Written evidence submitted by the Ministry of Defence

MOD Duty of Care Evidence Session Follow Ups

1. At what level in the chain of command can an exercise be called off due to safety concerns?

Training would normally be 'called off' by the chain of command and normally the Commanding Officer, however:

- Any commander can stop training/activity, and anyone can alert the training organiser to dangerous practice;
- Duty of Care is central to the Services' approach to risk management across activities;
- All commanders place the interest of their people at the forefront of decision making;
- When there is risk to people during training and other activity, commanders are obliged to cease that activity;
- During live firing, any firer or safety staff must shout 'stop' if they see anything dangerous.

There are also specific additional steps taken by each of the Services based upon the individual circumstances of their training programmes:

Royal Navy

Prevention of climatic illness and injury is robustly managed and covered by local Training Management Orders. In addition, there are regular central announcements (pipes) made when climatic conditions are applicable.

Commando Training Centre Royal Marines (CTCRM):

For smaller events like minor field exercises, weapons stances on the ranges etc then the event can (and would) be called off by any rank from troop Instructor (Corporal RM) and above. For major serials with more potential for heat illness such as speed marches and the 30 miler then the OIC of the event, Captain RM for the speed march or Major RM for the 30 miler, would make the final call, but would take advice from those 'in the thick of it' so to speak such as section Corporals.

All the procedures are laid down in Training Standing Orders (with an annex dedicated to heat/cold illness). Main Events List (MELs) are also held for each event and these MELs include the risk assessments which would have significant guidance on heat (and cold) injuries. All of the above are continually dynamically risk assessed at the lowest level as conditions change mid exercise.

CTCRM have significant medical cover for the 30 miler so any decisions made would have medical advice to take on board as well as advice from training staff. For the speed marches a weekly meeting coordinates the medical centre and the training teams for all marches. The med centre is on the same radio net as those on the ground and will advise in 'real time' when required.

HMS Raleigh:

All Raleigh Exercise Instructors are fully briefed and empowered to stop training or take required actions directly. Again, local Training Orders will cover these procedures.

The Royal Air Force

An indication of the culture within the RAF is that, if anything untoward is identified and brought to the attention of the Officer in Charge by anyone, it can result in the exercise/training being halted/stopped at any time.

For specific physical training activities, the RAF has detailed policy, practise and procedures:

- As per the RAF Manual on Physical Education (AP3342), the RAF trainer (or RAFT-R) or Supervisor must be a qualified and experienced Physical Training Instructor and holds overall responsibility for the safe conduct of the test. The Supervisor should identify senior officer present and confirm responsibilities. A RAFT-R is a Corporal or higher rank. In the event of any issue or incident the RAFT/RAFT-R Supervisor must then decide whether it is safe or not to continue. The RAFT/RAFT-R Supervisor, in conjunction with the Senior Officer present, can cancel the Patrol Action (Loaded March).

- For ranges and Force Protection training and exercises in accordance with JSP 375, the lowest level would be the Safety Supervisor (Lance Corporal) or ECO/RCO (Corporal up to Wing Commander) who would pause/stop the activity and the Senior Planning Officers and Exercise Director who would formally STOP the activity.

Army

Training is usually called off by the Commanding Officer; however, any commander can stop training or other activity. Any individual can alert the training organiser of dangerous practice. Duty of care is central to the Army's approach to risk management across activities. Commanders place the interest of their people at the forefront of decision making. When there is risk to individuals during training and other activity, commanders are obliged to cease the activity. For example, during live firing, safety staff or anyone (regardless of their rank or appointment) must shout 'stop' if they see anything dangerous. This is mandated in instructions and briefings.

2. How effective have the Defence Safety Authority and the Duty Holder Concept been in improving safety? How is safety measured?

During the 2016 hearings the then-DG DSA, Air Marshal Sir Richard Garwood, committed to conducting an independent external audit of the DSA from its formation in 2015. That audit took place in 2018 and was conducted by a team from the Health and Safety Executive and the Office for Nuclear Regulation led by retired Rear Admiral Chris Parry. The team's report concluded that 'since its formation in 2015, the DSA has substantially transformed attitudes and galvanised action within Defence with regard to risk and safety.'

