Service Inquiry Into The Death Of A SP Discovered In His Single Living Accommodation In Catterick Garrison On 23 Jan 20

18 March 2021

PART 1.1

Covering Note and Glossary

PART 1.1 – COVERING NOTE

APSG/SI/Catterick

18 Mar 21

SERVICE INQUIRY INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A SOLDIER AT BOURLON BARRACKS ON 23 JAN 20

1. The Service Inquiry Panel formally convened at Imphal Barracks, York on 02 Mar 20 by order of Major General C R J WEIR DSO MBE for the purpose of investigating the circumstances surrounding the death of a SP who was discovered in his Single Living Accommodation (SLA) at Bourlon Barracks on 23 Jan 20.

2. The following inquiry papers are enclosed:

Part 1.1 – Covering Note and Glossary.

Part 1.2 – Convening Orders and TORs.

Part 1.3 – Narrative of Events.

Part 1.4 – Analysis and Findings.

Part 1.5 – Recommendations.

Part 1.6 – Convening Authority Comments.

PRESIDENT

[Signature]

Lt Col [redacted] RA
Permanent President Service Inquiry (PPSI)
Army Personnel Services Group (APSG)

MEMBERS

[Signature]

Major [redacted] RE

[Signature]

WO2 [redacted]

PART 1.1 – GLOSSARY

Serial (a)	Acronym / Abbreviation (b)	Definition (c)
1.	ACSO	Army Command Standing Order
2.	AD	After Duties
3.	Adjt	Adjutant
4.	AE	Authorised Elsewhere
5.	AGAI	Army General and Administrative Instruction
6.	APSG	Army Personnel Services Group
7.	AWS	Army Welfare Service
8.	BAS	Bereavement and Aftercare Support
9.	BCCS	Basic Close Combat Skills
10.	Bde	Brigade
11.	BDO	Battalion Duty Officer
12.	BFS	Battlefield Study
13.	BHD	Bullying Harassment & Discrimination
14.	BOC	Brigade Operations Centre
15.	Br	Branch
16.	CAP	Care Assessment Plan
17.	Capt	Captain
18.	CCTV	Closed-Circuit Television
19.	CIS	Communications and Information System
20.	CJPU	Cyprus Joint Police Unit
21.	CNO	Casualty Notification Officer
22.	CO	Commanding Officer
23.	CoC	Chain of Command
24.	Cpl	Corporal
25.	COPPERS	Computerised System used by the Provost Marshal
26.	COS	Chief of Staff
27.	COVID	Coronavirus Disease
28.	Coy	Company
29.	CQMS	Company Quartermaster Sergeant
30.	CS	Communication System
31.	CSE	Communication System Engineer
32.	CSE (B)	Communication System Engineer (Basic)
33.	CSM	Company Sergeant Major
34.	DCMH	Department of Community Mental Health
35.	DCOS	Deputy Chief of Staff
36.	DCSU	Defence Cultural specialist Unit
37.	Dept	Department
38.	Det	Detachment
39.	DFO	Duty Field officer
40.	D&I (A)	Diversity & Inclusion (Army)
41.	Div	Division
42.	DMICP	Defence Medical Information Capability Programme
43.	DPHC	Defence Primary Healthcare
44.	EC	Emergency Contact
45.	EDIA	Equality Diversity and Inclusion Advisor
46.	Ex	Exercise
47.	Fd	Field

48.	FGenO	Force Generation Order
49.	FMT	Form Motor Transport
50.	FP	First Parade
51.	FRAGO	Fragmentary Order
52.	G1	General Staff Division 1 – Personnel & Administration
53.	G2	General Staff Division 2 – Intelligence & Security
54.	G3	General Staff Division 3 – Operations
55.	G4	General Staff Division 4 – Combat Service Support
56.	G5	General Staff Division 5 – Future Plans
57.	G6	General Staff Division 6 – Communications & Information Systems (CIS)
58.	G7	General Staff Division 7 – Doctrine & Training
59.	G8	General Staff Division 8 – Finance
60.	G9	General Staff Division 9 – Policy, Legal & Presentation
61.	GOC	General Officer Commanding
62.	GS	General Service
63.	HARDFACTS	Health, Accommodation, Relocation, Drugs, Finance, Attitude, Children, Training & Employment, Supporting Agencies
64.	HOTO	Handover-Takeover
65.	HQ	Headquarters
66.	HQ Fd Army	Headquarters Field Army
67.	hrs	Hours
68.	INCREP	Incident Report
69.	IS	Information Systems
70.	ISR	Intelligence Surveillance and Reconnaissance
71.	J1	Joint 1 – Personnel & Administration
72.	J2	Joint 2 – Intelligence and security
73.	J3	Joint 3 – Operations
74.	J4	Joint 4 – Combat Service Support
75.	J5	Joint 5 – Future Plans
76.	J6	Joint 6 – Communications & Information System
77.	J7	Joint 7 – Doctrine & Training
78.	JCCC	Joint Casualty and Compassionate Centre
79.	JFC	Joint Forces Command
80.	JIAG	Joint Information Activities Group
81.	JNCO	Junior Non-Commissioned Officer
82.	JPA	Joint Personnel Administration
83.	JSP	Joint Service Publication
84.	LCpl	Lance Corporal
85.	LFSO	Land Forces Standing Order
86.	LO	Liaison Officer
87.	Maj	Major
88.	MDT	Multidisciplinary Meeting
89.	Med Cen	Medical Centre
90.	MFD	Medically Fully Deployable
91.	MIS	Management Information System
92.	MLD-T	Medically Limited Deployable - Temporary
93.	MND-T	Medically Not Deployable - Temporary
94.	MO	Medical Officer
95.	MOD	Ministry of Defence
96.	MPAR	Mid Period Appraisal Review
97.	MPID	Military Police Investigative Doctrine

98.	MPOC	Military Psychological Operations Course
99.	MT	Motor Transport
100.	NCO	Non Commissioned Officer
101.	NLT	No Later Than
102.	NoK	Next of Kin
103.	NOTICAS	Notification of Casualty
104.	OC	Officer Commanding
105.	OCE	Operational Commitments Establishment
106.	OIC	Officer in Charge
107.	OPCOM	Operational Command
108.	OPG	Overall Performance Grade
109.	Ops	Operations
110.	Ops WO	Operations Warrant Officer
111.	PACEX	Preparation and Confirmation Exercise
112.	Para	Paragraph
113.	Pers Svcs Br	Personnel Services Branch
114.	PFA	Personal Fitness Assessment
115.	Pl	Platoon
116.	PM(A)	Provost Marshal (Army)
117.	PNCO	Potential Non-Commissioned Officer
118.	POC	Point of Contact
119.	POSM	Post Operation Stress Management
120.	Psy	Psychological
121.	PRC (N)	Personnel Recovery Centre (North)
122.	PRU (N)	Personnel Recovery Unit (North)
123.	PStat Cat	Personal Status Category
124.	PT	Physical Training
125.	Pte	Private
126.	QM’s	Quartermaster’s
127.	RAC	Readiness Administration Check
128.	RAF	Royal Air Force
129.	RCMO	Regimental Career Management Officer
130.	REDCAP	Provost Marshal (A) CIS Application
131.	Regt	Regiment
132.	RMP	Royal Military Police
133.	RSS	Royal School of Signals
134.	SFA	Service Family Accommodation
135.	Sgt	Sergeant
136.	SHA (A)	Senior Health Advisor (Army)
137.	SI	Service Inquiry
138.	SIB	Special Investigation Branch
139.	SJAR	Soldiers Joint Annual Report
140.	SLA	Single Living Accommodation
141.	SME	Subject Matter Expert
142.	SMO	Senior Medical Officer
143.	SNCO	Senior Non-Commissioned Officer
144.	SO	Standing Order
145.	SOHB	Staff Officers Handbook
146.	SOI	Standard Operating Instruction
147.	SOP	Standard Operating Procedure
148.	SP	Service Person / Personnel
149.	Spec Inf Gp	Specialist Infantry Group
150.	Sqn	Squadron

151.	SSgt	Staff Sergeant
152.	SSSA	Substitute Single Service Accommodation
153.	SVRM	Suicide Vulnerability Risk Management
154.	TAA	Target Audience Analysist
155.	TOR	Terms of Reference
156.	TRiM	Trauma Risk Management
157.	TY	Training Year
158.	UHC	Unit Health Committee
159.	UHWC	Unit Health & Welfare Committee
160.	UWO	Unit Welfare Officer
161.	VLO	Victim Liaison Officer
162.	VO	Visiting Officer
163.	VRM	Vulnerable Risk Management
164.	VRMIS	Vulnerable Risk Management Information System
165.	VTC	Video Teleconferencing Capability
166.	W/C	Week Commencing
167.	WIP	Workplace Induction Programme
168.	1 Bn REME	1 Battalion Royal Electrical & Mechanical Engineers
169.	1 IG	1 Irish Guards
170.	1 ISR Bde	1 Intelligence Surveillance Reconnaissance Brigade
171.	1 MI Bn	1 Military Intelligence Battalion
172.	1 Sig Bde	1 Signal Brigade
173.	11 (RSS) Sig Regt	11th (Royal School of Signals) Signal Regiment
174.	11 Sig Bde	11 Signal Brigade
175.	150 Pro Coy	150 Provost Company
176.	6 (UK) Div	6h (United Kingdom) Division
177.	77 X / 77 Bde	77 Brigade

PART 1.2

Convening Order and Terms of Reference

CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL C R J WEIR DSO MBE

GENERAL OFFICER COMMANDING 1 (UK) DIVISION

1. A Service Inquiry (SI) is to be convened, in accordance with Section 343 of the Armed Forces Act 2006 (AFA 06), to investigate the circumstances surrounding the death of [redacted] who was discovered in his Single Living Accommodation (SLA) at Bourlon Barracks on 23 Jan 20.

2. A SI is to assemble on 02 Mar 20. The SI is the Panel's priority task and takes precedence over any other duties.

3. The SI Panel President is [redacted] Lt Col [redacted]. Two further panel members will be nominated following a LOC trawl. A medical subject matter expert will also be nominated following the LOC trawl.

4. The legal advisor to the to the SI is to be confirmed.

5. The Panel is to investigate and report the circumstances surrounding the incidents, recording all relevant evidence and expressing opinions in accordance with the Terms of Reference at Annex A. The Panel is not to attribute blame, negligence or recommend disciplinary action.

6. Witness statements are to be taken on oath or by affirmation, as required, in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008. Any document or other matter produced to the Panel by a witness, for use as evidence, shall be made an exhibit and treated in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008.

7. Any person who, in the opinion of the President, may be affected by the findings of the Panel shall be treated in accordance with Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008. The President is to ensure that any such person is notified as early as reasonably possible.

8. The Panel may hear evidence from any such other witnesses or subject matter experts as it deems appropriate and may dispense with the attendance of any witness if it concludes that the witness evidence will not assist the SI. The President should note that a witness statement taken by the RMP/SIB may not be submitted as evidence to the SI, unless the express consent of the witness providing the statement has been obtained.

9. If it appears to the Panel at any time during the SI that any person may have committed an offence against Service Law, including a criminal conduct offence contrary to Section 42 of the Armed Forces Act 2006, the President is to adjourn the SI immediately and seek legal advice.

10. The President is to inform all witnesses that a transcript of the SI, whilst primarily for internal MOD use, may subsequently be released into the public domain. All such material accessible to the public would be released in a redacted form according to current Service policy on disclosure and adhering to current legislation, including the Data Protection Act 1998 and the Freedom of Information Act 2000.

11. The SI Panel is to express its opinion with regards to any material conflict in the evidence, which may arise and give reasons for reaching that opinion. Any conflict in the evidence should be determined on the balance of probabilities.

12. The President is required to submit monthly progress reports to the Convening Authority and APSG Service Inquiry Branch in accordance with Appendix 4 to Annex G to CH 2 of JSP 832 and paragraph 27 (h) of LFSO 3207.

13. **Administration**. 1 (UK) Division is to provide the following:

a. A professional Verbatim Court Recorder to be present to record evidence at Hearings as required.

b. An Orderly to assist at the Hearings as confirmed by the President.

c. Stationery as required by the Panel.

d. Travel and subsistence for the Panel for SI related business away from their primary place of residence.

e. Travel and subsistence as required by any witnesses (for SI business).

f. Service Accommodation, as appropriate and if required, for the nominated Panel members.

g. Access to clerical support as required.

h. Office space and IT (incl laptop), as appropriate and as required, for the Panel members.

14. The costs of the Service Inquiry are to be charged to 1 (UK) Division UIN: [redacted].

[ORIGINAL SIGNED]

C R J Weir DSO MBE
Major General
General Officer Commanding
1 (UK) Division

Date: 20 Feb 20

Annex A to
GOC 1 (UK) Div
SI Convening Order
Dated 14 Feb 20

TERMS OF REFERENCE FOR THE SERVICE INQUIRY INTO THE DEATH OF [redacted]

1. The Panel is to investigate the circumstances leading up to and surrounding the death of [redacted] who was discovered in his Single Living Accommodation (SLA) on 23 Jan 20.

