduous but not hazardous could be prosecuted under the Act.

Q14 **Stuart Anderson:** Thank you. Just for reference, Andrew, would you have said that that Special Forces selection was arduous or hazardous?

Andrew Cayley: It is very difficult for me to say. I am not trying to dodge the question. I am not a professional soldier. I suppose instinctively what I would say is that hazardous training is when live ammunition is being fired. That is instinctively what I would think. I think that training is very difficult, because these individuals have to be very, very fit in order to do what they do, but it does not seem like hazardous training to me, no.

Q15 **Stuart Anderson:** Thank you. Samantha, could you now expand to the Committee on how the HSE follows up on recommendations from Crown improvement and prohibition notices and Crown censures? It would be

great if you could expand on that for us.

Samantha Peace: Of course. The prohibition notices and the improvement notices are usually quite tightly defined, so if we are writing a notice we need to be able to judge whether or not it is being complied with. Therefore it is generally quite tightly drawn. The prohibition notices will be where we have spotted something that we think is a serious risk to life and risk of serious personal injury, and we want something to stop immediately and we want measures to be put in place.

We free people to carry on with that activity once they have put those measures in place even before we have been back to check that they are there, because it may be essential for them to be able to do so. However, it is clearly understood, and if we randomly go back and check and they have not done it, and they are running that risk again and have breached the notice, we would automatically go to much stronger action and censure them for doing so, as we would prosecute somebody for failing to comply with the notice.

For the improvement notices, which are clearly based on a very clear legal breach, as with the prohibition notices we will set out at least one means of complying with it. People are free to find another way to comply with it if they wish, and we will want concrete evidence that they have done so. For some issues, that might be quite easy to judge from documentation. For others, we need to go and have a look, and that is what we will do to check that whatever we have asked to be put right has been put right.

Again, for the censures, the recommendations tend to be a mixture of very specific things, maybe to a particular facility or frontline command or activity, in which case we will want to see concrete evidence that that has been done and put right. Some of the issues emerging out of the censures have been more themed. That is where we have had this inspection programme to go and test whether or not the broader themes of learning, assurance and some of the other issues that sit as the backdrop to some of these incidents are actually being tackled and have been put in place—hence that programme of work, which we feed in.

We also expect, of course, the MoD, with its own assurance exercises, to be looking to check that all these actions have been taken as well. We may look to see whether or not their audits are showing that that is the case.

Chair: Thank you. Derek Twigg, please.

Derek Twigg: *[Inaudible.]*

Q16 **Chair:** Sorry, Derek, we are having problems with your mic again. In case the witnesses did not hear that, we want to look at the command structure in relation to training and exercise, and how the decisions are made within that. Samantha, do you want to have a go at that?

Samantha Peace: Yes, indeed. My understanding is that this is about whether or not we have found that mistakes are made at any particular

level in the command structure. In fact, our work has not exposed an issue in a particular part of the command structure in the mistakes or decisions that lead to undesired outcomes happening; we find different things in different scenarios. I think that reinforces for us the importance of everyone in the command structure being equipped and geared to play their part and discharge what they need to in the management of risk properly.

Q17 **John Spellar:** This is a question directly to Philip. Do you think that the HSE should have a role in investigating incidents involving training overseas?

Philip White: To answer that straight, I would say no, for a number of reasons. Let me explain where I think the HSE does have a role. I think that there are not inconsiderable legal, organisational and practical issues for us to be investigating in someone else's jurisdiction, potentially. There are local regulators. If there is a death in Germany, Canada, Cyprus, or somewhere else in the world, there are obviously local agencies and authorities that will investigate that.

Our legislation at the moment curtails our locus effectively to Great Britain. If we do not have the locus, what we want to know is, if there has been a death on training overseas, what the lessons are that the MoD is taking on board. Then we would follow through very much in the way that Sam has outlined in terms of following a censure. Those are the sorts of things that we would be looking for, for assurance from the MoD that they have taken those lessons on, and then we will check those through.

The other thing that I would add to this is that since the Committee reported back in 2016 there have obviously been some governance changes within the MoD in relation to health and safety, and I am sure that they will explain that when they give evidence. They have put themselves into a position whereby we can now have some really good strong dialogue at the most senior levels, to provide a real "critical friend" challenge function to the MoD in relation to how they are addressing some of these issues, particularly matters that are happening overseas. It is an opportunity for us to get the lessons back: what have they found out, and how are they then acting on them in the UK and more broadly? Obviously, we will expect them to put the lessons that we learn from Crown censures into practice wherever they are doing their training, whether it is in Great Britain, Canada, Germany or wherever.

Q18 **John Spellar:** I can see that in Germany, for example, that might well be within German territory, but you mentioned Cyprus. What would happen if it occurred at an exercise in the sovereign base area?

Philip White: Again, we do not have locus even in sovereign base areas. HSE does not have a locus outside of Great Britain.

Q19 **John Spellar:** Do you think that you should have?

Philip White: I do not think that we should. For me, it would raise the question: where else, in other areas? What if British companies are

working abroad? An area that has been put to us is deaths that have occurred when people have been on adventure activities holidays, or schools have gone abroad and there has been an incident.

At the moment, we do not have the locus. We do not feel that we need to take that locus because there are local authorities that will deal with that. I am not sure about the arrangements that take place in the sovereign base in Cyprus with the local authorities there, but we do not have a locus, and I do not think that we ought to take a locus just within a base and not elsewhere, if that makes sense.

Q20 **Chair:** Just following up on John Spellar's points, you also have the Falklands, Gibraltar and other places. Is there not a concern that different standards might be pursued, rather than a more boilerplate approach?

Philip White: We would expect that the MoD would apply the same standards wherever they were working across the world. We see that in the private sector: UK worldwide businesses will apply UK standards for their operations, whether that is in South America, Africa or elsewhere. So we would expect those same standards to be applied.

Q21 **Sarah Atherton:** Good afternoon, all. This is a question for Andrew. The "Service Justice System Review", completed in 2020, considered that the Service Prosecuting Authority "may not have…the optimum mix of service and non-service lawyers or of experience and expertise that is required." How do you think that this will have impacted on the role that the SPA plays in relation to deaths and injuries during training exercises and selection?

Andrew Cayley: Yes, if you read the report—as you have pointed out—it indicates that some of our most junior prosecutors who come here do not have an enormous amount of experience of prosecuting serious cases. Just to be absolutely clear about this, these are not individuals who are involved in these very serious cases. At the higher, more senior end of the organisation, we do have both service lawyers and civilians who have much more extensive experience in advising on these very serious cases.

What I would point out, as I did at the beginning of this session, is that in respect of these cases—I mentioned two cases; I won't waste your time by repeating the points about them—we take external advice from independent counsel, so we go to the criminal Bar. In relation to those cases, in the first instance we took advice, in respect of the shooting of the young soldier on a range, from a very experienced silk, a man called Nigel Lickley QC, and in the second case, involving the deaths of the three SF reservists in Brecon, we took advice from Louis Mably QC, senior Treasury counsel. So for those particular cases, I think the issue of the lack of experience of our most junior people is not relevant, because we will always take advice on those very serious cases involving death of or injury to service personnel in training.