The DSA's greatest success has been in transforming attitudes and the Duty Holder concept has been a critical part of that. By making it absolutely clear to those named individuals responsible for managing activity safely that they will be held to account we have concentrated minds and driven the establishment of rigorous and active management of safety. Similarly, all those supporting organisations who face the Duty Holders have no doubt about what they are responsible for and the role and primacy of the Duty Holder in making decisions. Finally, the clear and simple three levels of the Duty Holder chain avoids overcomplication, enables clear communication and aids effective escalation and management of risks.

Another crucial indicator of the transformation of attitudes leading to positive action is the changes to governance of safety at the highest levels in the Department. The previous DG DSA, General Richard Felton, focused heavily on safety governance during his time in the role and his efforts played a large part in the reviews and decisions that led to the formation of the Defence Safety and Environment Committee (DSEC) and the appointment of Director Health Safety & Environmental Protection (HS&EP). As noted in answer to other questions, during the follow-up session, the leadership, by example from the members of the DSEC, is now bearing fruit in terms of Safety Culture and attitudes to safety at every level in Defence.

As we indicated in our written evidence, measuring safety is a challenge, particularly at MOD-centre level. The DSA has been working with senior risk owners in Defence on the issue of safety measurement to develop Measures of Effectiveness (MoE) which accurately reflect, in more quantitative terms, the safety performance of organisations and improvised safety outcomes. The HS&EP Directorate also assisted in that work.

This work is now being taken forward by the DSEC. A progress report in March 2020 indicated that there are still gaps in our ability to collate timely and accurate Management Information. There is no single reporting system, and this has created inconsistences in reporting practices and definitions. There is also a significant time lag for incidents appearing on systems. In the meantime, ten draft MoE formulated in 2018 plus reporting requirements set out in JSP 375 (Management of Health and Safety in Defence) form the basis of the performance measures currently mandated by Defence organisations in their Safety and Environmental Management Systems (SEMS).

3. Are there any plans to change aspects of the Duty Holder Concept for any of the Services?

Army

After a detailed review and series of recommendations by the Army Inspector, the Army will introduce a refined approach from January 2021 that ensures duty of care at the centre of all activity and the use of the Duty Holding concept when appropriate to do so based on anticipate levels of risk.

Royal Air Force

The RAF's Air Top Level Budget (TLB) already has a well-established Aviation Duty Holder construct which was expanded in 2019 to include a number of specified Functional activities. The AIR TLB Safety and Environmental Management System now requires that elements of Total Safety are managed through a legally accountable DH chain where DHs:

- have a personal duty of care for the personnel under their command;
- are legally accountable for the safe operation of systems in their Area of Responsibility and for ensuring that risk-to-life is reduced to at least ALARP (as low as reasonably possible) and Tolerable;
- and, are accountable and answerable to the SofS through the DH chain.

The DH Construct is only to be applied to military activities under the following conditions:

- The activity presents a justified, credible and reasonably foreseeable risk to life;
- The Duty of Care and other statutory arrangements are insufficient for managing the risk;
- Where the Department has mandated its application through regulation.

Whilst the DH construct is now well-established in the Air TLB, current and emerging activities are continually reviewed, and the DH construct may subsequently be further refined

depending on applicability as stated above. Any such refinements would be clearly articulated to all stakeholders so there is no doubt as to where Duty Holding is applied.

4. Do you have any plans to do an independent assessment of the Defence Safety Authority and/or the Duty Holder Concept?

As previously explained in our evidence, the DSA has already been subject to an independent external audit in 2018 and this commented favourably on the DSA role and achievements. Another independent audit will be planned for 2023 to provide further assurance of the continuing effectiveness of the DSA.

5. Training deaths can be complex and often involve a number of legal and criminal processes. Who ensures that families are aware of their legal rights and have access to relevant legal support?