2. The purpose of the SI is to:

a. Present the facts surrounding the death of [redacted]

b. Assess the fitness for purpose of relevant, extant policies.

c. Establish if policy and procedures relating to the welfare and care of the service person were followed.

d. As appropriate, identify lessons and recommendations to help prevent further incidents of self-harm or deaths in similar circumstances.

3. The Panel is to report on all relevant matters and, under each Term of Reference (TOR), is to provide findings (facts), opinion (analysis) and, where appropriate, make recommendations. In particular the Panel is to:

a. **TOR 1 – Establish the facts of [redacted] military career history up to the time of his death.**

b. **TOR 2 – Present the facts surrounding [redacted] being discovered in his SLA on 23 Jan 20.**

c. **TOR 3 – Determine the procedures in place within [redacted] for all personnel remaining within SLA in barracks during stand down periods. How are these understood, disseminated and assured by [redacted]**

d. **TOR 4 – Determine the handover procedures in place at [redacted] for their personnel on temporary assignment to other units. Examine how relevant policies, procedures, welfare practices and other provisions are applied, including but not limited to:**

(1) Establish what policies, procedures and regulations are in place both in the wider Army and within the [redacted] for the provision of welfare support to a situation based on the facts of this matter. These include but are not limited to: Army General and Administrative Instructions (AGAIs) Volume 2 Chapter 57 (Health Committees); Volume 3 Chapters 81 (Army Welfare Policy); Volume 3 Chapter 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy); Army Command Standing Order (ACSO) 3217 (Trauma Risk Management (TRiM)): and Joint Service Publication (JSP) 751 (Joint Casualty and Compassionate Policy and Procedures). Determine the unit level of understanding in relation to these policies.

(2) Establish any unit policies that were in place prior to the death of [redacted] with regard to alerting the Chain of Command of any welfare and medical concerns.

a. **TOR 5 - Determine the takeover procedures in place at [redacted] for personnel on temporary assignments to that unit. Examine how relevant policies, procedures, welfare practices and other provisions are applied, including but not limited to:**

(1) Establish what policies, procedures and regulations are in place both in the wider Army and within the establishment for the provision of welfare support to a situation based on the facts of this matter. These include but are not limited to: Army General and Administrative Instructions (AGAIs) Volume 2 Chapter 57 (Health Committees); Volume 3 Chapters 81 (Army Welfare Policy); Volume 3 Chapter 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy); Army Command Standing Order (ACSO) 3217 (Trauma Risk Management (TRiM)); and Joint Service Publication (JSP) 751 (Joint Casualty and Compassionate Policy and Procedures). Determine the unit level of understanding in relation to the policies.

(2) Establish any unit policies that were in place prior to the death of [redacted] relation to assignment of temporary personnel, their arrival and proposed integration/induction with existing cells.

b. **TOR 6 - Investigate what actions were taken by the Chain of Command following the death of [redacted] and any immediate recommendations made by both [redacted] and [redacted]**

c. **TOR 7 - Consider any other matters relevant to the Inquiry and, based on the evidence, make such findings and express opinions as are appropriate to support recommendations in order to prevent recurrence.**

Procedure

4. The Panel is to include in the Record of Proceedings a clear and concise précis of the case in an easily readable form, addressing each of the TORs listed above. In particular the Panel should:

a. Set out the facts that, in the opinion of the Panel, have been established by the evidence on the balance of probabilities.

b. Set out any additional facts, relevant to the matter under inquiry, disclosed from the evidence, which have not been specifically referred to in the TORs.

c. Ensure that contained in the record are transcripts of oral evidence, copies of witness evidence given to the Panel and any other evidence which the President decides should form part of the record.

d. Make any recommendations appropriate in all TORs for the units, Army and Defence.

5. The President is to forward a copy of the Record of Proceedings to the Convening Authority on completion of the Service Inquiry.

AMENDMENT 1 CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL C R J WEIR DSO MBE

GENERAL OFFICER COMMANDING 1st (UNITED KINGDOM) DIVISION

1. The following personnel have been appointed as Panel members and Legal Advisor to the Service Inquiry to investigate the circumstances surrounding the death of [redacted] [redacted] who was discovered in his Single Living Accommodation (SLA) at Bourlon Barracks on 23 Jan 20.

   a. **Panel Member:** [redacted] Maj [redacted] RE.

   b. **Panel Member:** [redacted] WO2 [redacted] RLC.

   c. **Legal Advisor:** [redacted] Maj [redacted] AGC (ALS)

[ORIGINAL SIGNED]

C R J WEIR DSO MBE
Major General
General Officer Commanding 1 (UK) Div

Date: 02 March 2020

AMENDMENT 2 CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL C R J WEIR DSO MBE

GENERAL OFFICER COMMANDING 1st (UNITED KINGDOM) DIVISION

1. The following personnel have been appointed as Panel members and Legal Advisor to the Service Inquiry to investigate the circumstances surrounding the death of [redacted] [redacted] who was discovered in his Single Living Accommodation (SLA) at Bourlon Barracks on 23 Jan 20.

.

a. **Panel Member:** [redacted] Maj [redacted] RE.

b. **Panel Member:** [redacted] WO2 [redacted] RLC.

c. **Legal Advisor:** [redacted] Maj [redacted] AGC (ALS)

[ORIGINAL SIGNED]

C R J WEIR DSO MBE
Major General
General Officer Commanding 1 (UK) Div

Date: 14 May 2020

AMENDMENT 3 CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL C R J WEIR DSO MBE

GENERAL OFFICER COMMANDING 1st (UNITED KINGDOM) DIVISION

1. The following personnel have been appointed as Medical SME to the Service Inquiry to investigate the circumstances surrounding the death of [REDACTED] who was discovered in his Single Living Accommodation (SLA) at Bourlon Barracks on 23 Jan 20.

.

a. **Medical SME:** [REDACTED] Lt Col [REDACTED] RAMC

[ORIGINAL SIGNED]

C R J WEIR DSO MBE Date: 16 June 2020
Major General
General Officer Commanding 1 (UK) Div

AMENDMENT 4 CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL CS COLLINS DSO OBE

GENERAL OFFICER COMMANDING 1 (UK) DIVISION

1. Maj Gen Weir convened a Service Inquiry (SI), in accordance with Section 343 of the Armed Forces Act 2006 (AFA 06), to investigate the circumstances surrounding the death of [REDACTED] who was discovered in his Single Living Accommodation (SLA) at Bourlon Barracks on 23 Jan 20.

2. The SI assembled on 02 Mar 20. The SI is the Panel's priority task and takes precedence over any other duties.

3. The SI Panel comprises:

a. President: [REDACTED] Lt Col [REDACTED]

b. Member: [REDACTED] Maj [REDACTED]

c. Member [REDACTED] WO2 [REDACTED]

4. The legal advisor to the to the SI is [REDACTED] Maj [REDACTED]

5. The Medical SME is: [REDACTED] Lt Col [REDACTED].

6. The Panel is to investigate and report the circumstances surrounding the incidents, recording all relevant evidence and expressing opinions in accordance with the Terms of Reference at Annex A. The Panel is not to attribute blame, negligence or recommend disciplinary action.

7. Witness statements are to be taken on oath or by affirmation, as required, in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008. Any document or other matter produced to the Panel by a witness, for use as evidence, shall be made an exhibit and treated in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008.

8. Any person who, in the opinion of the President, may be affected by the findings of the Panel shall be treated in accordance with Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008. The President is to ensure that any such person is notified as early as reasonably possible.

9. The Panel may hear evidence from any such other witnesses or subject matter experts as it deems appropriate and may dispense with the attendance of any witness if it concludes that the witness evidence will not assist the SI. The President should note that a witness statement taken by the RMP/SIB may not be submitted as evidence to the SI, unless the express consent of the witness providing the statement has been obtained.

10. If it appears to the Panel at any time during the SI that any person may have committed an offence against Service Law, including a criminal conduct offence contrary to Section 42 of the Armed Forces Act 2006, the President is to adjourn the SI immediately and seek legal advice.

11. The President is to inform all witnesses that a transcript of the SI, whilst primarily for internal MOD use, may subsequently be released into the public domain. All such material accessible to the public would be released in a redacted form according to current Service policy on disclosure and adhering to current legislation, including the Data Protection Act 1998 and the Freedom of Information Act 2000.

12. The SI Panel is to express its opinion with regards to any material conflict in the evidence, which may arise and give reasons for reaching that opinion. Any conflict in the evidence should be determined on the balance of probabilities.

13. The President is required to submit monthly progress reports to the Convening Authority and APSG Service Inquiry Branch in accordance with Appendix 4 to Annex G to CH 2 of JSP 832 and paragraph 27 (h) of LFSO 3207.

14. **Administration**. 1 (UK) Division is to provide the following:

a. A professional Verbatim Court Recorder to be present to record evidence at Hearings as required.

b. An Orderly to assist at the Hearings as confirmed by the President.

c. Stationery as required by the Panel.

d. Travel and subsistence for the Panel for SI related business away from their primary place of residence.

e. Travel and subsistence as required by any witnesses (for SI business).

f. Service Accommodation, as appropriate and if required, for the nominated Panel members.

g. Access to clerical support as required.

h. Office space and IT (incl laptop), as appropriate and as required, for the Panel members.

15. The costs of the Service Inquiry are to be charged to 1 (UK) Division UIN: [REDACTED].

[ORIGINAL SIGNED]

C S Collins DSO OBE
Major General
General Officer Commanding
1 (UK) Division — Date: 02 Nov 20

PART 1.3

Narrative of Events

TABLE OF CONTENTS – PART 1.3

	Page
Synopsis	20
HQ 6 (UK) Div Generation of the Uplift Requirement to 77 Bde	20
HQ 1 ISR Bde Generation of the Uplift Requirement to 77 Bde	21
1 MI Bn Generation of the Uplift Requirement to 77 Bde	21
77 Bde Immediate Uplift Joining Instructions	21
1 MI Bn FRAGO 56/19: 77 Bde Uplift	21
Military Psychological Operations Course (MPOC) – 2 to 13 Dec 19	21
SP Arrival at 77 Bde –16 Dec 19	22
SP Christmas Leave AD 16 Dec to FP 7 Jan 20	22 – 23
SP Hire Car Booking – 6 Jan 20	23
Uplift Personnel Arrival - 7 Jan 20	23
Witness 45 Email Recommending TAA Uplift Personnel to DCSU Teams	23
Witness 51 DCSU Welcome Brief to TAA Uplift Personnel – 9 Jan 20	23
Team Leader DCSU ENDURA Team Welcome Brief – 9 Jan 20	24
Week Commencing 13 Jan 20 (13 to 19 Jan 20)	24
Week Commencing 20 Jan 20 (20 to 23 Jan 20)	24
Discovery of SP	24
Coroner's Inquest	25
Unit Descriptions	25

PART 1.3 – NARRATIVE OF EVENTS

Reference

Synopsis

1.3.1. On 23 Jan 20 (approx 1000 hrs) the SP was discovered in his Single Living Accommodation (SLA), within Catterick Garrison. The SP was pronounced deceased by paramedics when they attended at approx 1020 hrs. The SP was on a temporary detachment from 1 Military Intelligence (MI) Bn (Catterick) to uplift 77 Bde (Hermitage), as part of an internal HQ 6 (UK) Div trawl, for the period from 2 Dec 19 to 7 Sep 20. The SP had been permitted by 1 MI Bn to retain his SLA in Catterick for personal reasons. The SP had attended a course (2 to 13 Dec 19) in preparation for his detachment and conducted a 77 Bde arrival package on 16 Dec 19. The SP was scheduled to spend parts of his Christmas / New Year leave (AD 16 Dec 19 to FP 7 Jan 20) within his SLA at Catterick.

1.3.2. The SP was last seen by Defence Cultural Specialist Unit (DCSU) and 77 Bde personnel on 16 Dec 19 at Hermitage. He was scheduled to return from leave on 7 Jan 20, this was to be the first day that the SP commenced work as part of DCSU. DCSU allocated the SP to a Team within DCSU and he featured on their organisational chart. However, it was not identified that the SP was missing at any time prior to 23 Jan 20.

Background

HQ 6 (UK) Div Generation of the Uplift Requirement to 77 Bde

1.3.3. On 17 Oct 19, HQ 6 (UK) Div issued a Force Generation Order (FGenO). The FGenO identified a lack of 77 Bde capacity in three capabilities; The Brigade Operations Centre (BOC) Mission Teams, Target Audience Analysis (TAA) and Web Operations. The lack of capacity was to be improved by an uplift of 30 personnel drawn from within 6 (UK) Div through an Authorised Elsewhere (AE) arrangement[1]. The FGenO was sent to 1 ISR Bde, 1 (UK) Sig Bde, 11 Sig Bde and the Spec Inf Gp. **F35**

1.3.4. The FGenO tasked 1 ISR Bde[2] to force generate ten suitably qualified and experienced personnel to fill specified roles. It included the following coordinating instructions: **F35**

a. **NLT 29 Oct 19.** Uplift manpower names submitted to 6 (UK) Div by Bdes.

b. **NLT 15 Nov 19.** Joining Instructions issued to Uplift personnel by HQ 77 Bde.

c. **2 to 13 Dec 19.** Target Audience Analysts attend the Military Psychological Operations Course at RAF Halton.

d. **16 Dec 19.** Target Audience Analysts report for duty at Hermitage.

