Written evidence submitted by Flt Lt James Jones RAF (Rtd)

Introduction

This submission is made in respect to the evidence given to the committee on 29th November 2016 which was a follow up to several matters from the Government's response to the report "Beyond endurance? Military exercises and the duty of care"

I will start by saying that whilst I do not have the rank and position of some of the distinguished people who have appeared before the committee I do feel that my knowledge and experience in the matters under discussion could be worthy of consideration.

I was deeply involved in the Nimrod inquest and support for the families who lost loved ones. I offered evidence to Hadden-Cave, and my input is recognised in the acknowledgement at the end of his report. In more recent times I have been involved in inquiries surrounding the Tornado accident over the Moray Firth, and in particular the failure to hold a Fatal Accident Inquiry. My revelation to the Scottish Justice Committee that service personnel were excluded from the mandatory process came as a shock to all committee members and the minister involved. This anomaly is in process of being rectified, following approval by the House of Lords and House of Commons to a section 104 Order raised by the Scottish Government.

During the course of this written submission I will focus on three main topics; the duty holder concept, risk assessment and corporate accountability.

Duty Holder Concept

Much emphasis has been placed, by both the Minister and Air Marshal Garwood, on the outstanding merits of the Duty Holder concept as a means of ensuring meaningful accountability. It is presented as a new approach, just one year old. However, Air Marshal Garwood is well aware it is not new, it is has been tried and tested within the MAA since 2010. It is well documented in MAA Regulatory Article 1210. Annex F of RA1210 makes it clear that the Duty Holder is legally accountable for safe operations and will be required to make an argument that risks have been made ALARP; however, the validity of this argument can only be decided definitively by the courts, should an accident occur.

Since the introduction of the Duty Holder concept, within the MAA, there has been the Tornado collision in 2012, Lynx - controlled flight into terrain in 2014, and Puma – wire strike in 2015. The total loss of life amounts to 12 in four years. In all cases the need for essential equipment had been identified in order to minimise the risk but not installed, and yet 2 star Duty Holders, knowingly, signed off to say that the associated risks were tolerable and ALARP.

As yet no Duty Holder has been held accountable; no Duty Holder has been called into a court to validate his ALARP case. In March 2015 I arranged for Angus Robertson to put forward the following written question, *'To ask the Secretary of State for Defence, with reference to paragraph 3 of Annex F of MAA RA 1210, how and when he expects the validity of Tornado GR4 ALARP statement to be decided by the appropriate court.*' The reply from Mr. Philip Dunne was *'There are no current or pending court proceedings in which the validity of the Tornado GR4 As Low As Reasonably Practicable statement would be decided.'*

Risk Assessment

For a risk to be considered as ‘safe’ it must be Tolerable and ALARP. (Tolerability is a function of hazard severity and frequency of occurrence). A prominent person involved in the Tornado Service Inquiry has stated,

> *‘In the end I feel the TOLERABLE and ALARP standard set out by the MAA is so subjective that Duty Holders choose to state whether it is or isn't depending on how they feel the risk is mitigated. I suppose this is the whole point, but it does mean they should be able to robustly defend their mitigation and decisions. That is yet to be done publicly’.*

In fact one Duty Holder signed off to say the risk was ‘ALARP (temporal)’, when there is no such thing. There is a misconception amongst some Duty Holders that if there is a plan to fit essential equipment at some time in the future, and in the quoted case it was three years, then the risk can be considered to be ALARP. This is a variance with the opinion of the HSE and Lord Cullen, both of whom I have approached

One of the main criticisms of the risk assessment process in the MoD is that it is reactive rather than proactive, another is that tolerability criteria is based on a figure adopted by the HSE, and should only be applied to substantial categories of workers for any part of a working life; the figure is 1/1000. This figure is being applied by Duty Holders for small categories of workers, such as Lynx, Tornado and Typhoon aircrew. To make matters worse the HSE figure applies to risk of death, not Risk to Life (fatalities and injuries). In November 2014, when I asked about the tolerability levels for Tornado and Typhoon aircraft, I was informed by the MoD that *‘The overall tolerability level has been calculated at 0.84 per 1000 of the "population at risk" (as defined in MAA Regulatory Article 1210) per annum for Tornado and 0 per 1000 of the "population at risk" per annum for Typhoon, which are both within 'Tolerable' risk boundaries’* In the case of the Typhoon it meant no accidents, therefore no risk; a rather strange concept of risk assessment. In the case of the Tornado the overall risk was still considered tolerable, even though three crew members had died less than two years earlier in a collision over the Moray Firth. At the time of the statement both aircraft types were without a collision warning system, but considered to be ALARP.