The families of Service personnel will have the same access and rights to legal support as other members of the public, but have the benefit of some specific military support that can signpost them to sources of assistance. For instance, it is the Coroner and the Coroner's team who lead on providing advice to a service family at inquest whilst the MOD personnel play a supporting role in the progress to inquest. The Defence Inquests Unit (DIU) will also look to assist the Visiting Officer in providing supplementary advice to the family on inquest related matters. Additionally, DIU will offer bespoke briefings to families, if requested, via the Visiting Officer to clarify our approach at inquest or specific inquest process if not covered by the Coroner's team in advance of the inquest.

It is worth noting that an inquest is not supposed to be adversarial; legal representation is not a must. Coroners seek to support the family and address all relevant questions that the family may have. The MOD does not routinely engage legal representation at inquest and will only seek legal representation if the case is particularly complicated or if the family/families have appointed their own legal team. Finally, there is no funding mechanism in the MOD to provide legal support to families at an inquest; applications for Legal Aid must be submitted to the Ministry of Justice's Legal Aid Agency.

6. Is there a 'them' and 'us' mentality when preparing for an inquest?

In short, no. There is not and should not be a 'them' and 'us' approach from the MOD when preparing for and conducting an inquest. The MOD, alongside other government departments, is committed to helping to make this process more sensitive to the needs of the bereaved. It is recognised that that the bereaved families should:

(1) Be at the heart of the inquest process;
(2) Feel confident that the inquest will get to the truth of what happened;
(3) Feel properly involved throughout and listened to.

The DIU's key role is to assist Coroners so that they complete relevant inquests fully, thoroughly, as quickly as possible, and to support the families through the inquests of Service and MOD civilian personnel. The DIU's role reflects the MOD's firm commitment to effectively support Coroners, bereaved families and Service personnel, through to the learning of lessons in order to prevent similar future incidents. We also make clear to attending military witnesses that their testimony is important to both the families and the Coroner; and that, collectively, we have a duty to assist the inquest process. The DIU Case Officer will always seek to engage with the family during the inquest, where the family are content, in order to make clear that all participants in the inquest process are there to assist them understand the circumstances of the loss of their loved one(s).

7. Are the distinctions made between Regular and Reserve training pathways appropriate?

The Defence Systems Approach to Training (DSAT) is part of the Whole Force Approach to the analysis, design, delivery and assurance of training. Where distinctions arise, they are in relation to role or readiness requirements or the most appropriate training delivery option. Any resulting training deficit is formally documented as a training gap that must be closed / completed as part of Pre-Deployment Training (if deploying on combat operations in that role) or are required to be at a particular readiness state.

Although selection standards are necessarily the same for Regulars and Reserves, the single Services recognise the differing levels of time and supervision available for training etc and have therefore put in place bespoke pathways for Reservists to address this and bring them safely to the same standard.

As each Service has specific training requirements, there will also be slight variations in the implementation of training pathways for Regulars and Reserves:

Royal Navy
In Basic Training there is close integration and co-operation between Regulars and Reserves. For Phase 2 (Trade) and Phase 3 (Specialisation) training, the depth of integration is based on scale of output, manning levels, and perceived risk. CTCRM maintains close liaison with Reserve units to ensure trainees meet the prerequisite qualifications and fitness requirements. Training for Reservists takes place separately to regular recruits. It takes a reservist a minimum of two years to complete the RM Commando training course.

Army
There is one selection standard for both Regular and Reserves based on a range of measurable criteria. Reserves follow a bespoke pathway through Basic Training and most of the Initial Trade Training qualifications to enable candidates to undertake training at an appropriate pace for their ability and with appropriate mentorship.

The Army Physical Training (PT) development policy accommodates the differences between the amount of supervised training time available for Regular and Reserve personnel. The Soldier Conditioning Review provides greater structure and tailored guidance to support a Reserve's unsupervised training pathway. The Lone Soldier programme of PT accounts for Reserves who may not be able to attend centralised PT sessions as their Regular colleagues do.