Q22 **Sarah Atherton:** That prompts the question: how would you engage with the family during this process?

Andrew Cayley: As you know, since the EU directive, we have the Criminal Justice (Armed Forces Code of Practice for Victims of Crime) Regulations 2015. I have this here; it is a massive document, but it does set out the responsibilities of everybody involved. I can only talk about our involvement, because a number of groups or bodies, including the service police, the unit and the victim liaison officer, are given obligations under the statutory instrument. I can say in practical terms how we now engage, in particular in the most serious cases, where somebody has died and so individuals—family members—have been bereaved. We essentially keep them informed from the beginning of the process right through to the end.

To give a concrete example, in respect of the shooting of the young soldier on the range, he happened to be a citizen of the Republic of Ireland. We consulted with his family. We advised them that we were bringing the prosecution. We organised it with the Military Court Service to bring the family to the UK in order to attend the proceedings. We had one of our prosecutors explaining to the family throughout what was going on during the procedure, and we explained the outcome at the end.

In fact, if you read the regulations, what we are expected to do is very detailed. We do make, I think, a much better effort than when I was first appointed as the director to deal with the families where somebody has died in these circumstances. And certainly where people have been injured in training and they are the victim, we would do exactly the same for them. In essence, we are just keeping them informed throughout of the criminal process.

Sarah Atherton: Thank you, Andrew. We are going to pursue the issue of engagement with the family later in the session.

Q23 **Martin Docherty-Hughes:** Andrew, can we go forward a bit? There have been 52 deaths during training since 2010. Will you tell the Committee how many prosecutions and convictions there have been, and what type of punishment has been the end result?

Andrew Cayley: Yes. I can only deal with cases referred to me, so I do not have any power under the Armed Forces Act to initiate investigations myself. In essence, I can only advise for a prosecution on a case that is referred to me by the service police—generally in these very serious cases anyway—specifically.

Do you want me to list the cases? I can do that, if you want. There is not that many—there are only six.

Martin Docherty-Hughes: I would like to have the time to do so, but—

Andrew Cayley: If I can summarise, between 2010 and 2019 there have been six cases. Almost all of them have involved charges of neglect of duty. As I explained earlier, where there is a death—now we are dealing with death cases only—the most serious charge would be gross negligence manslaughter. Where we cannot prove that, where there is an insufficiency of evidence to come to that level of proof for that offence, we would charge neglect of duty, which is a specific service disciplinary

offence under the Armed Forces Act that the civilian justice system does not have.

From what I can tell you about those six cases, most of them have been negligent performance of a duty. Of those six cases, there have been two sets of charges of gross negligence manslaughter; in the rest of the cases, negligent performance of a duty—neglect in flying in one case, involving a flying episode. We charged 12 offences overall—so really 10 offences of neglect of duty and two of manslaughter—and we have had six convictions and six acquittals.

To give you the example of the most serious recent case, post the last Committee meeting, I mentioned it earlier—the death of Ranger Maguire on Castlemartin range. We got a conviction for gross negligence manslaughter in that case. The officer who was convicted of that was given, I think, an 18-month prison sentence. I will check that I got that figure right and, if I have got it wrong, I will send a note. The other two individuals were fined and lost seniority: a lieutenant-colonel who was the superior of Captain Price was convicted of neglect of duty, and he got a loss of seniority and a fine; and a warrant officer also got loss of seniority and a fine. I will check on those sentences.

That is a summary. I can give you this in detail in writing, if that would be helpful.

Q24 **Martin Docherty-Hughes:** That would be useful and much appreciated. Finally, how many of those six that you talked about specifically have reached the threshold for a civilian offence?

Andrew Cayley: That is an interesting question. What I can tell you is that with a civilian offence—gross negligence manslaughter is a civilian-type offence, and neglect of duty is a service disciplinary kind of offence—the threshold is exactly the same, because we apply the same tests as the Crown Prosecution Service: is there a realistic prospect of conviction, and is there a sufficiency of evidence? To reiterate, the evidential standard for gross negligence manslaughter is higher than for neglect of duty, principally because we have to prove gross negligence—it has to be seriously negligent—whereas for neglect of duty, it is a lower level of negligence. Does that answer your question?

Martin Docherty-Hughes: Yes, that kind of gets to the point, so thank you.

Q25 **Richard Drax:** Andrew, may I ask you quickly for a legal perspective? Training of the regular forces and of special forces is different. Having been in the Army, I know that is a fact. The regular forces are, if you like, more safeguarded, whereas special forces are allowed to do far more training and to use their own initiative. If a trainer allows soldiers to use their initiative, but they do not use their initiative sufficiently—to take enough food or water, or whatever it may be—and get into trouble as a consequence, where legally does the liability lie?

Andrew Cayley: In respect of the special forces, in terms of straightforward charges under the Armed Forces Act—so neglect of duty—we would consider that in exactly the same way. A board within a court martial may be more sympathetic because of the reasons that you have just set out, but frankly, if I give the example of the Brecon Beacons, that involved the special forces. We applied the test in exactly the same way as we would do with the regular forces. Was there a sufficiency of evidence to demonstrate a neglect of duty?

My decision originally in that case was not to prosecute it, because I thought there were systemic failures which probably excused the two individuals who were investigated. We took advice, we charged them and it went to court and the case was dismissed at half-time. It never went further than the prosecution case for the reasons I have just said, so systemic failure.

I think we would consider all members of the armed forces in the same way, but the likelihood is a board—as you know, Mr Drax, you have served—is made up of serving individuals, officers and warrant officers from the armed forces. I would imagine, I don't know because I have never sat on a board, they would take into account exactly what you are saying—that the special forces operate differently from the regular infantry.

Chair: Thank you. Richard, do you need to declare that you were in the SAS for 15 years as a warrior, or shall we just not mention that?

Richard Drax: I was not in the SAS.

Chair: Thank you, Philip White, Samantha Peace and Andrew Cayley for your time. We very much appreciate your contributions in helping us in this session. We will say goodbye, or you are free to stay online to witness our next group of witnesses.

Q26 Examination of witnesses

Witnesses: Baroness Annabel Goldie, Isabel Letwin, Major General James Illingworth and Air Marshal Susan Gray.

Q27 **Chair:** I am very pleased to see my former ministerial colleague, Baroness Annabel Goldie, online, thank you for joining us this afternoon; Isabel Letwin, Director of Central Legal Services at the Ministry of Defence; Major General James Illingworth, Director of Land Warfare at the MoD; and Air Marshal Susan Gray, Director General of the Defence Safety Authority.

I should declare an interest myself. I was in a platoon at the Officer Training Corps at East Midlands OTC. I was at Loughborough University, the more superior university compared with Leicester, where James Illingworth was representing, but we are old friends. Thank you very much for your time. Also, Air Marshal Susan Gray, congratulations, am I right in saying you are the only three-star in the armed forces at the moment?

Air Marshal Gray: Female, Sir, yes.

Chair: That was what I was implying. I hope there will be more of you to come. Congratulations on your service. We appreciate what you are doing. Thank you to all of you here this afternoon. We will continue our study here.