---

[1] Authorised Elsewhere is described in the Liability and Manpower Planning Handbook (LMPH) 2016 as a process used for routine temporary liability [now known as workforce requirement] changes to provide a short term solution to a pinch point that is not envisaged to endure more than two years.

[2] The SP was a member of 1 MI Bn which is part of 1 ISR Bde.

e. **AD 18 Dec to FP 7 Jan 20.** 77 Bde Christmas stand-down period.

f. **7 Sep 20.** Manpower uplift ends.

HQ 1 ISR Bde Generation of the Uplift Requirement to 77 Bde

1.3.5. On 18 Oct 19, HQ 1 ISR Bde issued a trawl to all 1 ISR Bde Units with a requirement to identify volunteers for the ten Uplift personnel NLT 23 Oct 19. **F60**

1 MI Bn Generation of the Uplift Requirement to 77 Bde

1.3.6. On 18 Oct 19 the Ops Cell, 1 MI Bn sent the trawl requirement to all 1 MI Bn Sub-Units requesting that they nominate volunteers by 22 Oct 19 and submit nominations with penalty statements by 24 Oct 19. **F60**

1.3.7. On 21 Oct 19, Witness 21 submitted, by email, to the 1 MI Bn Ops Cell that the SP and one other JNCO (Cpl) were volunteers for the role of Target Audience Analyst, or Web Operations Operator. **T23/17/D** **F60**

1.3.8. On 24 Oct 19, Witness 8 consolidated the returns from the 1 MI Bn Sub-Units and emailed HQ 1 ISR Bde that the SP was a supported volunteer for the role of Target Audience Analyst (TAA). **F60**

1.3.9. On 28 Oct 19, the Ops Cell, 1 MI Bn informed the 1 MI Bn Chain of Command that the SP had been selected by HQ 1 ISR Bde as a TAA and all other submissions had been stood down. **F60**

77 Bde Immediate Uplift Joining Instructions

1.3.10. On 22 Nov 19, HQ 77 Bde issued the Immediate Uplift Joining Instructions. The Joining Instructions were cascaded by HQ 1 ISR Bde to the Ops Cell, 1 MI Bn on 22 Nov 19. The Joining Instructions named all the 30 Uplift personnel (rank range LCpl to Capt), including the SP. The Command State of Uplift personnel was stated as Operational Command (OPCOM[3]) 77 Bde for the duration of the uplift. **F93** **T8/67/E**

1 MI Bn FRAGO 56/19: 77 Bde Uplift

1.3.11. On 26 Nov 19, the Ops Cell, 1 MI Bn issued a Fragmentary Order (FRAGO) specific to the SP covering the temporary detachment of the SP to 77 Bde from 2 Dec 19 to 7 Sep 20, as a TAA. Full details of the FRAGO are within TOR 1. **F61**

Military Psychological Operations Course (MPOC)

1.3.12. Over the period 2 to 13 Dec 19 the SP attended the Military **F127**

[3] SOHB Defines the OPCOM command state as: OPCOM is the authority granted to a commander to assign missions or tasks to subordinate commanders, to deploy units and to reassign forces, and to retain or delegate operational and / or tactical control as it may be deemed necessary.

Psychological Operations Course (MPOC) at the Joint Information Activities Group (JIAG), RAF Halton. Full details of the SP attending the MPOC are covered under TOR 1.

The SP's Arrival at 77 Bde - 16 Dec 19

1.3.13. The SP reported to a Conference Room within Hermitage. The TAA Uplift personnel along with other Uplift personnel went through an arrivals process (including G1 Administration, issuing of arrivals packs and assignment of accommodation). Nine of eleven TAA Uplift personnel were expected to report on 16 Dec 19, and all were accounted for by Witness 46 who was directed as the "*Reporting POC*" by HQ 77 Bde in the 77 Bde – Immediate Uplift Joining Instructions. **F93** **F61** **F2/A/16**

1.3.14. On completion of the arrivals process; including individual Interviews, the Uplift personnel were stood down for Christmas leave and briefed to report back at 1000 hrs on 7 Jan 20. Full detail of the activity on Mon 16 Dec 19 is contained within TOR 1, including the detail of an initial interview conducted with the SP by Witness 46. **F93** **T48/244/A**

The SP's Christmas Leave

1.3.15. Witness 25 had established, by contacting the SP on 11 Dec 19, that he intended to remain in the SLA at Catterick over parts of the Christmas leave period. Witness 25 subsequently passed the information to Witness 22. Witness 22 informed Witness 15 that HQ Coy had two SP remaining in the SLA at Catterick over the Christmas leave period; one of which was the SP. **T28/157/F-G** **T24/36/H** **F154**

1.3.16. Witness 15 directed that the 1 MI BDO contact both SP daily whilst they were in the SLA as a duty of care check. The period this applied to for the SP was 27 Dec 19 to 6 Jan 20. Full details surrounding the 1 MI Bn decision to conduct welfare checks on SP remaining in SLA over the Christmas leave period and the detail of the actual BDO actions carried out are covered in detail under TOR 3. **F64**

The SP's Christmas Leave - W/C 16 Dec 19

1.3.17. On either 18 or 19 Dec 19 Witness 25 encountered the SP in Catterick Garrison. He noted that the SP appeared "*happy, content"* and that "*he was looking forward to the tour* [attachment to DCSU, 77 Bde]". **T28/157/E-G**

1.3.18. Over the period 20 Dec to 27 Dec 19 the SP spent time away from Catterick with Witness 10. He described the SP as being in good spirits noting "*The Christmas period was probably the happiest I've seen him in quite a long time*". **T11/24/C-F** **T11/31/A-C**

The SP's Christmas Leave - W/C 23 Dec 19

1.3.19. On 27 Dec 19 (approx 1200 hrs) Witness 10, dropped the SP back at his SLA. Witness 12 encountered the SP in the SLA on 27 Dec 19. He described the SP as "*upbeat*" and having enjoyed the time spent with Witness 10 over the Christmas period. **T11/24/G** **F153** **T13/47/E-H** **T13/48/C-D**

1.3.20. On 28 Dec 19 (approx 1900 hrs) Witness 6, encountered the SP in **T6/47G-H**

Catterick Garrison. Witness 6 took the SP to TESCO [Catterick] and then through the McDonalds drive-thru [Catterick]. Witness 6 described the demeanour of the SP during the encounter as "*in good spirits and quite happy*", he noted he had not met the SP previously.

T6/49/E
T6/48/D-G
T6/49/H

1.3.21. On 29 Dec 19 Witness 17 encountered the SP at the gym he described the SP as both happy and content.

T18/164/B-C

The SP's Christmas Leave - W/C 30 Dec 19

1.3.22. On 30 Dec 19 (approx 1250 hrs) and 31 Dec 19 (approx 1433 hrs) the SP used the gym and his entry was captured on local CCTV.

F1/A-3

1.3.23. On 31 Dec 19 Witness 9 had a 30 min Facetime video call with the SP. He noted that the SP was in his room in the SLA and that "*he seemed happy…he seemed fine*" during the call.

T10/25/B
T10/29/C

1.3.24. On 1 Jan 20 (approx 1511 hrs) the SP used the gym and his exit was captured on local CCTV.

F1/A-3

SP - Hire Car Booking

1.3.25. The SP had a hire car booked via 1 MI Bn MT for a one way hire vehicle to be collected by him on 6 Jan 20 (1200 hrs) to travel to Hermitage. The SP did not collect the hire vehicle on 6 Jan 20. 1 MI Bn were not made aware that the SP had not collected the hire vehicle. The hire car policy in force at that time is examined in TOR 7.

F66

Uplift Personnel Arrival - 7 Jan 20

1.3.26. On 7 Jan 20 (approx 1000 hrs) the Target Audience Analyst (TAA) Uplift personnel allocated to DCSU and Mission Planning Uplift personnel allocated to the BOC 77 Bde assembled at Hermitage. This was the first full working day that the 77 Bde Uplift personnel came under 77 Bde (Mission Planners) and DCSU (TAA) following their attendance on the MPOC. They were met by Witness 44, and Witness 45.

T40/71/C
T46/244/A
T47/272/D
T47/274/C
T47/278/B

1.3.27. DCSU did not notice that the SP had not returned from Christmas leave. Witness 38 who had met the SP on the MPOC noticed in passing that he was not present but assumed he had a different reporting date. The activity of the TAA Uplift personnel on 7 to 8 Jan 20 is covered within TOR 5.

T47/274/B-H
F93 / F93A
T47/275/D
T40/73/A-G

Witness 45 Email Recommending TAA Uplift Personnel to DCSU Teams

1.3.28. On 8 Jan 20 Witness 45, sent an email to HQ DCSU making recommendations for allocation of the TAA Uplift personnel by name to Teams within DCSU. Witness 45 recommended that the SP be allocated to the ENDURA Team. It had not been confirmed that the SP had arrived on 7 Jan 20 before the email was sent.

F91
T47/281/C

Witness 51 DCSU Welcome Brief to TAA Uplift Personnel - 9 Jan 20

1.3.29. Witness 51 delivered a DCSU welcome brief to all TAA personnel,

T42/125/G
T54/500/C-D

including the TAA Uplift personnel, at Hermitage. The SP was shown on an organisational chart used by Witness 51 as allocated to the DCSU ENDURA Team and his name was read out. No nominal role was taken prior to, or during the brief, therefore the absence of the SP was not noticed. Details of the welcome brief are covered under TOR 5.

T54/500/F
T54/501/A-E

Team Leader DCSU ENDURA Team Welcome Brief - 9 Jan 20

1.3.30. Following the CO DCSU welcome brief, Witness 47 conducted a welcome brief to the DCSU ENDURA and INTORT Teams. No nominal role was taken at this brief, the absence of the SP remained unnoticed.

T49/345/D-H
T49/349/B-F
T49/348/C-D

Week Commencing 13 Jan 20 (13 to 19 Jan 20)

1.3.31. During the week commencing 13 Jan 20 the absence of the SP was not noticed by DCSU. He had not been allocated a SNCO Line Manager or a SP placed specifically in charge of the TAA Uplift element of the DCSU ENDURA Team based at Hermitage. There was no workspace allocated to the SP as *"hot desking"* was in operation for JNCOs.

T49/352/A
T39/56/B-C
T43/155/H

1.3.32. On 14 Jan 20 Witness 47 conducted initial interviews for two of the three TAA Uplift personnel joining the DCSU ENDURA Team, Witness 39 and Witness 36, when they visited RAF Henlow as part of an optional visit. Witness 47 recalled noting that the SP had not attended for an interview, or had been on the list of those personnel scheduled to attend RAF Henlow for interview. He noted, "*I didn't think too much at the time or how significant it was".*

T49/357/F
T49/359/F-H
T49/360/E-G
F184
F220/3

Week Commencing 20 Jan 20 (20 to 23 Jan 20)

1.3.33. During the week commencing 20 Jan 20 the absence of the SP remained unnoticed by DCSU.

T49/357/A-C

1.3.34. On 20 Jan 20, Witness 25 sent the SP a WhatsApp message. He had been requested to do so by Witness 14, to ensure the SP was "*settling in OK*". Witness 25 got no reply from the SP and engaged with the Ops Cell, 1 MI Bn to request contact details for the SP. However, before he could make contact, the SP was discovered on 23 Jan 20.

T28/158/A
F155
T128/159/C
F220/5

1.3.35. On 20 Jan 20 a member of the TAA Uplift personnel, Witness 37 who had met the SP on the MPOC, noticed that they had not seen the SP since the MPOC but assumed he was elsewhere. Witness 37 mentioned it to Witness 39, a friend and also a member of the TAA Uplift personnel, in passing, who remarked he had not seen the SP either. Witness 39 was not aware that the SP was also a member of the ENDURA Team.

T39/51/A-F
T41/106/F
T41/107/B

1.3.36. On 21 Jan 20, Witness 47 received an organisational diagram from Witness 40. The organisational diagram only showed two of the three TAA Uplift personnel (Witness 36 and Witness 39) allocated to the DCSU ENDURA Team, it did not include the SP. Witness 47, viewed the email on 22 Jan 20 and noticed that the SP was not on the diagram. He did not raise the issue the following day, 23 Jan 20, as he was out of office.

F175
T49/361/H
T49/362/A-H

Discovery of the SP

1.3.37. On 23 Jan 20 (approx 1000 hrs) the SP was discovered in his SLA within Catterick Garrison by two JNCOs that lived within the SLA. Paramedics subsequently (approx 1020 hrs) confirmed the SP was deceased.	**T13/53/C-G** **T14/75/E** **F142**

1.3.38. Full details of the discovery of the SP are covered under TOR 2. The 1 MI Bn TRiM support provided is covered under TOR 4. The 1 MI Bn response and DCSU response is covered under TOR 6.