Royal Air Force
Career development pathways recognise the differing time available for Regulars and Reserves, the latter typically only available to train in the evenings and weekends. All Basic Training follow on Trade Training and Pre-Deployment Training for Regulars and Reserves is designed to meet the required performance standards.

8. What is happening with the specialist cadre of coroners?

The Chief Coroner's specialist cadre of coroners dealing with Service deaths continues to formally exist, in line with the Chief Coroner for England and Wales' Guidance No. 7. It

should be noted that the Chief Coroner has not provided any further training to this cadre since 2013 and a number of the original 11 members of the cadre have since moved on. The DIU continues to support and enable any bespoke military advice and guidance to coroners. DIU also remains prepared to assist if the Chief Coroner intends offering further training to the specialist cadre, as was provided by DIU in 2013 and planned for Autumn 2020 (cancelled due to Covid). The last time that bespoke MOD advice was provided to one of the specialist cadre of coroners occurred in 2017 and 2018, when the Senior Coroner for Birmingham was briefed by Army personnel on the workings of the Challenger 2 (CR2) tank main armament. This related to the inquest investigating a fatal training incident in 2017 where two Royal Tank Regiment Junior Non-Commissioned Officers died as a result of an explosion within their CR2 tank.

9. How do you ensure that the Services do not use administrative action for incidences that should be referred to (a) the Service Police and the Service Prosecuting Authority or their civilian equivalents and (b) the Health and Safety Executive?

Royal Navy

Through NLIMS (Navy Lessons and Information Management System) process, which includes reporting all incidents and near misses are sent to the safety centre in Portsmouth who would in turn forward any relevant incidents to the Health and Safety Executive via RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrence Regulations).

HMS Raleigh: Any incident during training is reported in the first instance to the Military Training Unit management to ensure required actions are taken. Any occurrence is reported to RAL service police/ Health and safety team as required in addition to the completion of the Navy Safety Occurrence Report (NSOR).

CTCRM: CTCRM NLIMS (Navy Lessons and Information Management System) has recently been held up as an example of good practice by the Navy Safety Centre. For an incident to be referred to the Service Police, it would have to involve an individual (an instructor for example) knowingly and willingly ignoring the MEL or risk assessment.

A quote from the opening paragraph of our Heat Illness annex to our Training Standing Orders is as follows: “Commanders and training staff have a duty to assess the risks of heat illness arising from military training and supporting activities to ensure that these risks are minimised as far as is reasonably practicable. Failure to manage this risk may expose individuals and the Ministry of Defence to prosecution under the Health and Safety at Work Act and criminal law.” Any fatalities would automatically be reported to the Service and civilian Police.

Royal Air Force

RAF Disciplinary Policy directs the unit Personnel staff who are responsible for Discipline (P1) to always consider in the first instance whether any incident which is brought to their attention involves a Disciplinary or criminal offence, prior to turning to any thought of Administrative Action. Leaflet 801 - MAAP Policy (Mar 20) para 12. JSP 830 (Manual of Service Law) Vol 1, Ch 6 provides clear guidance/direction to Commanding Officers and their staff regarding the correct referral of casework and provides a list of circumstances in which cases must be referred to the Police. Thus, the initial thinking of unit P1 staff is whether or not the matter is to be referred to Civilian (Civ Pol) or Service Police (RAFP) prior to any other course of action.

When a Disciplinary or criminal offence is clearly involved, the matter is immediately referred to the RAFP, who will either handle the matter themselves, or refer it to Civ Pol where appropriate. When there is any doubt about whether or not the matter involves a Disciplinary or criminal offence, SME guidance is sought from Air Personnel Casework (APC) and/or the Regional Legal Office (RLO). Incidents are only dealt with Administratively once Disciplinary or criminal offences are ruled out.

In most circumstances, it is the RAFP who inform P1 that they are investigating a potential Disciplinary or criminal offence which has come to their attention. If there is no prospect of a successful case for the RAFP or Civ Pol to pursue towards Disciplinary or criminal charges, the RAFP may refer the matter to the unit to consider any appropriate Administrative Action which could be taken.