Q28 **Stuart Anderson:** Having attended Leicester University, I have to agree with the General on that one. The first question is to the Minister. Since the 2016 report, "Beyond endurance?", what changes have taken place for regulars and reserves for training exercises to ensure more protection or safety is put in place for our servicemen and women? Were any actions from the report implemented?

Baroness Goldie: Thank you, Mr Anderson, and can I thank you, Mr Chairman, for your kind remarks and for inviting myself and my colleagues to appear before you this afternoon? I know there is a lot of material that the Committee will want to get through, so we will endeavour to keep our responses informed but will try to be as brief as possible.

Mr Anderson asks a very important question. For me as a Minister relatively new to the department, I have seen a change that I would describe as transformative. It is quite simply this—it is a fundamental alteration to governance and structure within MoD.

The main changes since your Committee's report of 2016 have arisen as a result of an MoD governance review of safety and head office that was known as the Ryan review. The review's recommendations were accepted by the department in January of last year. Very importantly, this led to the formation of a directorate of health, safety and environmental protection within MoD and the creation of the Defence Safety and Environmental Committee.

The Committee is chaired with a permanent under-secretary. Its members include all four-star commanders and the chief executives of other defence organisations. It meets quarterly, it is supported by a three-star Committee steering group, and it lies at the heart of the whole new MoD structure for safety and accountability, which I think is at the heart of your question, Mr Anderson. It enables us to constantly monitor our performance and practices, and it means that accountability flows from the Committee through the commanders and chief executives to those across defence conducting training exercises and selection events.

It is also worth pointing out that there is a healthy and very helpful relationship with the external Health and Safety Executive, which was evident from the earlier evidence that you heard this afternoon. I can confirm that the new memorandum of understanding has been drafted between the HSE and the MoD, and we have agreed the text. The director for defence, health and safety and environmental planning in the MoD has signed the general agreement for that MOU, and I understand that Mr White hopes to be signing it on behalf of the HSE within the next few weeks.

I would describe all these changes as fundamental and significant. To me, they demonstrate that—at the highest level now within the MoD—safety, welfare and responsibility for our armed forces in their training is right at the top of the organisation and cascading down through every part of the organisation, bringing a new awareness and, I hope, a new environment within which our armed forces can train. If I may, I might ask Air Marshal Gray and General Illingworth to comment a little further from their different perspectives.

Q29 **Chair:** Air Marshal, would you like to go first?

Air Marshal Gray: The only thing I would add is that the DSEC—the Defence Safety and Environment Committee—looks not just at training exercises, but across the gamut of activities that defence undertakes. For instance, post-Grenfell Tower review, we would have looked at the whole of the defence estate to understand where we needed to change practice in order to do things differently. The DSEC is a very powerful organisation. It has all of those that are accountable, ultimately, and it is therefore the right place for us to improve and generate a safety culture—the one that we wish to present. That is all I have.

Major General Illingworth: Before I answer Mr Anderson's question, can I qualify your introduction, Chair? As Director Land Warfare, I am a senior officer who is part of the Field Army, so I am speaking on behalf of the Army and the Field Army today. That is where my post exists—effectively working as part of General Ivan Jones's command as part of the British Army.

In answering your question, Mr Anderson, I would reference my comments to that Army level, in terms of capturing some of the stuff that we have conducted in the last couple of years relating to reserves' and regulars' training exercises and selection events. With your background, you will probably be aware that in 2015 the Army conducted what is called Army 2020 Refine, which essentially saw the restructuring of regular and reserve units. It directed robust and repairing relationships between our regular and reserve units, thus enabling more effective training and development. A good example—you will probably be aware of this—is 4 Parachute Regiment, 299 Parachute Squadron Royal Engineers and 144 Parachute Medical Squadron. They are all part of 16 Air Assault Brigade and have a relationship with the regular parachute regiments that contributes to this training and exercising.

That is at the unit level. I would also add that, when it comes to the trade training that our reservists conduct, I am responsible for that within the Army. We conduct this through the Land Warfare Centre, an organisation that was refreshed in its structure in April last year. It is very much part of the Field Army, and links very closely to all the British Army's formation headquarters 3, 1 and 6 Divisions—in order to deliver the Army's outputs, both regular and reserve. We have the mechanisms and the structure, both in the frontline and within the training environment, to make sure that both regular and reserve elements of our Whole Force train and act together.

I should just add that whilst I am not responsible for basic training, I work very closely with the general officer commanding the Army's recruiting and initial trade training, who is based in Upavon. Again, the intent and structure allow us to seamlessly dock our trade and basic training, such that we have this Whole Force output.

Q30 **Stuart Anderson:** Thank you very much. It is clear to see the rationale behind this transformation; as a former soldier, I am delighted that it is taking place, and it is very clear that it is with the governance. To ask a simple question—I do not mind which one of you answers this first—all this has been put in place, we have a changing culture, and it is going to be far better for our troops. However, why have injuries gone up since 2016?

Baroness Goldie: If we look at the defence stats for 2018-19, it is the case that there were sadly 13,461 injuries to defence personnel, of which 6,320 related to the armed forces. The figure for the previous year, 2017-18, is not significantly greater: there were 13,683 injuries, of which 6,532 were to members of the regular armed forces.

What we have to try and understand—this is what we are concentrating on within the MoD—are the causal factors behind these injuries. Why are they occurring? That is the component that needs further analysis. Now, the analysis clearly depends on the quality of the data reported, which in turn depends on the effectiveness of our reporting culture. I suppose there is an argument that the fact that more people are reporting injuries could be a sign that attitudes to safety are improving, and that is positive in the sense of improving safety culture. We would have to weigh against that the possibility that there could be under-reporting, so in such a large and complex organisation, the quality of data underpinning these statistics is variable.

Improving the robustness of the data and being able to fully analyse it is now a priority workstream for the Defence Safety and Environment Committee, and the director of the health, safety and environmental protection unit with the MoD will continue to work with Defence Statistics and with DSTL to try and produce assured, pan-defence safety data. As I say, the numbers are an indicator, but what really matters is why these numbers are occurring and what is at the root of that. I might suggest that Air Marshal Gray comments a little further on that, based on her own experience within the DSA.

Air Marshal Gray: Thank you, Baroness. While we have seen a decline in the number of accidents, which speaks to progress in safety culture, we now find that we need more information about those incidents that did not result in fatalities but are near-misses, as we would explain it in the aviation world. We need to understand, "We got very close, but what did we do that got us that close to having an accident or an incident?"

We are again finding that we are having more near-miss reporting, but we have different systems in different services. That is where the key lies: bringing all those together in a defence-wide reporting system that is then

analysed by experts within the centre and can then be given to the Defence Safety and Environment Committee, to enable them to take action. At the moment, we have lots of different reporting mechanisms that are absolutely reporting the right information, but we are not necessarily collating it in the right way. What we need from that is action. We are making progress, but we are not there yet.

Q31 **Chair:** Can I just ask about the culture that was mentioned before and whether it has changed? General, you were just ahead of me in going to Sandhurst. You then returned to Sandhurst as a member of the directing staff. Is that correct? And now you look back at it, do you see culturally a change in the attitude of service personnel in recognising that this is a concern and that, if mistakes are made, they can put their hand up? I can give you a simple illustration. At my platoon commander's battle course, at the end of the course one of my colleagues—I will not mention his name—found a grenade in his webbing. Rather than put it in the amnesty box, thinking that he would get into trouble, he took it back home and threw it in his dad's pond, thinking that that was the best way to get rid of it. He was relieved to have got rid of a real grenade, but then got in more trouble because he killed his dad's supply of fish.