Coroner's Inquest

1.3.39. A Coroner's Inquest has yet to occur at the time of this report was submitted to HQ APSG.

Unit Descriptions

1.3.40. The four Units that the SP was assigned / attached to during the period Aug 05 to Jan 20 were:

a. **1 Irish Guards (1 IG).** A Regular Light Role Inf Bn currently based in Wellington Barracks, London. 1 IG is under the operational command of 11 Inf Bde, as part of 1 (UK) Div.	**F199/1**
b. **11th (Royal School of Signals) Signal Regiment (11 (RSS) Sig Regt).** An Initial and Subsequent Trade Training Regiment, based in Blandford Camp, Blandford Forum, Dorset. 11 (RSS) Sig Regt are part of the Defence College of Technical Training and report to the Defence School of Communication and Information Systems as part of the AIR TLB.	**F199/4**
c. **1 Military Intelligence (MI) Battalion.** A Regular MI Bn based in seven locations in the UK: Catterick Garrison; York; Colchester; Northwood, Innsworth, Larkhill and Plymouth. 1 MI Bn is under the operational command of 1 ISR Bde, as part of 6 (UK) Div.	**F199/3**
d. **Defence Cultural Specialist Unit (DCSU).** A hybrid and Tri Service unit that provides intelligence support to information activity based at RAF Henlow, Bedfordshire. DCSU is under the operational command of 77 Bde, as part of 6 (UK) Div.	**F199/2**

PART 1.4

Analysis

TABLE OF CONTENTS – PART 1.4

	Page
Introduction	28
Methodology / Event Factors Terminology	28
Probabilistic Terminology	29
TOR 1	30 – 49
TOR 2	49 – 50
TOR 3	50 – 56
TOR 4	56 – 64
TOR 5	64 – 73
TOR 6	74 – 77
TOR 7	77 – 86

LIST OF FIGURES – PART 1.4

Figure 1.4.1 – Probabilistic terminology

PART 1.4 ANALYSIS

Introduction

1.4.1. Section 1.4 contains the key elements of the Service Inquiry findings accompanied by the analysis and opinion of the Panel followed by where appropriate the resulting recommendations. It starts by outlining the methodology taken by the Panel and explaining the Event Factors and probability definitions used by the Panel to capture, discuss and weight the findings of the Panel. It covers each Term of Reference (TOR) question individually. Each TOR section outlines the key findings against each question and provides an opinion based on the evidence found throughout the Inquiry which aims to support the recommendations made. Recommendations are listed at the end of each relevant topic / section and are collated at Part 1.5.

Methodology

1.4.2. The purpose of the Service Inquiry is to establish the facts of the matter in order to prevent recurrence. To understand what may prevent recurrence the Panel need to understand what caused the events in question or made them more likely. To provide a construct or framework to assist this understanding and to aid the explanations offered in this report the Panel have adopted Event Factors terminology. The event in this Service Inquiry is the death of the SP[4]. Once an Event Factor had been determined to have been present it was then assigned to one the following categories.

a. **Causal Factor(s).** Those factors which, in isolation or in combination with other causal factors and contextual details, led directly to the incident. Therefore, if a causal factor was removed from the event sequence, the death of the SP would not have occurred. There were no causal factors identified by the Panel relating directly to the death of the SP.

b. **Contributory Factor(s).** Those factors which made the event more likely to happen. That is, they did not directly cause the event. Therefore, if a contributory factor was removed from the event sequence, the event may still have occurred. There were no contributory factors identified by the Panel relating directly to the death of the SP.

c. **Aggravating Factor(s).** Those factors which made the final outcome of the event worse. However, aggravating factors do not cause or contribute to the events. That is, in the absence of the aggravating factor, the event would still have occurred. Aggravating factors in this Service Inquiry centre around actions / omissions relating to the welfare checks of the SP in his Single Living Accommodation (SLA) over Christmas 19 / New Year 20 leave period and the accountability of the SP.

d. **Other Factor(s).** Those factors which, whilst shown to have been present, played no part in an event. They are, however, noteworthy and include deviations from policy. Other Factors may provide the basis for additional Recommendations or Observations.

[4] It should be noted that the circumstances of the death of the SP have yet to be determined by a Coroner's Inquest.

e. **Observations.** Observations are points or issues identified during the investigation that are worthy of note to improve working practices, but which do not relate to the events being investigated and which could not contribute to or cause similar future events. The term also applies to issues which have been identified earlier and remedial or mitigating action has already been completed.

Probabilistic Terminology

1.4.3. The probabilistic terminology detailed below clarifies the terms used in this report to communicate levels of certainty or uncertainty within the report. It is used to describe the degree of confidence the Panel has in their stated opinion and conclusions.

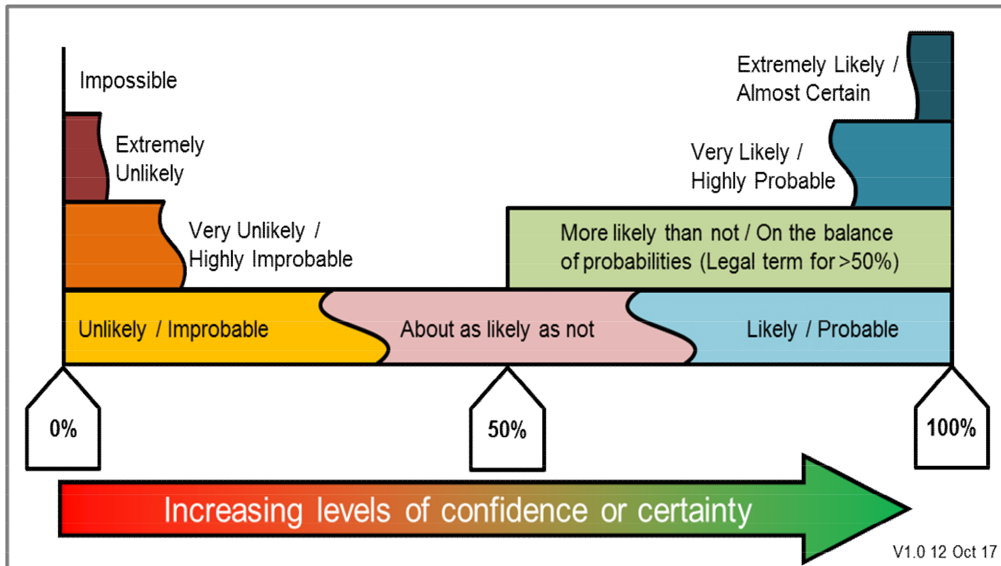


Figure 1.4.1 – Probabilistic terminology

TERMS OF REFERENCE (TOR)

	Reference
TOR 1. Establish the facts of [the SP's] military career history up to the time of his death.	
Findings:	
1.4.4. The SP commenced his Initial Army Training at the Infantry Training Centre, Catterick, on 4 Jan 05, aged 18. The SP qualified as an Infantry Soldier Class Three on 12 Aug 05.	**F8A** **F7** **F27**
1.4.5. Following a period of summer leave the SP joined 1 IG on 22 Aug 05 based in Wellington Barracks, London.	**F7** **F27A**
Operational Tour / Post Operational Stress Management (POSM)	
1.4.6. Over the two month period 19 Aug 07 to 25 Oct 07 the SP deployed on Op TELIC in Iraq as a signaller within the 1 IG Battle Group Headquarters. The SP was awarded the Iraq Medal on 11 Dec 07.	**F6** **F7** **F6**
1.4.7. The SP's Unit Personal Folder (Army Form B9999) stated he had never received a POSM brief of any kind following his last (only) operational tour.	**F8A** **F7**
1.4.8. The Army POSM Policy in 2007 was covered by Land Forces Standing Order (LFSO) 3209 – Land POSM (dated Jan 06) which states "*it is mandatory that the process* [POSM] *is followed..."* and "*POSM forms part of the Army's duty of care as an employer in respect of health and safety and its management*".	**F197A**
Opinion	
1.4.9. The Panel are in agreement with LFSO 3209[5] that for a significant number of SP, an operational deployment is a positive experience but there will be a number for whom the experience can have negative effects. Therefore, it is essential that POSM activity is both conducted and appropriately recorded. The Panel determined that the SP not conducting POSM following his operational tour to Iraq in 2007 was an Other Factor. The Panel did not make a recommendation on 1 IG as the lack of POSM occurred over 13 years ago.	
2008 / 2009	
1.4.10. For the reporting period 1 Jun 08 to 31 May 09 the SP was based in Aldershot and Windsor. He was employed as a Signaller within the Signal Platoon, HQ Coy working in Battlegroup Headquarters. In his annual report he obtained an Overall Performance Grade (OPG) of B[6], with developing potential for promotion and a recommendation for continued employment within the Signal Platoon.	**F6** **F9**
2009 / 2010	

[5] LFSO 3209, para 2.
[6] B Grade is defined as "Performing to the standard expected in all respects".

1.4.11. For the reporting period 1 Jun 09 to 31 May 10 the SP was based in Windsor, employed as a Signaller within the Signal Platoon, HQ Company. The SP obtained an OPG of C[7] with no recommendation for promotion and an employment recommendation as a Company Storeman. **F6 F10**

2010 / 2011

1.4.12. For the reporting period 1 Jun 10 to 31 May 11 the SP obtained an OPG of C with no potential for promotion and a recommendation for continued employment within the Signal Platoon. The SP attended a Lower Limb Rehabilitation Course at the Headley Court Rehabilitation Centre over the period 23 Jun 10 to 13 Jul 10, 13 Oct 10 to 4 Nov 10 and 3 to 20 May 11. **F17B F16E F6 F11**

1.4.13. **Return to 1 IG / Army Welfare Service (AWS) Involvement.** The SP attended Headley Court Rehabilitation Centre from 15 Jun to 7 Jul 11. In Jul 11 the SP was referred to the AWS by Headley Court Rehabilitation Centre as the SP had expressed concern about returning to 1 IG following his time at Headley Court. On 8 Jul 11 the AWS supported the SP at a return to work meeting to integrate him back into the unit, with a plan agreed for him to return to 1 IG on 30 Aug 11 following summer block leave. **F17B F16E F130**

2011 / 2012

1.4.14. For the reporting period 1 Jun 11 to 31 May 12 the SP was employed as a Signaller within the Signal Platoon, HQ Company and also assisted within the stores. He obtained an OPG of B-[8], with developing potential for promotion and a recommendation for employment as a Section Second in Command. **F6 F12**

1.4.15. In Dec 11 the SP got married and on 14 Feb 12 declared that his Personal Status Category (PStat Cat) had changed from PStat Cat 5[9] to PStat Cat 1[10] on 17 Dec 11. **F7**

Application / Selection for Redundancy

1.4.16. On 30 Jan 12 the SP submitted an application to be considered for redundancy under Tranche 2 of the Armed Forces Redundancy Programme. The SP was selected for compulsory redundancy, which he acknowledged on 12 Jun 12 with a termination date of 11 Dec 12. **F6A F7 F52/08**

Departure from 1 IG

1.4.17. The SP spent the remainder of 2012, either deployed in support of Op OLYMPICS, or working in Aldershot. 1 IG produced a Certificate of Service to cover the eight year period 4 Jan 05 to 11 Dec 12. The military conduct of the SP was assessed as *"very good"*. The CO commented "[The SP] *is a trustworthy and likeable character who works diligently under* **F6 F7**

---

[7] C Grade is defined as "Performing to the standard expected in some respects".
[8] B- Grade is defined as "Performing to the standard expected in most respects".
[9] PStat Cat 5. This Category includes all those personnel not categorised as either 1, 2, 3 or 4, therefore an individual who is single and has no financial obligations for children, spouse or former spouse, either voluntary or by court order.
[10] PStat Cat 1. Legally married, or in a registered civil partnership and living with their spouse/civil partner or who would be but for the exigencies of the Services.

direction and is a good addition to a team. He has good technical knowledge gained through his time in the Army".