If an Administrative Action process is being conducted, and a potential Disciplinary or criminal offence becomes evident to P1, APC, or the RLO as that process unfolds, then APC will immediately direct P1 to refer that element to the RAFP for consideration. That may involve the Administrative Action process being suspended until the RAFP have dealt with the referral, to ensure that the two separate processes do not conflict. The RAF is confident that its policies and processes provide multiple overlapping layers of assurance, which ensure that Disciplinary or criminal offences are dealt with by the appropriate authority.

Administrative Action is only taken in regard to Health and Safety (H&S) related circumstances when H&S SMEs have conducted their own separate investigations or processes, and subsequently made a referral to APC to consider any appropriate Administrative Action in the circumstances. Any work-related fatality is reported directly to the Health and Safety Executive (HSE) through their Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reporting process. In addition, Air Command voluntarily report all non-fatal accidents and incidents where the RIDDOR reporting criteria applies, even though Defence has an exemption from such reporting for Service Personnel. This ensures that the HSE are made aware at the earliest opportunity of any fatality, accident or incident that results in RIDDOR reportable injuries, and they have the power and ability to trigger an investigation should they wish.

Army

The Armed Forces Act 2006 mandates that any offence under Civil law of England and Wales becomes an offence under Service law. The Act sets out which offences a Commanding Officer must report to the Service Police, these are known as Schedule 2 or ‘non-Commanding Officer’ offences.

Disciplinary action should be used where the offence is wholly deserving of the consequences of the application of Service law. Administrative Action is intended to set straight shortcomings which breach the Service test, which asks the question: “Have the actions or behaviour of an individual adversely impacted or are they likely to impact on the efficiency or Operational Effectiveness of the Service?”

Administrative Action should only be used for matters that would amount to criminal conduct or to a disciplinary offence that has ‘criminal’ elements, if this course is supported by a Grade 1 individual. Advice will be provided on the requirement for legal advice. Such support will only be given in cases where the interests of justice do not require the Chain of Command to take disciplinary action. This may include offences dealt with by a civilian court which have affected Operational Effectiveness or where facts were revealed during a disciplinary investigation or trial, which were not dealt with in the disciplinary process. This is set out in Army General and Administrative Instructions 67 Administrative Action.

Whilst units can deal with any situation at local levels within the Safety, Health, Environmental Protection or Fire space, there is nothing to stop any issue from being referred up the Chain of Command or to the Service Police and the Service Prosecuting Authority or their civilian equivalents and the Health and Safety Executive. There are resources and guidance available to help units at a local level. For example, there is a Safety Matrix (c.146 personnel) in place to assist all units at various levels, which provides advice and guidance on assurance and conducting investigations. In addition, there are also c.90 Environmental Health Technicians.

10. Crown censures have been described to the Committee as simply "an administrative exercise" carried out "behind closed doors" with no public scrutiny or accountability. Are crown censures enough to make MoD accountable?

Like other Crown bodies, the MOD has Crown Immunity from prosecution by the Health and Safety Executive for breaches of health and safety legislation. The penalties under the Health and Safety at Work etc Act 1974 seek to drive up standards to eliminate or reduce the risks that led to an accident and to prevent a recurrence. The Crown Censure process achieves equivalent outcomes in the MOD. The investigative process and follow-up procedures are the same as those for non-Crown bodies. The Censure process and the hearing itself allows the MOD to demonstrate how it has responded and implemented measures to prevent a recurrence. It is only the enforcement process that differs due to the doctrine of Crown immunity. The Health and Safety Executive's follow-up process includes monitoring whether identified failings have been properly addressed. Details of all Crown censures are made publicly available on the Health and Safety Executive's website. The MOD is therefore no less accountable than a non-Crown employer. The MOD takes receipt of a Crown Censure extremely seriously. Should one be served on the Department, it is a matter of considerable regret.