While that might be an interesting story, it reflected at the time a reticence to show any regard for health and safety for fear of getting into trouble. Do you see a change now with the emphasis coming through and how you as DS and how you as the leaders are actually trying to emulate and encourage this in the Army of today?

Major General Illingworth: From a personal perspective, my journey has been particularly interesting, not least because I am an aviator and the events with the Nimrod crash in Afghanistan in 2006 highlighted the need for an adjustment to the safety culture that existed within the military, it has come on an incredible amount in the last 10 years. That is how I would caveat going back to the early days of when we were at Sandhurst in the OTC. The reality is that in the last 10 years there have been significant changes and adjustments. That takes nothing away from the severity and the seriousness of the loss of our soldiers on the Brecon hill, as well as Rifleman Evans and Corporal Hoole.

Lord Justice Haddon-Cave's report was very clear in terms of what a safety culture entails. There are sub-cultures within this: the flexible culture, the reporting culture, the learning culture, the questioning culture, and the just culture that effectively says to the soldier who took that grenade back to his father's pond, "This is not the right thing to do. I will declare this. If I've made an honest mistake, I will not be punished for it." That is where we are definitely taking things at the moment. I am pleased to say that since the establishment of the Military Aviation Authority, and on the back of the DSA being set up, and the emphasis on these sub-cultures, particularly the reporting culture that allows and contributes to the ability to learn from lessons, we are in a far, far better place, but that is not to say that we are complacent in any way at all.

Chair: Thank you. Sarah Atherton, do you want to move us forward?

Q32 **Sarah Atherton:** Good afternoon, all. I have a question for Air Marshal Gray. The 2018-19 Defence Safety Authority annual assurance report provides an assessment of limited assurance across defence, but I have to highlight that there was a 30% rise in the number of training injuries in the past four years. What weaknesses have you identified?

Air Marshal Gray: Thank you for the question. As you know, the annual reports acknowledge that progress is being made. However, we did identify several significant weaknesses in the systems of internal control of safety and how you manage safety, which led to that limited assurance assessment.

What do I mean by internal controls? Internal controls include the challenges of managing change, particularly in the safety environment, the change in organisational structures, and the change in the way activities are undertaken. It also includes the shortage of suitably qualified and experienced personnel in key specialist areas. It includes safety management itself as having that process and that just culture in place to be able to encourage individuals to be open and honest, and also adequate self-assurance by the main budget holders, the TLBs. One of the key aspects was around the safe management of defence infrastructure, which I, as director general of the Defence Safety Authority, do not look at, but the Defence Infrastructure Organisation is there to do that on defence's behalf.

None of those in themselves make us unsafe, but when you put them together, we could do better. Therefore, we felt that was a "limited" assurance at that time. You may not be surprised to hear that we have written this year's report and the assessment will probably still be at "limited". It has improved. It is moving up that scale. We have not quite tipped over into "substantial", but we are not that far away from it.

If all the initiatives, including those taken forward by the Ryan review and the Parry review into the way the DSA operates, come to fruition, we will be in a much better place. I hope that answers your question.

Q33 **Sarah Atherton:** Thank you. If you will indulge me, while I have the opportunity, I would like to go off script. You are the highest-ranking woman in the military with an accomplished career. I am also a former soldier. I have concerns about women in the Army still being under-represented. Although I accept advancements have been made, we are still missing the mark. Do you have any comments about the role, number and retention of women in the military?

Air Marshal Gray: Okay. I am not unfamiliar with the question, clearly. Things are improving. Again, I would suggest it is not at a rate that we would be comfortable with, nor should we be comfortable with it. The three services differ markedly, I do not know whether that is for historical reasons, because the Air Force and the Navy are getting there first—albeit the Army is very close behind.

We are starting to see that flexibility in careers is allowing more females to dip in and out of a service career. I think that is really important for those

who want to have a family and a career. I can only really speak for the Air Force. At the moment, it is flying—excuse the pun—in terms of senior females. I am on three stars. There are several two stars. There are more up and coming. We are now starting to see a groundswell at the one-star, colonel and OFI level.

Whether that is because we have had a few role models who have managed to get a bit further and encourage, or because the mind set of taking equality and diversity seriously, I don't know. The Navy and Army also take that seriously. Having the opportunity to portray that and having the post to place women in is also important.

I am sure every woman would say this, but I only want to do it on my own merit. There is a bit of a counterculture, which says, "I don't want to be a quota; I want to be there because of my own merits." More and more, we are finding that male mentors are mentoring females and saying, "You can do this, you are more than capable of doing it, so absolutely go for it."

If we get the equality and diversity piece right—which clearly the Ministry of Defence is trying hard to do by putting in place flexible employment, work-life balance and now, as we have all experienced under covid, working from home, and being able to work effectively from home—there is no reason why women should not continue to prosper in the armed services.

Sarah Atherton: Thank you. I could keep talking about this, but I had better defer back to the Chair.

Baroness Goldie: Might I intervene briefly? One of the hats I wear in the MoD is as Minister with responsibility for diversity and inclusion. I have been trying to take a big broom to sweep that cupboard out. Some very positive and good things are happening. Sue Gray rightly referred to a number of them. Two aspects that are worth mentioning: we now have an ongoing initiative, exercise, review—whatever you like to call it—within MoD to look at diversity and inclusion, whereby I and senior personnel—the permanent secretary and the chief of defence staff—have undertaken to come back before defence staff in an all-staff dial-in at the end of October to report on exactly what has been happening in trying to improve diversity and trying to improve inclusion.

In addition to what Sue Gray was saying, one of the areas we are looking at, Sarah, is in fact in respect of recruitment. We are trying to make sure we are broadening out the recruitment process and that we are getting a better feel for who wants to come in. Then how do we ensure from the very beginning we are really looking at diversity and creating the spread of different talents and different attributes and different backgrounds that we want to see and that will certainly enrich not just the armed forces cohort of MoD but also the civilian presence as well?

Sarah Atherton: Thank you, Minister. I will watch with interest.

Q34 **Chair:** I do not want to digress too far. I simply and humbly make the

point that the process you have of filling appointments, despite there being a convergence at full colonel level, is still rotated through Army, Air Force and Navy. General, when you worked in Washington DC, your boss, the defence attaché, was an RAF appointment because it was the RAF's turn. I think there needs to be a little bit of flexibility if the best person is to go forward, rather than not being able to go forward because they are not previously in the uniform of the turn that it is. I do not know if you want to come back on that, James.

Major General Illingworth: Forgive me, Minister, if I am treading on your toes here. From an Army perspective, I know that the Chief of the Defence Staff has introduced a much more competitive selection procedure to avoid the rotational nature of what was going on. I can speak from personal experience in that my previous post to this one, as the Commander of the British Forces and Administrator in Cyprus, where it would normally have gone to an RAF officer after me and then back to an Army officer. It will continue to be a competed post in a way that many others are now within defence.