Application to Re-join the Army

1.4.18. In Jan 2015 the SP applied to re-join the Army via the Re-joiners Team, within Recruiting Group. On 23 Apr 15, the R SIGNALS Staff and Personnel Selection Officer interviewed the SP, his interview notes remarked "*there were no admin, welfare or discipline issues to prevent him re-joining or undertaking training".* The SP was allocated a re-joining date of 12 Oct 15. **F6B**

Royal School of Signals

1.4.19. Over the period 12 Oct to 16 Oct 15 the SP conducted the Royal School of Signals Induction Course. On 19 Oct 15 the SP commenced the 47 week Communication Systems Engineer Course (Basic) at the Royal School of Signals, Blandford Forum, Dorset. The SP was part of Ulster Troop, 3 Squadron, 11 (Royal School of Signals) Signal Regiment (11 (RSS) Sig Regt). **F6B** **F7** **F13**

Deliberate Self Harm Attempt

1.4.20. **Incident.** An INCREP raised by 11 (RSS) Sig Regt stated that "*On Sun 6 Mar 16,* [the SP] *informed a member of his Troop Staff that he had made an attempt on his own life on Fri 04 Mar 16 at approximately 1900 hrs within the 3 Sqn accommodation."* The incident was reported to Witness 53 on 7 Mar 16 at 0800 hrs. **F118**

1.4.21. **Incident Reporting.** Witness 53 raised an INCREP on 9 Mar 16 sent to HQ Defence School of CIS[11]. Witness 53 could not recall whether the incident was reported to the RMP at the time. **F118** **F132**

1.4.22. **Self-Harm Reporting to the RMP.** AGAI 110 – Army Suicide Vulnerability Risk Management (SVRM) Policy states at para 110.014. "*All incidents of attempted suicide must also be reported to the SIB* [RMP] *…., if the SIB cannot be contacted then a call to the local RMP unit should be made" and* at para 110.15 that instances of self-harm are to be immediately reported to the SIB. HQ Provost Marshall (Army), (HQ PM(A)) were able to confirm via their record systems (REDCAP and COPPERS) that no telephone call or notification had been received relating to this incident. **F196** **F33A**

1.4.23. **Medical / Welfare Support.** 11 (RSS) Sig Regt arranged an interview with the Unit Welfare Team on 7 Mar 16 and an appointment at the Blandford Medical Centre also a DCMH[12] referral was subsequently made. **F114** **F16**

1.4.24. **Unit Risk Conference.** On 8 Mar 16, 11 (RSS) Sig Regt held a Vulnerability Risk Assessment Conference. At the Meeting it was determined that the SP should be added to the Unit SVRM register (VRMIS) and managed by a Care Assessment Plan (CAP). A CAP Lead was appointed. **F114** **F118**

1.4.25. **Care Assessment Plan (CAP).** The CAP Lead created a CAP on VRMIS[13] on 8 Mar 16. They noted following the Vulnerability Risk Assessment **F114**

---

[11] Witness 53 stated that HQ Defence School of CIS was the immediate higher formation to the 11 (RSS) Sig Regt.
[12] DCMH (Department of Community Mental Health) a MOD organisation which provides Tri Service mental healthcare.
[13] VRMIS (Vulnerability Risk Management Information System) is a command tool for the management of SP who are considered to be vulnerable to, and at risk of suicide or self-harm behaviours.

Meeting, that DCMH had categorised the SP as low risk following a perceived one off event with no protective measures required. The CAP contained the following entry tags: Medical issues (deliberate self-harm, personal issues outside of the Army and financial issues).	
1.4.26. **PStat Change.** On 8 Mar 16 the SP declared that his Personal Status Category (PStat Cat) had changed from PStat Cat 1 to PStat Cat 3[14].	**F7**
1.4.27. **AWS.** On 8 Mar 16 the SP was referred to the AWS by Blandford Medical Centre having expressed welfare and financial concerns.	**F129**
Opinion	
1.4.28. The Panel are of the opinion that reporting of the self-harm incident conducted by 11 (RSS) Sig Regt was not policy compliant; in that the RMP were not informed as required by AGAI 110 – Army SVRM Policy. The Panel are of the opinion that the involvement of the Service Police permits the independent investigation (independent of the unit involved) of the circumstances surrounding the incident, in order to determine if any criminality had occurred. The Panel determined that the omission to report the self-harm incident to the RMP was an Other Factor.	
Recommendation	
1.4.29. 11 (RSS) Sig Regt ensure that all incidents of self-harm are reported to the RMP in accordance with AGAI 110 - Army VRM Policy.	
Mar to Sep 16	
1.4.30. The SP continued with his Communications Systems Engineer Course Basic (CSE (B)) until the course concluded on 9 Sep 16. During the period he was supported by appointments at DCMH Tidworth (Mar 16 onwards) with the AWS (Mar to May 16 and Jul to Sep 16) with an active CAP in place.	**F114** **F129** **F16**
1.4.31. **Medical Review.** On 21 Apr 16 the SP attended a Medical Board where he was graded as Medically Not Deployable – Temporary (MND - T).	**F116/3** **F16**
1.4.32. **CSE (B) Course Report.** On 9 Sep 16 the SP concluded the CSE (B) course. The course report described him as "*proactive and polite*" with a "*natural aptitude for technical problem solving….a promising soldier who has shown a great deal of potential*". On completion of the CSE (B) course, the SP conducted Driver Training at the Royal School of Signals.	**F13** **F113**
Oct 16	
1.4.33. **Basic Close Combat Skills Course (BCCS).** The SP attended BCCS over the period 17 to 21 Oct 16 in preparation for a PNCO Course. The SP did not pass a prerequisite fitness test and was therefore unable to continue on the PNCO Course and commenced Reconditioning PT, as a Soldier Not Under Training.	**F112A** **F117** **F113**

[14] PStat Cat 3 is a SP who provides financial support for their spouse, former spouse, civil partner, former civil partner, or any dependent child by voluntary agreement.

Nov 16 to Jul 17

1.4.34. The SP remained as a Soldier Not Under Training conducting Reconditioning PT, graded as Medically Not Deployable – Temporary (MND - T). During the period he was supported by appointments at DCMH Tidworth (concluding in Apr 17) and an active CAP remained in place (until removal from the Unit VRM register). **F113 F117 F116**

1.4.35. **Removal From Unit VRM Register.** At the 11 (RSS) Sig Regt Individual Case Conference held on 6 Mar 17 a decision was made to remove the SP from VRMIS. The VRMIS record notes "*CO decreed at the Case Conference that soldier is ready to be removed from his CAP*". A final interview held by the CAP Lead noted "*soldier has been informed that he is being removed from the CAP and he is very happy about the situation".* **F115 F114**

1.4.36. **Medical Review.** On 8 May 17 the SP attended a Medical Board at Blandford Medical Centre where he was upgraded to Medically Limited Deployable – Temporary (MLD - T). **F116/8**

1.4.37. **Medical Review.** On 4 Jul 17, following further reconditioning PT the SP attended another Medical Board at Blandford Medical Centre where he was upgraded as Medically Fully Deployable (MFD). **F16**

1.4.38. **PNCO Course.** From 24 Jul to 4 Aug 17 the SP attended a PNCO Course at 11 (RSS) Sig Regt. He successfully completed the critical command and leadership objectives of the course and a conditional pass was awarded. A successful upgrade to satisfactory PFA within six months was required before he was considered to have completed the PNCO Course. **F7**

Transfer of Closed CAP from 11 (RSS) Sig Regt to 1 MI Bn

1.4.39. 11 (RSS) Sig Regt did not transfer the closed VRMIS CAP to 1 MI Bn. The Unit SVRM Lead stated he "*was unaware of the direction in AGAI 110 Army SVRM policy"*. He believed that the requirement to transfer for a closed CAP was not clear within AGAI 110 – Army SVRM Policy. **F131**

1.4.40. **Requirement to Transfer a Closed CAP.** AGAI 110 – Army SVRM Policy[15] stated at para 110.023. "*Assignment or Temporary Detached Duty. If a soldier who is subject to (or has been the subject of) a CAP is assigned to another unit then the following action must be taken: (1) Losing Unit is to: (a) Forward the CAP for the personal attention of the new CO, irrespective of whether the CAP is still live or closed"*. The direction was contained within a paragraph entitled "*Reports*" within a section entitled "*Stage 3 Initiating the Care Assessment Plan*". **F196**

Opinion

1.4.41. The Panel are of the opinion that the closed CAP was not handed over in accordance with AGAI 110 – Army SVRM Policy. This meant that 1 MI Bn were not aware that the SP had attempted self-harm on 4 Mar 16 whilst at Blandford and the subsequent support he received. This significantly reduced the situational awareness of 1 MI Bn. The Panel are of the opinion that had 1 MI Bn received the closed CAP from 11 (RSS) Sig Regt, that it is probable,

[15] AGAI 110 – Army Suicide Vulnerability Risk Management (SVRM) Policy dated Aug 12 in force.

that 1 MI Bn would have conducted an Individual Case Conference prior to, or immediately following the arrival of the SP. The knowledge of the previous self-harm attempt would have permitted 1 MI Bn to place into context any subsequent events, or interaction with the SP. Although the Panel note that the attempted self-harm event would remain visible to Defence Primary Healthcare via the medical records of the SP. The Panel determined that the closed CAP not being handed over in accordance with AGAI 110 – Army SVRM Policy was an Other Factor.

1.4.42. It is the opinion of the Panel that the version of AGAI 110 – Army SVRM Policy in place in Aug 17 contained only a single sentence directing the requirement to handover a closed CAP and that the sentence was not located within the most appropriate section of the AGAI. The Panel determined that the direction contained in the extant version of AGAI 110 – Army SVRM Policy in place in Aug 17 mandating the handover of a closed CAP of a SP being posted to a new unit lacked clarity and was an Other Factor.

1.4.43. The Panel note that the reissue of AGAI 110, now titled Vulnerability Risk Management (dated Aug 20), contains direction on the requirement to transfer a closed CAP that is significantly clearer, more appropriately located within the document and that it makes specific reference to SP moving from a training unit into a regular unit. The reissue of AGAI 110 in Aug 20, has removed the requirement for the Panel to make recommendations relating to the clarity of the direction to handover a closed CAP on assignment within AGAI 110.

Recommendations

1.4.44. 11 (RSS) Sig Regt ensure that the Unit comply with the requirement contained within AGAI 110 – Vulnerability Risk Management to handover a closed CAP when a SP is assigned to a new unit.

1.4.45. Professional Development Branch, Directorate of Personnel, Army HQ review the effectiveness of the training delivery during the All Arms Adjts Course of the requirement contained within AGAI 110 – Vulnerability Risk Management to handover a closed CAP when a SP is assigned to a new unit is covered during the course.

Posting to 1 MI Bn / Arrival at 1 MI Bn

1.4.46. On 14 Aug 17 the SP was assigned as an acting LCpl to 1 MI Bn, Catterick as a Communications Systems Engineer Technician (Class 3) for a five year posting until 14 Aug 22. He joined the six man[16] Communication Information Systems (CIS) Dept within HQ Company as the Information Communications Systems JNCO.

F8
F5
T2/15/B
F14

Chain of Command Arrival Interviews

1.4.47. **HQ Coy.** On 7 Sep 17, Witness 4 conducted an arrival interview. It was recorded that the SP had completed a PNCO course at 11 (RSS) Sig Regt but had yet to pass a PFA. Witness 4 noted under welfare issues that

F54
T4/29/B-C

F51/2

[16] 1 x SSgt, 2 x Sgt, 1 x Cpl, 2 x LCpl.

the SP had personal issues. He referred the SP for an interview with the Unit Welfare Staff, as he had mentioned financial issues during his initial interview.

T2/13/B

Welfare interview

1.4.48. On 2 Nov 17 Witness 5 conducted a welfare interview with the SP. A full HARDFACTS assessment was carried out. The SP stated he was in good spirits. Witness 5 noted that the SP "*is very positive and motivated for his Army career".* Witness 5 noted that the SP expressed that he was confident to approach the CoC if he needed further support. Witness 5 confirmed with the AWS that there was no open / ongoing case for the SP.

F52

Sep 17 to Sep 18

1.4.49. Witness 2 noted the SP fitted in well, was liked by his co-workers, and that his initial impressions were "…*he was motivated and willing to learn*". Witness 3, commented that he "...*seemed genuinely keen to learn and happy to be there*".

T2/12/D - F
T2/15/C
T3/20/B

1.4.50. **PNCO Course.** Over the period 9 to 20 Jul 18 the SP attended a two week PNCO Leadership at Defence College of Technical Training. Witness 4 noted that the SP was required to retake the PNCO course due to not having completed an outstanding requirement within the specified timescale from his previous PNCO course.

F8
F7/13
F7
T4/29/C

1.4.51. **SJAR 17 / 18.** On 31 Jul 18 the SP received his SJAR covering the period 14 Aug 17 to 31 May 18. He was graded B[17] with a Yes recommendation for promotion one rank up. Witness 2 reported the SP had deployed on various exercises and had successfully delivered CIS and BOWMAN lessons to 45 soldiers.

F14

Sep 18 to Sep 19

1.4.52. **Off Duty Assault.** On 9 Nov 18, (approx 0235 hrs) the SP was assaulted whilst socialising off duty in Catterick. Following treatment by Catterick Garrison Medical Centre on 12 Nov 18, the SP was placed fit for Limited Duties for 10 days which was subsequently extended by a further 35 days on 22 Nov 18. (See TOR 7 for further details).

T11/29/E-H
F72
F72C
F16D

1.4.53. **SJAR 18 / 19.** On 7 May 19 the SP received his SJAR for the period 01 Jun 18 to 31 Mar 19. Witness 25 reported he had obtained CSE Class 2 status. Witness 25 noted "*he has worked hard to improve his CIS technical knowledge…*[the SP] *has delivered high quality Tactical CIS training to Bn personnel….He is an honest and dependable JNCO".* The SP was graded B – as an overall performance grade, with a developing recommendation for promotion one rank up.