At the meeting on 29th November, Mrs Moon referred to an incident on the Brecon Beacons when a soldier almost died; she called this a ‘near miss’. Nevertheless, near misses are in fact risks to live, but in my examination of safety statements issued by Duty Holders they are ignored in the risk assessment. Between 1983 and 2013 there were 104 Class A near misses involving Tornado aircraft, these get little or no consideration in the Duty Holders evaluation. (A Class A near miss is when passing aircrew can almost read the time on each other’s watch). Even the Tornado collision itself was considered by Air Marshal Garwood was a near miss that went wrong. Had it been a near miss, like the soldier on the Brecon Beacons, it is unlikely that it would have had any impact on the risk assessment outcome.

Corporate Accountably

The personal accountability of Duty Holders cannot be taken as a substitute for the corporate accountability of a large organisation such as the MoD. Individual Duty Holders have a personal responsibility of duty of care for personnel under their command by virtue of their temporary involvement. MoD has a duty of care on a permanent basis.

Duty Holders cannot be held accountable for failings related to the inadequate equipment, training, or failings in the overarching management system within the MoD to deliver much needed equipment, such as Collision Warning systems. I draw the committee’s attention to an

extract from the judgement in the Snatch Landrover case delivered by Lord Justice Moses, Lord Justice Rimer, and Lord Neuberger (Master of Roles).

> *'It seems to me [Justice Moses] that both the equipment and training claims arguably fall outwith the scope of combat immunity. The MOD seeks to prove too much. If, without hearing any evidence, these claims fall within the scope of combat immunity it must be because the decisions as to the equipment to be provided and the training to be given relate to active operations to be conducted sometime in the future. If that is the extent of the reach of the immunity, it is difficult to see how anything done by the Ministry of Defence falls beyond it'.*

In her book, 'The Crash of Nimrod XV 230 – A Victim's Perspective', Trish Knight (mother of Ben Knight), quotes from the Hadden- Cave report; *'My report concludes that the accident to XV230 was avoidable, and that XV 230 was lost because of a systemic failure of the Military Covenant brought about by significant failure on the part of MoD, BAE Systems, and QinetiQ'* Trish Knight, like other family members that I have come into contact with want accountability of the organisations involved in the death of their loved ones. It is not about the fine, it is about the act of criminal prosecution for the failure of a duty of care. It's about public naming and shaming, not so much an individual, but the whole dysfunctional structure of an organisation. Service Inquiries, by their very terms of reference, cannot accomplish that; they remain in-house inquiries where MoD marks its own homework. Service inquiries are far from independent; they are carried out and signed off by serving career officers.

In a letter from Air Marshal 'Timo' Anderson, Air Marshal Garwood's predecessor, dated 8th February 2011, to PS/2nd PUS, in which he disagrees with the a tolerable and ALARP statement made by the Duty Holder, he states, *'I feel safe to assume that, were a catastrophic collision to occur, those involved in the delay or deleting the programme would inevitably face detailed scrutiny'.* Eighteen months later such a catastrophic collision occurred. It was a breach of MoD's duty of care, and corporate homicide. No one has been held accountable.

Conclusions

I realised that in the Chair's opening address he said that the committee should not get involved in individual cases, but I am afraid that the devil is in the detail. Only by examining individual cases can flaws in MoD's case for continued exemption be exposed.

The new and 'powerful' Duty Holder concept and associated risk management system is tried and tested, and I submit that it is not fit for purpose. It is powerful in word only, not application. The concern for the committee must be that a failed system, within the MAA, is being rolled out across the newly formed DSA. It cannot be seen a justification for retaining the current exemption.

15 December 2016