Q35 **Chair:** We have digressed enough. Sue, did you want to come back quickly? We could have a whole session on this. You will have the last word.

Air Marshal Gray: My post, DGDSA, is a competed post. It has been Air Force, Air Force, Army and then it was back to Air Force. It is competed at the senior appointments committee. We are seeing much more of that now.

Chair: The last chap was a pilot, I think, but that just happened to be circumstantial. There we go.

Q36 **Martin Docherty-Hughes:** Minister, it is good to see you. We have looked at culture within the armed forces in what we have talked about so far. What the Committee wants to really know is why are lessons not being learned. Do you think this is a cultural problem within the armed forces?

Baroness Goldie: We do acknowledge that there have been some specific and serious failures in the past, but more broadly, we would argue that we are not failing to learn the lessons. We are a large organisation and changing behaviours and raising awareness will necessarily take time, but we are learning and changing at every level. I discussed earlier on the fundamental improvements to governance at the very top of the organisation, which is cascading down through MoD. I think that is positive. The single services and enabling organisations have established these safety centres. These are staffed by suitably qualified individuals and have dedicated safety and environmental management systems in place.

The Department is systematically updating policy and guidance in areas such as on heat illness and road safety, but as General Illingworth was explaining in response to an earlier question, it very much now is down to the command chain to make sure that what I describe as the cascade is

actually reaching down through all the arteries and through all the veins, through the very levels of service stations. General Illingworth might want to add a little more to that.

Q37 **Martin Docherty-Hughes:** Before we go on to the general—I will come back, specifically to the air marshal—in terms of the cascade, Minister, and you have talked about the work you are leading on within the Ministry, who do you see across the table when you are talking about this to service personnel? Is there anyone who is not an officer or a civil servant? Who is your interlocutor with the vast majority of the members of the armed services?

Baroness Goldie: My principal ministerial contact inevitably will be with senior service command chiefs; it will be with senior civil servants. It will be with the units which we charge with responsibility for delivering the issues that we are discussing this afternoon.

For example, I will meet regularly with Sue Gray and with David King, the head of MoD's Health, Safety and Environmental protection team. However, I will also have an open door, as will every other Minister, so that if people have concerns, they are to feel free, and I think they do feel free, to raise them if they want at ministerial level, or they may choose to have an interlocutor who is not in the form of someone like me but in the form of someone like you; they may choose to go to their MP.

At ministerial level, I am restricted in the extent to which I could literally get round all military, naval and RAF bases, but I still do that, Mr Docherty-Hughes. When I am there on a base, I endeavour to speak to the servicemen and women who are based on these stations. I want to hear about their experiences; if they have concerns, I want to learn about them.

Q38 **Martin Docherty-Hughes:** In the previous Committee when this has come up, there was often discussion that, unlike most of our NATO allies, we do not have a representative body for members of the armed forces personnel to inform culture, to inform policy and to engage with Ministers. Do you think that that is an issue that we should really be looking at? Maybe you do not agree with it, but it is certainly something like our NATO allies that we should give due consideration to.

Baroness Goldie: What I am aware of is that the chief of defence staff, Nick Carter, engages regularly with his forces counterparts, and through that structure they will be able to engage with individual elements within the three services. I think that is the pyramid within which people can speak.

At the end of the day, implicit within the structure of the services is a command structure. So, at the end of the day, people will work through that command structure. But it is important that people feel that, if they have concerns, they can speak out with them and that there is there is a facility for people to do that if they have concerns or worries. It may not be about health and safety; it may be personal issues, welfare issues, or

mental health issues. And we have made sure that helplines are there for people to deploy.

Q39 **Martin Docherty-Hughes:** Finally, before I come to the Air Marshal, in the previous sittings of the Committee, when we had the armed forces ombudsman in person before us, that clearly was not happening. I just think, Minister, that when you are doing your review, or, as you say, whatever you are calling it, you should be mindful—I am sure you will be—that that has been said to the Committee by the previous ombudsman.

With that, I move on to Air Marshal Gray. One of the findings of your report was that there was a risk of avoidable accidents being caused by complacency. In your opinion, what has caused that?

Air Marshal Gray: If I may, I will just add to the Baroness's answer to your previous question around the opportunity for individuals to bring matters not just to the Defence Safety Authority's attention during our audits, which we would do in a no-blame, just-culture way. So, absolutely, on the frontline, individuals, when they are being asked questions, are invited to come forward with safety issues in particular—

Q40 **Martin Docherty-Hughes:** Forgive me for interrupting you, Air Marshal, but in the Committee in the previous Parliament, again when we had the ombudsman in front of us, that clearly was not working, because regarding some of the impact on women and black and minority ethnic members of the armed forces, the reports from the ombudsman were appalling.

Air Marshal Gray: I can only speak for safety and I believe that the DSA has a very just culture in terms of reporting, but only around the safety issues. I respect that that not does cover the gamut of what an ombudsman would look at.

Q41 **Martin Docherty-Hughes:** Can we go back to the original question and the findings in your report?

Air Marshal Gray: Complacency was an issue that we raised, as you have mentioned. What we found is that even the best people were making mistakes. On the rare occasions that these might lead to incidents, we have safety systems in place that are designed to make sure that our people have the right training, are competent, are well practised and have the information to handle all the situations that they might find themselves in. We also ensure that there are barriers put in place to catch any mistakes. However, clearly some mistakes were getting through. We found that people who were very experienced were making unforced errors. We did not necessarily know—

Q42 **Martin Docherty-Hughes:** Do you mean the people who were engaging with you, at a level of engagement, and not necessarily the lower ranks, so it is officer corps we are talking about?

Air Marshal Gray: No, because these came out of the service inquiries that the Defence Safety Authority has done over the years. We were

finding that there were some very experienced people across the ranks who were making unforced errors, potentially because they were pushed for time or under pressure for any number of reasons, and because they were experienced and had a way of doing business that they felt was a better way. We find that it is very hard to correct that sort of behaviour. You revise procedures, increase supervision and re-educate, but typically the people making those errors were the people who were doing some of the training and who were really experienced in the first place.

We have looked at how we improve our training to the point that those that are really experienced do not just think they know how it works and they know what to do. We have lots of things like peer reviews, making sure that the senior leadership is more effective in countering complacency and is able to listen to those who are saying, "Enough is enough. We have reached a barrier. We can't do any more. We are going to make mistakes." The communications, the listening culture and the more just culture that would allow people to say, "I nearly made a mistake. I am going to tell you about it because somebody else might make that mistake and could cause an incident." We feel we have improved the communication aspect of it, but inevitably people do make mistakes from time to time.

Q43 **Martin Docherty-Hughes:** Let me take that final point, Air Marshal, and follow it with one little bit. In your report, you also say: "Failure to follow procedures, lack of appropriate supervision, the taking of inappropriate levels of risk and a lack of or inadequate leadership remain prevalent." Can you elaborate on that?

Air Marshal Gray: Yes. These are all elements that could lead to an accident or are elements that we have seen. They have not been the main reasons, but they are elements that have played a part in the investigations that we have done.

Most commonly, it is not because people are being deliberately careless but, again, because of pressures of time and circumstance, they have taken a short cut and do not necessarily pay enough attention to what others are doing, especially if they are in a supervisory role.