F15

1.4.54. **Ex GREEN ROOSTER.** The SP participated in Ex GREEN ROOSTER, an adventure training exercise which took place in France over the period 2 to 11 Aug 19. The expedition organiser, noted that the SP participated fully in the exercise, appearing "*relaxed*" and "*happy*".

F122
T25/53/G-H

[17] B Grade – Defined as "Performing to standard expected in all respects".

1.4.55. **Radio Collection Duty.** On 12 Sep 19, the SP and another JNCO were tasked by Witness 18 to collect the BOWMAN radio equipment required for Ex GREEN VANGUARD.	**T20/212/C** **T20/192/G**
Radio Equipment Check / Potential Administrative Action	
1.4.56. **Radio Equipment PACEX.** On either 12 Sep or 13 Sep 19 Witness 25 asked the SP to carry out a PACEX[18] equipment check of the radios to be used on Ex GREEN VANGUARD. The SP informed Witness 25 that he had already conducted the PACEX of radio equipment and was happy all the BOWMAN equipment was fit to deploy.	**T28/163/B-E** **T28/142/B-C** **F69**
1.4.57. **Radio Equipment Checks.** On 17 Sep 19, prior to deploying in support of Ex GREEN VANGUARD, Witness 18 conducted a management check of the radio equipment. He discovered that three BOWMAN radios were unserviceable. The radios were required as safety communications to be used on Ex GREEN VANGUARD. Witness 18 therefore determined that the PACEX could not have been conducted by the SP.	**T20/212/D** **F69** **T20/195/D**
1.4.58. **CIS Dept WhatsApp Message to The SP.** Witness 18 made and sent a video message to the WhatsApp CIS Group demonstrating the failings of the SP to PACEX the radio equipment.	**F158**
1.4.59. **Witness 25 Interaction.** On 25 Sep 19 Witness 25 spoke to the SP and gave him some positive feedback regarding his performance on Ex GREEN VANGUARD. Additionally, he informed him that he would face Administrative Action[19] in relation to him having stated he had conducted a PACEX of the radio equipment prior to Ex GREEN VANGUARD.	**T28/142/H** **T28/143/A-D**
The SP's Concerns Over Potential Administrative Action / Alleged Mistreatment Within the CIS Dept, 1 MI Bn – 25 Sep 19	
1.4.60. **Initial Concerns Raised to Witness 23**. At approx 0930 hrs Witness 13, went to see Witness 23 and informed him that "…*He'd noticed a change of character of* [the SP] *within the block and he was concerned that he was being sort of mismanaged and bullied within his section".* As a result of the interaction, Witness 23 informed Witness 21, and also sent for the SP.	**F67** **T25/54/G** **T25/55/A** **T25/56/B**
1.4.61. **Immediate Follow Up by Witness 23.** At approx 1130 hrs Witness 23 spoke to the SP and noted he was anxious and concerned about the impending Administrative Action. The SP also highlighted his concerns about his perceived unfair treatment within the CIS Dept. Witness 23 informed the SP that he would brief Witness 21 on the issue and that it would be investigated on 26 Sep 19.	**T25/56/D-F** **F69** **F67** **T25/57/A-D**
HQ Coy Alleged Mistreatment Investigation - 26 Sep 19	
1.4.62. At approx 0830 hrs Witness 23 went to see Witness 21 to discuss the concerns raised by the SP, handing him a copy of a written statement made by Witness 13.	**T25/58/D-E** **F152** **T23/23/A**

[18] PACEX – Preparation and Confirmation Exercise.
[19] Administrative Action - action taken to safeguard or restore the Operational Effectiveness and efficiency of the Army by commanders using their command authority under Queens Regulations (Army). (AGAI 67 Administrative Action, Para 67.003)

1.4.63. At approx 0900 hrs Witness 21 interviewed the SP. Witness 23 recorded in his contemporaneous notes that the SP raised issues that he felt he was; "*treated differently in the section...*, *leave not granted when he requested it…, feeling of no support from his CoC… constantly being under a microscope, the placement of work around the section and being made to feel over worked*". In addition, the SP was "*unsure why AGAI* [Administrative Action] *was awarded and why such a harsh punishment was discussed*".

F67
F69

1.4.64. At approx 1000 hrs Witness 21 held a meeting with Witness 18 and Witness 25, he presented the concerns raised by the SP and Witness 13. The agreed outputs from the meeting were for the CIS Dept SNCO's to amend their management style to be more inclusive. Witness 21 determined "*it wasn't a case of he* [the SP] *was being shoved out or treated differently…,...it became apparent that they had a good management style, it was just misunderstood by* [the SP]". Witness 21 noted "*I don't believe he was being bullied*". Witness 25 recalled that an outcome of the meeting was that he was to have an informal chat with the SP in order to find out what his issues were and what he can do to allay them.

T28/149/D
F67
T23/8/B-F
T23/26/A
T23/9/A-D
T28/149/H

1.4.65. At approx 1100 hrs Witness 21 held a follow up meeting with the SP; Witness 23 was in attendance. The SP was informed of the meeting held with the CIS Dept SNCOs. Witness 21 noted that the SP was "*happy"* with the outcome and recommendations given to the CIS Dept "*to make people feel more included within the Dept*". The SP later informed Witness 23 that he "*felt the Chain of Command were not taking him seriously*" and that he "*didn't feel his investigation was getting done*".

F67
T23/9/C
T25/84/C-D

1.4.66. Witness 21 informed Witness 14 of the conduct and outcome of his investigation, including a summary of each meeting. No other potential witnesses were interviewed. The details of the allegations made by the SP were not logged or the details of the meeting with the CIS Dept SNCOs.

T23/9/E
T23/25/B
T23/25/E
T23/26/C-D

Conduct of Alleged Mistreatment Investigation

1.4.67. During Hearing 1 it was confirmed that JSP 763 MOD Bullying and Harassment Complaints Procedure was not followed when the SP reported his concerns. 1 MI Bn had a Diversity and Inclusion Standing Order 1016 (dated 20 Feb 18) which stated "*If an individual believes they are being treated unfairly then a commander at the appropriate level, should take action immediately to understand the nature of the problem and see if it can be dealt with informally there and then by means of a simple apology. The Lead Equality Diversity and Inclusion Advisor (EDIA) is to be immediately made aware and if the situation has not been resolved he / she will ask for an officer to be appointed to investigate the matter".* This 1 MI Bn Standing Order was only partially followed and the Lead EDIA was not informed either immediately or subsequently, noting "*I had no awareness prior to him being found dead*".

T23/24/B
F203
F79A/4
T27/113/G

1.4.68. The Panel note that within 1 MI Bn, Witness 23 knew of two SNCOs and three JNCOs that were aware of the SP being treated differently. He noted the two SNCOs had "*seen him being mistreated*". Witness 23 informed the HQ Coy, 1 MI Bn Chain of Command, however the SP were not interviewed as part of the mistreatment investigation. Witness 13 produced a statement dated 25 Sep 19 for what he described as "*during the bullying case*" and that it was "*a pretty detailed account of what* [the SP] *was*

T25/55F-H
T25/64/B
T25/56/A
F152
F68
T14/82/G

going through at the time". The statement was not used as part of the mistreatment investigation. Witness 14 did not recall "*being aware of the document*" and Witness 21 could not recall receiving any written statements relating to the SP. **T14/82/D** **T15/120/A** **T23/23A**

1.4.69. The Panel are aware that the SP kept a timeline of events covering the period 21 Jun 18 to 26 Sep 19 recording his perceived mistreatment. This document only came to light following his death and was provided to the SI and the North Yorkshire Coroner by the NoK. **F165**

Service Complaint

1.4.70. The SP had not submitted a Service Complaint. Although he had expressed an intent to Witness 10 and Witness 23. The SP had also discussed making a Service Complaint with Witness 20 and requested them to assist him which they agreed. Witness 20 commented they were "*more than happy to help him",* advising him for it to be factual and contain evidence. The SP did not subsequently contact Witness 20 for advice. Witness 23, noted that the SP "*had mentioned a service* complaint *…and I had said I would support him in doing so if he wished…"*. **T11/27/D** **T25/68/H** **T25/74/G** **F68** **T22/264E-G** **T23/17/F**

1.4.71. JSP 831 Redress of Individual Grievances: Service Complaints gives guidance relating to bereaved families identifying potential complaints after a SP has died. **F202**

a. Chap 11, para 4 states "*A family member of a deceased service person cannot make a service complaint. That does not mean however that if they discover an issue after the death that relates to the deceased's service in the armed forces no action should be taken to help them. Who they should be advised to approach will depend on the matters raised*:

(1) *Alleged mistreatment: the deceased's Commanding Officer.*

Opinion

1.4.72. The Panel are of the opinion that by not following JSP 763 MOD Bullying and Harassment Complaints Procedure or the Unit Diversity and Inclusion Standing Order 1016 in full and by not interviewing all known witnesses and seeking other potential witnesses, that the investigation into the potential mistreatment of the SP did not follow policy and was not effective. The Panel determined that not following JSP 763 MOD Bullying and Harassment Complaints Procedure or the Unit Diversity and Inclusion Standing Order 1016 to investigate the alleged mistreatment of the SP was an Other Factor.

Recommendations

1.4.73. 1 MI Bn follow the direction in JSP 763 MOD Bullying and Harassment Complaints Procedure when investigating allegations of mistreatment.

1.4.74. 1 MI Bn follow the direction in 1 MI Bn Diversity and Inclusion Standing Order 1016 when investigating allegations of mistreatment.

1.4.75. Bereavement and Aftercare Support (BAS), Pers Svcs Br, HQ APSG inform the NoK of the SP that JSP 831, Redress of Individual Grievances: Service Complaints, Part 2 Guidance, Chapter 11 gives guidance relating to bereaved families identifying potential complaints after a SP has died, including alleged mistreatment.

1.4.76. **Witness 25 Follow Up Meeting with The SP.** On 26 Sep 19 Witness 25 held a follow up meeting with the SP. He told him "*I am here to discuss what we can do to make you feel better about your situation in the CIS Dept*". During the meeting the SP tried to talk Witness 25 out of conducting Administrative Action. The SP highlighted the issues of concern; dislike of living in the SLA, having to take block leave in the summer, wanting to deploy on a tour and not enjoying working in the CIS Dept. Additionally, the SP informed him that "*he felt suicidal in the block in the summer",* but felt alright now. Witness 25 did not log the detail of the meeting with the SP nor did he report the conversation to the Chain of Command.

T28/152/B
T28/150/B-H
T28/152/A-H
T28/152/B-C

Incident in the SLA - 26 Sep 19

1.4.77. At approx 1900 / 1930 hrs Witness 23 was contacted by Witness 13 and informed that the SP was in the SLA upset. Witness 13 sat with the SP who was "*in an emotional state"* concerned about the potential Administrative Action.

F67
F69
T14/64/D-G
T14/65/C

1.4.78. Witness 23 informed Witness 21 of the incident as it was occurring. Witness 21 called the SP and talked for over an hour reassuring him and confirming that he was not a threat to himself or others; he also informed Witness 20 and outlined the support services in place to the SP (Medical services, 1 MI Bn Welfare Dept, and Padre). The incident ended as the SP calmed down, became more positive and returned to his room. Witness 21 informed the SP that he would speak to him the following morning during a prescheduled routine SLA inspection.

T23/10/A-E
T23/11/E
T14/65/G
T23/11/E

SLA Inspection / Medical Appointment - 27 Sep 19

1.4.79. **SLA Inspection.** At approx 0800 hrs following a SLA inspection Witness 21 and Witness 23 spoke to the SP in his room. He was "….*sat on his bed…..crying, hysterical, uncontrollably crying, but when asked what was making him sad he didn't know"*. Witness 23 noted that he raised issues relating to the impending Administrative Action and his encounter with Witness 25 on the afternoon of 26 Sep 19.

T23/11/B-G
F69
T25/61/G
T23/12/A

1.4.80. **Medical Appointment.** At 1030 hrs the SP attended a medical appointment at Catterick Garrison Medical Centre, arranged by Witness 21, accompanied by Witness 23. The MO spoke to Witness 23 following the appointment and informed him that the SP was fit to attend a forthcoming Battlefield Study (BFS) to Malta and that he was not at risk of self-harm. Witness 23 was told by the MO that he recommended the SP be removed from his current working environment.

F16
T23/11/B-G
F5/111
T25/63/A-H
F67

1.4.81. **Medical Appointment Recording.** It was not recorded on DMICP

that the MO had interacted with Witness 23 following the appointment with the SP and also provided him with employment advice relating to the SP. Witness 27, of the Catterick Garrison Medical Centre noted that "*It would have been helpful for it to have been recorded on* DMICP*....in addition to that, it also means that you've documented the occupation advice given on record".* T30/189/C T30/189/E

Opinion

1.4.82. It is the opinion of the Panel that medical interaction with the Chain of Command and the provision of employment advice should be recorded on DMICP in order to maintain a comprehensive record of medical support / advice provided. The Panel determined that the non-recording on DMICP of the provision of employment advice and interaction with the Chain of Command whilst not a deviation from policy was an Other Factor.