11. As well as more information on the FOI (see below), could you provide the Committee with a breakdown of annual figures for heat and cold compensation from 2010- present day, including the number of cases, the amount paid out in compensation and the amount paid to lawyers.

The figures quoted were taken from FOI2019/10742 and the 'over 3,000' figure for service personnel identified as suffering from either heat or cold injury in a 4-year period was provided by Defence Statistics Health.

The £27 million figure was based on the total amount of compensation that has been paid in relation to those NFCI common law claims fully settled between 1 April 2015 - 31 March 2018. The data was based on live data as at October 2019. It should be noted that this was for a 3-year period so a different time period than above. If we consider the same 4-year period that Defence Statistics Health were reporting on, i.e. 1 April 2015 – 31 March 2019 and using live data as at 13 August 2020, 506 NFCI common law claims cases were fully settled with £46.1 million paid out in compensation on these claims. The definition of a fully settled case is one where both damages and legal costs have been paid.

The £46.1 million figure does not cover any compensation paid out to current and former service personnel under the no-fault Armed Forces Compensation scheme (AFCS). Where there has been an AFCS award, any common law compensation award is abated to prevent double recovery.

The £7.1 million figure relates to MOD legal costs only and not the claimant's legal costs. This figure was for a 3-year period so a different time period than above. It should be noted that, as a result of a data cleansing exercise, a reporting error was identified by our claims handling contractors and this figure has been revised to £6.4 million. When considering the four-year time period between 1 April 2015 – 31 March 2019, £9.8 million was paid on MOD legal costs and £22.5 million paid on claimants' legal costs.

Compensation paid out for common law heat injury claims is NOT included in the £27 million figure which is purely based on NFCI claims. Previously, our current contractors did not classify claims in terms of heat illness/injury; however, they have since reviewed and categorised all claims so that we can now report on heat injuries. The number of heat injuries is extremely small in comparison with NFCI cases.

Average damages have increased from the period FY1516 to FY1819. This is in part due to the change in the personal injury discount rate used to calculate damages in March 2017. The rate reduced from plus 2.5% to minus 0.75% making a significant difference to the value of claims. It increased again in July 2019 but only to minus 0.25%.

Figure 1: Total NFCI Claims and costs (millions) by Financial Year

NFCI Claims	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	Total: 10/11-18/19
No claims brought	79	105	116	147	153	197	104	121	160	1182
No claims fully settled	46	77	54	60	46	61	150	166	129	789
Compensation	£2.9	£4.3	£1.8	£3.1	£3.1	£3.8	£9.7	£13.6	£19.0	£61.3
Claimant's legal costs	£1.3	£3.0	£1.7	£2.1	£2.0	£2.8	£6.4	£6.5	£6.8	£32.6
MOD's own legal costs	£0.2	£0.8	£0.4	£0.6	£0.7	£1.0	£2.3	£3.1	£3.3	£12.4

Figure 2: Total Heat Injury Claims and compensation by Financial Year

Heat injury Claims By FY claim fully settled	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	Total 10/11-18/19
Claims brought	4	3	1	1	1	6	3	1	3	23
In-house claims fully settled	-	2	-	-	1	1	2	7	1	14
Compensation	-	£4,750.00	-	-	£53,500.00	£250,000.00	£120,000.00	£1,877,945.00	£48,000.00	£2,354,195.00
Claimant's legal costs	-	£9,566.00	-	-	£28,500.00	£265,000.00	£348,600.00	£409,901.73	£200,000.00	£1,261,567.73
MOD's own legal costs*	-	-	-	-	£7,136.28	-	-	£997,773.08	-	£1,004,909.36

Note: Some individual heat injury/illness cases have resulted in multiple claims brought during the period.

This table includes clinical negligence claims connected with heat injuries that were not previously included in the FOI as well as some further claims identified by our claims handling contractors following a review of their cases.

*A small element of MOD's own legal costs is not included in the above table for some of the in-house claims these figures need to be treated as a minimum. The claims Database search field will not necessarily pick up all heat related claims although we are confident the numbers are very small. The figures should be treated as a minimum.

24 September 2020