Q44 **Martin Docherty-Hughes:** Forgive me, Air Marshal, let me stop you there. I may be a civilian, but members of my family are in the forces. If I look back at a previous question session, there were 52 deaths during training alone over the last 10 years. That is a pretty damning indictment. That is about five deaths a year in the last 10 years. You said earlier that you cannot really change some behaviours.

Air Marshal Gray: It is not that we cannot change the behaviours, but they do take time. Being such a complex and large organisation, they take time to change, in particular with the safety culture. Over the intervening years, we have seen a slow change in some areas. In other areas we could do better, and we need to do better. Yes, any death is one too many but inevitably we need to learn from those incidents about how to change behaviours, which are not the easiest things to change. We can change

technical and procedural problems, but we need to inculcate that safety culture from top to bottom.

Q45 **Martin Docherty-Hughes:** If you want to change culture in a place of employment, you usually engage with the trade unions. Is it not time for the Ministry of Defence to eventually consider what the vast majority of our NATO allies already have: an armed forces representative body for members of the armed forces, without the right to strike, to inform culture, policy and process?

Air Marshal Gray: I cannot speak to all the areas that a body like that might be party to, but, particularly in the safety area, the new director of health, safety and environmental protection has already engaged with the trade unions. We have been particularly focused, during the current crisis, about how we manage our forces through the crisis, with all the challenges that we have been asked to—

Q46 **Martin Docherty-Hughes:** With respect, Air Marshal, that is a trade union for members of the armed forces who are not officers—the vast majority of members of the armed forces.

Air Marshal Gray: Yes, that is true, but that may be the start of something that we could look at. I feel that there are enough—there should be enough—mechanisms, if used properly, for people to be able to voice their concerns.

Martin Docherty-Hughes: That is the answer I am looking for. I can see that the Chair is looking for us to wind up, so thank you very much indeed.

Chair: I am also having flashbacks, Martin, because when I was a Minister at the Dispatch Box, you would ask me that question again and again: "Should we have unions involved?"

Martin Docherty-Hughes: And I will continue to, Chair. Thank you.

Chair: But your point is very pertinent. Having attended the Tolpuddle martyrs event that takes place every year in the Dorset area, the advance of the unions and what they do, in providing an understanding of health and safety, is second to none. I think that is recognised. If there are aspects that the armed forces can learn from them, without necessarily actually unionising our armed forces, I think that is still a step forward, and hopefully that will bring a smile to Martin's face.

Martin Docherty-Hughes: Maybe that is a road to Damascus moment for you, Chair. I am glad to hear it.

Chair: How about that. That is right. Emma Lewell-Buck, can we turn to risk assessment please?

Q47 **Mrs Lewell-Buck:** My question is for the Minister. In a recent regulation 28 letter, it was reported that senior commanders are still not being properly trained when it comes to risk assessment. Can the Minister explain what mechanisms are in place to monitor the standard of risk

assessments across services, so they are more than just a tick-box exercise?

Baroness Goldie: Thank you for the question. We acknowledge that the deficiency that you identify was a part in the tragic death of Corporal Hoole. Indeed, in her regulation 28 letter, the senior coroner highlighted concerns regarding the circumstances surrounding Corporal Hoole's death. The Army has now addressed those. Following a comprehensive training needs analysis in October 2019, a plan is now in place to meet the immediate needs and to build safety risk management training into career training for all soldiers and officers.

That training will be rolled out in three phases. Phase 1 is the risk assessment training, a train the trainer pilot course, to qualify Army force protection advisers to deliver risk assessment training. I am pleased to say that, as of 13 July, 1,854 service personnel have been trained as risk assessors and that qualification lasts for three years. The aim was to train all key personnel by the end of March, but of course we could not achieve that due to restrictions arising from covid-19. Smaller training events will continue, but that may take six months to complete.

Phase 2 is what is called surge safety risk management training. The training content is being developed along with methods and media. It is anticipated that training will begin in October this year, and surge training will remain in place until what we call the steady state solution has been implemented. That will be phase 3.

The steady state training—safety risk management training—will be embedded into career courses to deliver the right training at the right point in a career, with each course building on the last. Elements of that phase have started, with an expected completion date of 2022. I hope that reassures you that the regulation letter that the senior coroner issued was taken very seriously, and we have endeavoured to address the principal concerns. General Illingworth might want to say more about that.

Q48 **Mrs Lewell-Buck:** On phase 2, the Secretary of State said in January of this year that it would be completed in February of this year. I know that we have had coronavirus, but it still seems a big jump to say that it will now be completed in October. Can you explain the delay between those dates?

Baroness Goldie: Obviously, the impact of covid-19 has been hugely significant for the MoD, particularly where we are dealing with the need to have people congregating together. Quite simply, it was not possible to progress training to the timetable that was originally proposed, just because of the implicit risks associated with that in the advice to ensure that people remain safe during the pandemic.

Obviously, we regret that, but we are not alone in having had to defer some of those measures and we are hoping to get back. We are now in July, with August and September before us, and we hope that it will be possible, safely, to recommence that training in October 2020.

Q49 **Mrs Lewell-Buck:** Could you explain what benchmarks and timescales are in place for risk assessments to be reviewed and updated?

Baroness Goldie: That will be part of the ongoing regime of delivering the training programme.

Mrs Lewell-Buck: Sorry, Minister, but what are the current benchmarks and timescales for updating and reviewing risk assessments?

Baroness Goldie: That might be something on which Air Marshal Gray would be better able to comment. Sue, is that something within your ambit?

Air Marshal Gray: It is, in terms of the audits that the DSA carries out. We do that with a risk-based approach; we go to the high-risk areas first and would review those when we thought it was needed—if not before, on a yearly basis. Clearly, there are other areas that do not attract our attention that often and, in moving to a risk-based approach, we hope that we do not miss anything and we look to have an annual programme that will pick up high-risk activities from a safety perspective.

Q50 **Mrs Lewell-Buck:** Thank you both for your answers, which are appreciated, but on current timescales, what I am hearing is that there aren't any at the moment. Is that right—there are no existing timescales for looking at and reviewing risk assessments?

Air Marshal Gray: There are; each individual TLB has a specific programme that does risk assessments and each of their safety centres will review those. I cannot tell you the exact timescales, but there is absolutely a timetable for when they should be reviewed.

Q51 **Mrs Lewell-Buck:** Do you know, roughly, how often that happens—is it annually? I am trying to drill down into how often it happens, and I am struggling because nobody seems to know.

Air Marshal Gray: I am sorry that I cannot give you a straight answer, because the only knowledge that I have is of the Defence Safety Authority, and again, we do it on a risk-based approach. We would not say, "We will do it every year," because it might not be necessary next year. What we have is a decision conference every month that says where our highest risks are and we would then go and audit those areas and do the third-party assurance risk assessments.

Major General Illingworth: I think I can reassure you that, as part of the annual audits that take place across all different forms of activity—not least many of the safety issues that we are discussing—checks are done on what risk assessments and qualifications are in place. What I do not want you to have in any way is a feeling that this training is the beginning of the Army conducting risk assessments—far, far from it. We are in a very good place.