Recommendation

1.4.83. Defence Primary Healthcare (DPHC) remind medical teams to record all significant communication regarding the health / employment suitability of a SP with the Chain of Command, within the SP's DMICP record.

1.4.84. **Medical Appointment Follow Up.** Following the appointment on 27 Sep 19 Witness 23 phoned Witness 14 and informed him of the events and also that two SNCOs and five JNCOs had come forward to say that the SP was being treated differently and that this could not be ignored. Additionally, he informed Witness 19 and it was decided that the SP would report to the Welfare Dept on 7 Oct 19. **T25/64/A - H** **F16** **F67**

Ex MALTESE CROSS

1.4.85. The SP took part in Ex MALTESE CROSS, a 1 MI Bn led BFS to Malta, over the period 30 Sep to 5 Oct 19. Witness 23 noted that "*during the 5 days I could clearly see a difference in him, his character was completely different",* describing his demeanour as "happy", adding "*It was like how I saw him back in August, so he was acting as if nothing had happened*.." Witness 20 noted they were with the SP on the exercise *"he was relaxed and did not exhibit any of the symptoms that he had shown on 27 Sep 19*". **F124** **F67** **T25/67E-F** **F68**

Week Commencing 7 Oct 19 (7 to 13 Oct 19)

Welfare Interview

1.4.86. On 7 Oct 19 the SP had a HARDFACTS welfare interview with Witness 20. Witness 20 recorded in the interview notes that "*I do not believe he is a risk to himself at this time. He is not suicidal and is not having thoughts of self-harm at this time. He is however highly stressed and anxious about going back to work in the CIS section. He has made notes and will make a Service Complaint if the situation isn't resolved*". The SP informed Witness 20 "*…. that he'd been suicidal in the block for the last two Christmas's* [2017 / 2018]" adding in relation to summer leave 2019, "*He made the same comment about that and saying that he'd been forced to take three weeks leave, which meant that he was suicidal in the block".* The SP also stated, "*He did try and take his own life back in 2015 whilst at Blandford….".* **F5/113** **F68** **T22/256-257** **T22/277/E-** **T22/278/F** **F68**

1.4.87. On 8 Oct 19 the SP had an additional interview with Witness 20. The SP highlighted concerns relating to the impending Administrative Action and outlined concerns relating to "*workplace bullying, different management styles… dictatorial approach on the management side*".

T22/258/A-H
T22/259A-F

1.4.88. Witness 20 distributed a detailed HARDFACTS interview record on 8 Oct 19 to Witness 14, Witness 19, Witness 21 and Witness 23. Witness 20 included detail that "*He did try and take his own life back in 2015 whilst at Blandford…*" and that the SP had informed Witness 25 that he had been suicidal during summer block leave. Witness 20 did not include the details that the SP stated he had been feeling *"suicidal in the block for the last two Christmas's* [2017 / 2018]" in the interview record. Within the interview record Witness 20 noted "*I do not believe he is a risk to himself at this time. He is not suicidal and is not having thoughts of self-harm at this time. This he was pressed on several times*".

F68
T22/278/F
T22/279/F-G
T220/13
F68

1.4.89. Neither the originator, nor the recipients of the HARDFACTS interview record reported the knowledge of the previous self-harm attempt, or that the SP had been on occasion feeling suicidal to the 1 MI Bn VRM Lead. The 1 Bn VRM Lead noted that they would have expected to have been informed of a previous suicide attempt and also that the SP had expressed suicidal feelings. Witness 28 confirmed that he would have expected to have been informed of those events, noting that "*we would have had a case conference*" adding "*I think it would have been really important to discuss in a case conference with the doctor involved*". Witness 28 clarified "…*my welfare team and headquarters company didn't pass as much information to me as they should have done*" adding "…..*in this particular case they just got the wrong call and that it would have been the right thing to do to tell Battalion Headquarters* [and], *had a case conference.*

T32/278/A-B
T31/243/H
T31/244/C
T31/247/E-F

Opinion

1.4.90. The Panel are of the opinion that originator and recipients of the HARDFACTS interview report not informing the 1 MI Bn VRM Lead of their knowledge of a previous self-harm attempt, or that the SP had been on occasion feeling suicidal denied BHQ 1 MI Bn the information on which to consider holding a case conference. The Panel note that Witness 28 was clear that had he been made aware of the events a case conference would have been held, with medical input. The Panel determined that personnel not informing the 1 MI Bn VRM Lead of the previous self-harm attempt, or that the SP had been on occasion feeling suicidal was an Other Factor.

Recommendation

1.4.91. 1 MI Bn advise all unit personnel that the Unit VRM Lead must be made aware of any disclosure of previous suicide attempts or expressions of suicidal ideation by SP in order that an Individual Case Conference can be held in accordance with AGAI 110 – Army VRM Policy to formally consider risk.

1.4.92. **Medical Appointment.** On 8 Oct 19 the SP attended a medical appointment at Catterick Medical Centre. The MO gave the SP six days unfit for work. The MO noted on the proforma that he had discussed this case with Witness 19. The SP took sick leave from 8 to 14 Oct 19.

F5/113
F56
T30/184/A
F16

1.4.93. **Decision to Move the SP to the QM's Dept.** On / around 11 Oct 19 (witness unsure of exact date) Witness 14 made the decision to move the SP temporarily from the CIS Dept to the QM's Dept. He made the decision on the basis that the relationship between the CIS Dept and the SP had "*broken down*" and that he had "*administrative action hanging over him".*

F5/113 T15/97/G T15/98/D-G

Week Commencing 14 Oct 19 (14 to 20 Oct 19)

1.4.94. **QM's Department.** On 14 Oct 19 the SP started working in the 1 MI Bn QMs Dept under the supervision of Witness 23. It was noted that the SP remained concerned about the impending Administrative Action but was "*happy he wasn't in the CIS* [Dept]". The period 14 to 16 Oct 19 was used to assess how the SP was following the period of sick leave.

F5/114 T25/69/G T25/70B

1.4.95. **Witness 21 Contact to Medical Centre.** On 15 Oct 19 Witness 21 contacted Catterick Garrison Medical Centre to discuss the SP noting "*his general morale had dropped again from returning from Malta".* The MO arranged a medical appointment for the SP on 16 Oct 19.

F16 T23/13/E

1.4.96. **Witness 14 Contact to Personnel Recovery Unit (North) PRU (N).** On 15 Oct 19 Witness 14 attended a conference where the PRU (N) presented details about the support that they could offer to SP. Following the presentation Witness 14 spoke to Witness 7, PRC (N) to discuss potential support for the SP and it was agreed that Witness 21 would make contact.

F16 T15/99/A-G T7/53/A-E F126

1.4.97. **Medical Appointment.** On 16 Oct 19 the SP attended a medical appointment at Catterick Garrison Medical Centre. The MO issued a Light Duties Proforma to the SP "*Fit for Limited Duties – Unfit Weapon Handling 14 days*."

F16 F56 T30/190/C

1.4.98. **Knowledge of Light Duties Limitations.** 1 MI Bn received the Light Duties Proforma issued to the SP by the MO on 16 Oct 19. However, Witness 18, Witness 21, Witness 23 and Witness 25 were not aware that the SP had been issued a Light Duties Proforma preventing his access to weapons for a 14 day period. The SI Panel were unable to determine the reason why 1 MI Bn personnel were not aware of the restrictions.

F56 T23/18/D T25/74/F T28/156/D T20/218/E F56A

Opinion

1.4.99. The Panel are of the opinion that when issuing Light Duties Proforma that contain safety critical restrictions (ie unfit driving, unfit Weapon Handling) that the issuing Medical Centre should consider the risk, related to patient safety, of the Light Duties Proforma not being received by the Unit Chain of Command. The Panel determined that lack of awareness amongst 1 MI Bn personnel that the SP had been issued a Light Duties Proforma preventing his access to weapons for a 14 day period was an Other Factor.

Recommendation

1.4.100. Defence Primary Healthcare (DPHC) remind all staff to consider risk to the patient when issuing safety critical Light Duties proforma (ie unfit weapon handling) and where a medical concern exists relating to patient safety they are to contact the Chain of Command directly to ensure that the SP has presented the Light Duties proforma and to discuss the risk mitigation

measures / patient safety; the interaction is to be recorded on the SP's DMICP record.

1.4.101. **Formal Interview.** On 17 Oct 19, Witness 25 conducted a Formal Interview with the SP. Witness 23 was in attendance. The interview was in relation to the conduct of SP prior to Ex GREEN VANGUARD 1/19. **F69** **T25/72/D**

Week Commencing 21 Oct 19 (21 to 27 Oct 19)

The SP Not Reporting for Duty

1.4.102. On 21 Oct 19 the SP did not report for work in the QM's Dept at 0830 hrs. Witness 23 instructed Witness 13 to go to the SLA to look for him. Witness 13 discovered the SP in his room in the SLA and informed Witness 23 that the SP "*has slept in and is a bit worse for wear*". **T25/71/B-C**

1.4.103. Witness 23 went to the SP's room, the SP explained to him that "*he had a drink to try and get to sleep*". Witness 23 advised the SP to go to the MO if he had difficulty sleeping and the subsequently took him to the cookhouse before the SP went into work. Witness 23 noted that the incident was "*out of character*" this was the only incident where the SP had "*failed to show for work…..it was the only blip in the whole three – four month period I dealt with him*". For the remainder of the week Witness 23 noted that the SP was happy and in engaging in work within the QM Dept. **T25/71/D-G** **T25/72/B**

1.4.104. **PRU (N) Engagement.** On 22 Oct 19 the SP visited PRU(N) at Catterick accompanied by Witness 21. Witness 7 showed the two of them around PRU (N) and it was agreed that the Centre could offer the SP some respite support as part of an ongoing trial being conducted by the PRU (N). **T23/15/B** **T7/54/B** **F126**

1.4.105. **Medical Appointment.** On 23 Oct 19 the SP attended a medical appointment at Catterick Garrison Medical Centre. The MO referred the SP to DCMH. **F16** **F17A**

1.4.106. **The SP Selected for 77 Bde Target Audience Analyst (TAA) Trawl.** On 21 Oct 19 Witness 21 informed the Ops Cell, 1 MI Bn that the SP was a volunteer for a trawl to support 77 Bde over the period 2 Dec 19 to 7 Sep 20 based at Hermitage. On 24 Oct 19, Witness 28 approved the selection of the SP as a supported volunteer for the Trawl. On 28 Oct 19, 1 MI Bn were informed by HQ 1 ISR Bde that the SP had been selected for the 77 Bde trawl as a Target Audience Analyst (TAA); the only SP from 1 MI Bn. **F1/11** **F60**

Week Commencing 28 Oct 19 (28 to 10 Nov 19)

The SP Attends PRU (N) Course

1.4.107. On 28 Oct to 1 Nov 19, the SP attended a residential course at PRU (N) in Catterick, the aim being to provide him "*respite*", Witness 7 engaged with the SP during the course and conducted an interview with him at the end of the course noting "*he seemed much happier in himself, a lot brighter*". Over the period 4 to 8 Nov 19 the SP attended a second residential course at the PRU (N). **F126** **T7/54/F** **T7/56/C-E** **F126/2**

1.4.108. Witness 7 noted that the SP had said that "….*he was a little apprehensive about returning to work but felt supported by his Chain of Command". Adding* that "*He didn't display any vulnerable or suicidal signs*" and regarding the temporary attachment to 77 Bde "*that he'd volunteered"* and *"was looking forward to it"*. Witness 21 believed that the intent on making the SP's mindset more positive coming out of the PRU had worked.

F126/3
T7/59/G
T23/16E

Week Commencing 11 Nov 19 (11 to 17 Nov 19)

1.4.109. **Return to the CIS Dept.** On 11 Nov 19 the SP returned to work in the CIS Dept, 1 MI Bn. Witness 25 noted that for the two week period leading up to his departure for the 77 Bde trawl his demeanour was normal and that he was "*happy…… interested…..engaging*", adding "*didn't seem at all anxious..".* The main focus was on enabling the SP to prepare for his temporary attachment to 77 Bde.

F5/118
T28/147/E-F

1.4.110. **DCMH Medical Appointment.** On 11 Nov 19 the SP attended an an Initial Assessment medical appointment at DCMH Leeming having been referred by the MO on 23 Oct 20.

F16
F17A

1.4.111. **Welfare Interview.** On 11 Nov 19, the SP had a welfare meeting. Witness 20 noted "*you could see he'd really got a lot of being at the* [PRU (N)]*".* The SP discussed his thoughts on making a Service Complaint, Witness 20 reiterated that they were more than happy to help.

T22/260/E-H
T22/261/H
F68
T22/264/E-H

1.4.112. **DCMH Follow Up / Determination.** On 13 Nov 19, DCMH Leeming held a Multidisciplinary Meeting (MDT) which considered the SP. The conclusion of the MDT was "*no mental health input required, discharge from DCMH with advice to contact Unit Equality and Diversity Advisor*, *AWS for support and Speak Out* [helpline]".