I should just say, on our resumption of training post lockdown, that every single department and organisation has been involved in a thorough risk assessment of the process that is entailed. The roll-out that the Secretary

of State has referred to, as did the Baroness earlier, effectively puts that level of understanding to the very highest levels.

If you wanted assurance on how we are involved in and doing risk assessments, the audit mechanism provides that assurance, whether it be at the first, second or third line.

I can give you a vignette, if it helps, with regard to how we do business. I have a very interesting vignette from an exercise that we conducted last month with regard to how the chain of command gets involved in risk assessment and how it conducts risk management. That might help not least to give you a level of assurance that we are in a good place—not a complacent place—with how we do risk assessment across the organisation.

Mrs Lewell-Buck: I am satisfied with that answer, Chair. Thank you all, and my apologies—I need to go.

Q52 **Chair:** Thanks very much indeed. May I turn to Isabel Letwin? I will start with you; others may want to comment on this. It is to do with compensation for heat and cold injuries. I see that in a four-year period over 3,000 service personnel were identified as suffering from either heat or cold injury. Are the lessons being learned?

I am slightly concerned that, according to a freedom of information request, £27 million was paid out in common law compensation and you had to spend £7.5 million on lawyers. That seems a huge amount of money. You could have bought an awful lot of gloves for that amount, to have kept them warm, and some hats as well. I do not mean to be flippant, but £27 million in compensation is a huge sum of money. Ms Letwin, do you want to start?

Isabel Letwin: Yes. Sorry, Chair—I do not have anything particular to say on the amounts involved that you have quoted. I think we would need to do some drilling down into exactly what was involved. We could certainly write to you about that.

Q53 **Chair:** Please. I would be grateful. Are there are any other comments from the panel? Minister?

Baroness Goldie: I think the best way of addressing the issue that you have identified is to, of course, look at how we take further steps to prevent and manage, for example, heat injuries. While on the one hand it is good that people who suffered were compensated—you referred to the evidence of that—I think we would all be a lot happier if an environment were created whereby these claims were dramatically reduced.

If the question behind that is whether lessons have been learned, and whether we have taken further steps in the prevention and management of heat injuries, yes we have. Importantly, we have improved awareness by commanders of the relevant JSP, which is 539, which covers heat illness and cold injury prevention and management. We have done that since 2013, and certainly since the tragic death of Corporal Hoole, but we

are continuing to do more. All commanding officers are briefed on that JSP, and to further raise its profile actions are being taken to reinforce the importance of its content through single service channels.

At the end of the day, what we want to do is try to effect a reduction in the numbers of personnel who are being exposed to this sort of risk. We also have, I think, done something sensible. We are going to disaggregate the relevant JSP so that advice and guidance will be removed and inserted in a new chapter of another JSP, and the more clinically focused medical care required for heat and cold injuries will in turn move to 950 and be taken out of 539. That will give a renewed focus and clarity on prevention and then on actual treatment. There are steps afoot, Chair, to try to ensure that in the field we are addressing this issue effectively.

Chair: Thank you for that. Richard, did you want to pursue this a bit further?

Q54 **Richard Drax:** Yes. Minister, the regulation 28 report said that it was the commanders who were not really aware of what the rules are. As I told you, I served for nine years, and I inspected a lot of soldiers' feet on exercise because that was one of my duties. Obviously, we had to walk from A to B and feet are really quite important. Are you content that the commanders in the field are aware of what their responsibilities are?

Baroness Goldie: Certainly, efforts have been made to improve their awareness, as I indicated. It may reassure you to learn that we have produced a field guide titled "Heat illness and cold injury". That was produced in October of last year, and that provides commanders with a short reference guide to assist in understanding climatic injuries. But importantly, the new heat illness prevention policy is being delivered at pace by the review team, led by Defence Health, Safety and Environmental Protection. It is going to be published later this year following extensive testing and review. So I hope that reassures you, Mr Drax, that there is a framework to try and achieve the better dissemination of information and the heightening of awareness that you refer to.

Q55 **Richard Drax:** That is good for the future. Why were the changes not made immediately after the incident in 2013?

Baroness Goldie: The incident in 2013 principally gave rise to the creation of the Defence Safety Authority, which was an important development. It was the ongoing consideration of how to continue addressing health and safety within MoD that led to the governance changes to which I referred at the start of the evidence session. A lot has happened that has been, I would say, significant and material in terms of change to the structures within MoD.

Richard Drax: Thank you very much, Minister.

Q56 **Stuart Anderson:** If there are systemic failures within the MoD, does it mean that individuals are not getting properly trained to do their job? Why should the MoD be exempt from prosecution in cases of hazardous

training? Or should the MoD be exempt?

Baroness Goldie: In terms of accountability, which is at the heart of your question, it is an area that is complex. That was made clear by the comments of Philip White and Andrew Cayley in the earlier evidence session. If, for example, we look at Crown censures issued by HSE, we believe that these are sufficient to make the MoD accountable when failures in duty of care are identified. As Philip White explained, the Crown censure is akin to a criminal prosecution of a non-Crown body for H&S failings. MoD takes that very seriously. Should a Crown censure be served to the Department, it is a matter of profound regret and gravity as far as we are concerned. It is important to note that the investigative process and the follow-up procedures by health and safety are the same as for non-Crown bodies. Philip White confirmed that it is only the enforcement process that differs. So the MoD takes the view that we are no less accountable than a non-Crown employer. What we are at the heart of trying to do is to diminish and mitigate the circumstances that may lead to the sort of levels of risk which have been resulting in the fatalities and injuries with which the Committee has naturally been concerned. I do not know whether Air Marshal Grey would like to comment briefly, or whether Isabel Letwin would like to come in on that.

Air Marshal Gray: I will if I may, Baroness. It is not just the issuing of Crown censures that are taken seriously, it is also the threat of an issue of a Crown censure. I can speak personally to that effect. Certainly, when the Chief of the Air Staff is approached and told that there is a threat of a Crown censure, I can attest to his displeasure. It absolutely is taken most seriously. We normally find that if a Crown censure is then issued, all of the recommendations have been implemented in full by that stage. Even a threat, never mind the actual issue, is taken seriously. It is taken equally seriously by the other services. It is not something that we take lightly in any shape or form.

Isabel Letwin: I will add a postscript to that. The MoD is not in any special position in relation to health and safety legislation. No Government Department is subject to prosecution. Every Government Department is subject to the Crown censure process, so it is not a special thing for the MoD.

Q57 **Stuart Anderson:** General, as a follow-up question, I know we have touched on and dipped in and out of this subject, but I want to go back to the regulation 28 report, which said that there are serious concerns that lessons have not been learned from the past. I know that things are being put in place to address that. How are we ensuring that every single level of that chain of command, from the infantry soldier—or whatever the regimental corps is—right the way up to the top, are getting updated on every single policy that comes out, and how is that being disseminated?

Major General Illingworth: There is a stepped approach to this. We make sure that people are aware of the guidance and policies, how we actually apply them and how we assure our application of that guidance. I

refer back to the policy that the Minister spoke about, JSP 375, which will be published some time in the next couple of months, adjusted to capture everything relating to heat illness in chapter 41. There is a cascade of those policies that need to be known by the whole chain of command. For the Army, we have what is called the Army Command Standing Order 3222, which is your go-to document that signposts to everything. The Commanding Officers of units are effectively expected to know what is in that document, from front page to back page, and they are briefed on that at the Commanding Officers' Designate Course such that they have that training and understanding.

In terms of broader awareness than that, we teach our commanders about the safe system of work throughout their career, in how they plan and execute exercises and robust training. You, I am sure, will recall that there would have been an envelope behind what your training involved, and sometimes how you were responsible for, I am sure, implementing training. The Trades Training courses—in the infantry, the Armoured Corps, in all our trades—is where you learn about how exercises are conducted, your part in that and what is your role should be with regards to what is safe or not safe.

Throughout an individual's career, there will be development courses that they will go on. A lot of it is education-based, where they will get refresher education and training. The most obvious example of that is what every soldier will go through with their military annual training tests—the MATs, you might recall. MAT 2 and 3 are very specific to climatic injuries. Every soldier has a part to play. When I say soldier, soldiers and officers will be acutely aware of what guidance is laid down in that document. That refers back to ACSO 3222 and into JSP 375.

That hopefully gives you an idea about the awareness of the guidance that is out there. How do we bring people's attention to that? Through multiple media sources—the Army briefing notes, the chain of command, and we have the ability to log on to MODNet where these issues are signposted. We put out advertisements of what is going on and what the new policies are as necessary, but the chain of command has the major responsibility for making sure that people are aware.

I saw the other day a Part 1 Orders from a Commanding Officer in the Yorkshire Regiment who directed what is expected that people should and should not be doing with the higher temperatures. When I say people, I am talking about soldiers who are off duty as well as on duty—there is an understanding this is not just about when people are in the workplace—encouraging, learning lessons and implementing accordingly.

On that last bit about assuring our application, we have talked about it a little bit. There are clearly first, second and third lines of defence assurance. The unit commander has the responsibility at first line, and then we have a whole lot of other mechanisms and audits to make sure that that awareness and understanding is playing out in asking questions of Commanding Officers and of soldiers, in an effort to make sure they truly understand what the policies are and what they should be abiding by.

However, I will say, as Air Marshal Gray has already pointed out, that there is always a risk that orders are not going to be followed, mistakes made or policy misinterpreted. In such a people-based organisation, human factors are always at play, and occasionally people get it wrong, no matter how effective our leadership or control measures are. We are a human, people-based organisation, and human factors will play out.

Chair: Thank you for that Stuart, and thank you, general. I am conscious of the time, because we have a vote heading our way soon. I want to turn to the support to the families. Richard Drax, will you take us forward here?

Q58 **Richard Drax:** Minister, if I may aim this at you initially, when things go wrong with big organisations such as the MoD, the NHS or anyone else for that matter, sometimes they tend to close ranks. Families have told us that they are often frustrated with not receiving full disclosure of the information that they should be getting. What is being done about that? To add to that question, we have also been informed of a number of instances when the MoD was unhelpful or inflexible after a loved one's death. Is there a one-cap-fits-all approach by the MoD, or how should and does the MoD handle these things?

Baroness Goldie: Thank you, Mr Drax. I am concerned to hear the last part of your question, because we take the support of families very seriously. The MoD understands the importance to the family of the whole process, including the inquest process, and of improving their understanding of what has happened to their loved one.

In so far as the component parts of your question are concerned, initially every effort will be made to give the family basic information about what has happened. More detailed information may not at that stage be available. Obviously, where a service inquiry is convened, the next of kin are involved. They are always offered a copy of the final service inquiry report—I accept that parts of that may be redacted—but they are also offered a face-to-face brief by the SI panel, and the visiting officer also attends the briefing panel to answer any questions that the family may have.

Of course, it is the case that certain information, such as witness statements, might not be released to the family, due to the Department's obligations under freedom of information, but the JSP 832 requires that, if possible, statements are redacted in accordance with the general data protection regulations and that they are released to the family. If a service inquiry has concluded before an inquest, all the evidence is disclosed to the coroner to assist with their inquiries. The coroner will then determine which bits of the evidence are relevant and whether it is necessary for them to be disclosed to other interested parties, such as the next of kin.

On the support to the families, they are supported not just by the visiting officer but by the Joint Casualty and Compassionate Care Centre, which co-ordinates across services what the approach should be. I was certainly concerned to hear of the impression that some families have that there

has been a lack of empathy or sympathy, and inflexibility. That is certainly not the impression that we would want to convey.

Q59 **Richard Drax:** Minister, forgive me, but may I be very rude and butt in? In my question, I am thinking of myself as a father. If a member of my family were hurt, I would want to know what happened, where it happened and why it happened, as soon as I could, because that helps the process and keeps the family much calmer. When does the family get all the information that they need? Is that not until after, for example, a coroner's court, or would you see the family to say, "Look, there has been a training accident. He was shot on the range by mistake. It is being investigated"? How much information? The question implies that families are not getting sufficient information—they are having to chase all the time: how did my son or daughter die; how did my son or daughter get injured?

Baroness Goldie: That should not be the situation, because right from the beginning there will be a need to inform the family as to what has happened, according to the information available at that early stage. You are quite right: it is natural that that is what the family want to know.

Clearly, in cases of complexity, there will be an investigation and that, as I said, may lead to a service inquiry. That is where more information may unfold in terms of the examination by the service inquiry panel of what has been happening. That, in turn, may lead to a coroner's inquest.

Throughout all that, however, the visiting officer should be offering support right from the beginning. To go back to the earlier part of your first question, that support should be flexible, according to what the family want. Some families may seek less support. Other families may want more support. The system is intended to address the particular needs of individual families. Where there has been a bereavement they are all offered what is called the Purple Pack bereavement guide. That is a joint venture between the Joint Casualty and Compassionate Centre and the Defence Bereaved Families Group.

In so far as factual information is concerned, there may be a frustration on the part of the family that they cannot get a full disclosure from the service inquiry as to exactly what happened. As I have explained, that may be for reasons that concern issues of security; but they should be able, from the inquest, subject to the direction of the coroner, to get full information. What I would say, Mr Drax, is that it is an area where we want to do the best we can. If there is more we can do—if we can learn a better way to approach this—then we would very much welcome suggestions.

Q60 **Richard Drax:** General, I saw you nodding your head during the Minister's reply. Is there anything you would like to add to clarify on this issue of family dissatisfaction when things go wrong?

Major General Illingworth: Mr Drax, I would only add and reinforce what the Minister said about the important role of the Visiting Officer, and their linkages with the service inquiry personnel or those involved in the

follow-up action. The Visiting Officer is absolutely crucial and we spend an awful lot of time making sure that these people are suitably trained, empathetic, and have the right appreciation of the linkages both with the families but also with those doing any investigation.

Chair: Thank you very much indeed. I very much appreciate all your time today. I think it is clear that Isabel Letwin got off lightly this afternoon. We may have to have you back and grill you a bit further.

Isabel Letwin: I look forward to that.

Chair: I very much appreciate all the contributions today in helping us with our understanding and investigation of military exercises and the duty of care. I thank Baroness Annabel Goldie, Isabel Letwin and General James Illingworth and Air Marshal Susan Gray for your time this afternoon, and the Committee members as well.