F16
F17A
F16B

DCMH Discharge Process

1.4.113. On 13 Nov 19, DCMH Leeming attempted to contact the SP by telephone to inform him of his discharge from DCMH. Phone contact could not be established and there was no facility to leave a message therefore DCMH Leeming conducted the discharge by email. The email contained details of recommendations for further support; EDIA, AWS, Speak Out helpline and to contact DCMH Leeming if he had any questions.

F17A

1.4.114. The Case Review conducted by DCMH Leeming on 27 Jan 20 following the death of the SP identified that "*attempts at telephone contact had failed, this should have been pursued".* The DCMH Case Review made a local DCMH Leeming recommendation (that has been implemented) relating to the requirement to speak directly to patients when feeding back results of a MDT decision and to follow up one off assessments with the offer of a face to face appointment to check that recommended pathways are being followed.

F18
F16A/5
F18

Opinion

1.4.115. The Panel are of the opinion that when DCMH clinicians are providing feedback to patients on the results of a Multidisciplinary Meeting or when discharging them from DCMH care that they must make attempts to speak directly to the patient before sending an email. The Panel determined

that DCMH Leeming not contacting the SP in person to inform him that he was being discharged from DCMH care was an Other Factor.

Recommendation

1.4.116. Defence Primary Healthcare (DPHC) should adopt clear policies that, wherever possible, DCMH Multidisciplinary Team meeting (MDT) decisions should be communicated in person, either directly, by video consultation or by phone and that only after several attempts have been made to contact the patient in person should discharge decisions be communicated by email or letter.

Week Commencing 18 Nov 19 (18 to 24 Nov 19)

1.4.117. **MPAR TY 19 / 20.** On 21 Nov 19 the SP received his MPAR from Witness 25 covering the first part of the reporting period from 01 Apr 19 to 31 Mar 20. The MPAR noted that "*first half of the year had seen contrasting periods…..He has continued to deploy on dept taskings and delivered BOWMAN training to the Bn at a good standard ….I have seen a good improvement in fitness; an area of weakness that he is turning around into one of relative strength".* **F15A**

Week Commencing 25 Nov 19 (25 Nov to 1 Dec 19)

1.4.118. **1 MI Bn 77 Bde Uplift FRAGO.** On 27 Nov 19, the Ops Cell, 1 MI Bn issued a 1 MI Bn Fragmentary Order (FRAGO) 56/19 to cover the detachment of the SP as a TAA to 77 Bde. Witness 25 forwarded the FRAGO by email to the SP, he noted that he was a volunteer for the trawl and was "*really happy to go, he really wanted to go".* The FRAGO noted that Uplift personnel were joining existing teams. **F61** **T28/155/A-D**

a. The FRAGO tasked the SP to:

(1) Complete the Military Psy Ops Course 2 to 13 Dec 19. **F61/4**

(2) Operate as a Target Audience Analyst in support of 77 Bde.

(3) Conduct tasks as directed by 77 Bde Chain of Command.

(4) Provide 1 MI Bn Ops with positive confirmation of safe arrival at RAF Halton, Hermitage and safe return to the Unit on completion.

b. The FRAGO required the SP to report as follows:

(1) **Military Psy Ops Course.** 2 Dec 19 (NLT 0900 hrs), Joint Information Activities Group, lecture theatre, RAF Halton. The SP was directed to confirm safe arrival to 1 MI Bn Ops. **F61/7**

(2) **77 Bde Uplift.** 16 Dec 19, 77 Bde Conference Room, Hermitage. The SP was directed to confirm safe arrival to 1 MI Bn Ops.

1.4.119. **1 MI Bn Readiness Administration Check (RAC)[20].** On 28 Nov 19, the SP conducted a personal 1 MI Bn RAC prior to his temporary detachment to 77 Bde. He also confirmed that he had verified his Emergency Contact and Next of Kin details on JPA prior to attending the RAC. A 1 MI Bn RAC Check Sheet was completed along with a Temporary Absence Form showing the dates of his detached duty as 2 Dec 19 to 7 Sep 20.

F8

Military Psychological Operations Course (MPOC) - RAF Halton

1.4.120. Over the period 2 to 13 Dec 19 the SP attended the MPOC at the Joint Information Activities Group (JIAG), RAF Halton. The course was attended by a total of 28 SP. Witness 34 had daily interaction with the SP during the course noting that "[The SP] *demonstrated a positive attitude, appeared cheerful and interacted well with both instructors and other students"* adding "*he was looking forward to going and working at 77 Bde*". The SP passed the course.

F141
F127
F170

1.4.121. Witness 37 interacted with the SP both during the course and socially, describing feelings of the SP towards the MPOC as "*he was enthusiastic to be involved with it and get on with it".* Witness 38 noted that during the MPOC the SP was "*really keen to start at 77 Bde*" and described his state of mind as "*optimistic*". Witness 39 described the SP as "*enjoying the course*" and about his attitude towards going to 77 Bde as "*he seemed pretty excited about it*".

T39/43/B-G
T39/44/E
T40/65/G
T40/66/A
T41/95/B-C

1.4.122. On 4 Dec 19, Witness 46 visited the MPOC. As part of his visit he briefed the Uplift personnel collectively to ensure that they knew their next reporting timing and location was 16 Dec 19 at Hermitage as per the 77 Bde Uplift JIs.

T48/297/E-H
T48/298/E

Arrival at 77 Bde - 16 Dec 19

1.4.123. On 16 Dec 19 the SP, reported to a Conference Room within Hermitage. Witness 46 was the Reporting POC for the TAA Uplift personnel as detailed in the 77 Bde – Immediate Uplift Joining Instructions. He was responsible for coordinating the TAA Uplift personnel on the 16 Dec 19 as the arrival POC. He noted of the expected TAA Uplift personnel, "*9 of the 11 were due to turn up on 16 December and every one of those was accounted for".* He stated that *"The Target Audience Analysts Uplift personnel arrived…..they began their arrivals admin procedures with the Brigade G1 staff that were present on a set of desks around the conference room*".

F2/4
T48/301/A
F61, F93
F65A
T48/302/A
T48/302/E

T48/301/D

1.4.124. Following the arrivals administration Witness 44 delivered a 77 Bde Baseline Presentation (approx 30 mins) to the uplift personnel. This was followed by a camp orientation tour and individual interviews before concluding at approx 1200 hrs with a central farewell brief by Witness 44. On conclusion of the farewell brief Witness 44 confirmed to all SP that the next reporting time was at 1000 hrs on 7 Jan 20 at Hermitage.

T46/241/D-E
T46/240/F
T46/243/F
T46/244/C

[20] Unit Administration Manual (UAM), Chap 9, Sect 4, Para 09.401 states the purpose of the RAC is to confirm by physical inspection that SPs G1 documentation is correct and in date.

1.4.125. **Arrival Confirmation / Location Preference.** Witness 43 in HQ DCSU, at RAF Henlow recalled that Witness 45 based at Hermitage, informed him by telephone on 16 Dec 19 that "*all Uplift personnel had arrived, they had been interviewed, they have conducted their arrivals process as per the joining instructions and had been secured on leave*". Witness 45 emailed Witness 43 on 16 Dec 19 a list of location preferences for the TAA Uplift SP, he listed the SP as "*keen to go to Henlow*".

T45/194/A-B
F89

1.4.126. **SP's Interview.** Witness 46 interviewed the SP on 16 Dec 19 and made contemporaneous notes. He confirmed that the SP had taken over his SLA at Hermitage. He noted that the SP "…*seemed pretty positive and upbeat….I would say he was looking forward to joining the Brigade*". There were no welfare issues raised and the SP said he was planning to spend his leave "*up North"* and was *"keen to move to Henlow"*. Witness 46 recalled that during the interview "*They were all told, every individual I told, that they had to report back on the 7th January"*. Witness 45 noted that one purpose of the interview was to determine the suitability of each SP for allocation to the DCSU Mission Teams.

T48/301/E
F82
T48/304/B
F2/10
T48/301/E
T47/267/F

1.4.127. **SP Administration.** On 16 Dec 19, the SP completed a JPA Unit Arrivals Proforma as part of the G1 administration. He confirmed that he had verified his Emergency Contact and Next of Kin details on JPA.

F22
F201

1.4.128. **SP Interaction With Other SP.** Witness 38 and Witness 39 saw the SP on 16 Dec 19 but only briefly and in passing as they completed the G1 administration process.

T40/70/D
T41/96/D

1.4.129. **Communication With 1 MI Bn.** 1 MI Bn FRAGO 59/19 – 77 Bde Uplift tasked the SP to confirm safe arrival at Hermitage on 16 Dec 19 to 1 MI Bn Ops Cell. The SP did not carry out this action. The failure to confirm safe arrival was not followed up by 1 MI Bn Ops Cell. See TOR 4 for further detail.

F61/7
F61/4
T9/7/A
T9/10/G

1.4.130. **SP Departs on Christmas Leave.** On 16 Dec 19 the SP departed Hermitage (approx 1400 hrs) and arrived at Catterick Garrison at approx 1930 hrs. The SP was due to report to Hermitage on 7 Jan 20 to commence working as a TAA for DCSU within 77 Bde. He never reported for duty at Hermitage on 7 Jan 20. The activity of the SP over leave is covered under the Narrative Section and the actions of the 1 MI Bn Duty Staff in TOR 3. The actions of DCSU from 7 Jan 20 onwards is covered in both the Narrative section and under TOR 5. The Force Generation Process for the 77 Bde Uplift is covered under TOR 7.

F65A
F2

Opinion

1.4.131. The Panel are of the opinion that 1 MI Bn provided suitable support to the SP when they became aware of his concerns about the impending Administrative Action and his concerns about working in the CIS Dept. The Panel note the support provided included; temporary employment with the QM's Dept, Welfare Dept support, Chain of Command arranged medical appointments and two, one week courses at PRU (N).

1.4.132. The Panel are of the opinion that the SP had received sufficient notice for the trawl deployment date. The Panel note that 1 MI Bn raised a

bespoke FRAGO for the temporary detachment of the SP and conducted an individual Readiness Administration Check for the SP.	
1.4.133. The Panel are of the opinion that the SP was a volunteer for the TAA trawl as part of the 77 Bde Uplift over the period 2 Dec 19 to 7 Sep 20 and that he was looking forward to it. The Panel were of the opinion that his CoC willingly supported his aspiration to volunteer for the trawl. The Panel note the enthusiasm and positive demeanour displayed by the SP during the MPOC and on his initial interview on 16 Dec 19.	
1.4.134. The Panel note that the SP had been correctly moved and tracked on JPA as part of the planned 77 Bde Uplift arrivals process on 16 Dec 19. The Panel are of the opinion that the SP was aware that he was required to report back to Hermitage on 7 Jan 20, as were DCSU.	
TOR 2. Present The Facts Surrounding [The SP] Being Discovered In His SLA On 23 Jan 20.	
Findings:	
The SP's Single Living Accommodation (SLA)	
1.4.135. The SP occupied SLA within Catterick Garrison, North Yorkshire. The SLA was part of a single corridor of six separate ensuite rooms (three on each side of the corridor) which shared a combined kitchen / laundry area and a separate common room. Each of the three floors of the SLA were split into three corridors of six rooms. The SLA block contained 54 single rooms housing soldiers from a variety of units within Catterick Garrison. In the six rooms of the corridor, only three were allocated to occupants in Dec 19 / Jan 20, including the SP.	**F146**
The SP's Permission to Retain 1 MI Bn SLA	
1.4.136. 1 MI Bn had given the SP permission to retain his existing 1 MI Bn SLA during his temporary attachment to 77 Bde over the period 2 Dec 19 to 7 Sep 20 for personal reasons. The SP was scheduled to return to 1 MI Bn on 7 Sep 20 and serve with 1 MI Bn for a further two years until the end of his current posting on 14 Aug 22.	**F2** **F55** **F8**
Events Leading Up To The Discovery of The SP	
1.4.137. On the evening of 5 Jan 20, Witness 12 and Witness 13 returned from Christmas leave to their SLA. They both noticed that the room light of the SP was on (and remained on). Both Witness 12 and Witness 13 were aware that the SP was away on detachment and thought no more about it. No action was taken by either witness regarding the room light being left on.	**F143, F146** **T13/49/E** **T13/49/G** **F144** **T14/73/C-D**
1.4.138. On 21 Jan 20, Witness 12 noticed within a combined kitchen / laundry area clothes which he was aware belonged to the SP sitting on the side in the kitchen. Witness 12 took no action to contact the SP as he was aware that he was retaining his room in the SLA and assumed he would be returning to collect them.	**T13/50/D-E** **F143** **T13/50/E-H** **T13/51/C**
1.4.139. On the evening of 22 Jan 20 Witness 12 accompanied by Witness	**T14/74/B-F** **F144, F143**

13 entered the combined kitchen / laundry area and they both noticed clothes they identified as being owned by the SP. T13/51/H

Discovery of the SP - 23 Jan 20

1.4.140. On 23 Jan 20, (approx 0950 hrs) Witness 33 was approached in his office at the Garrison Support Unit by Witness 12 and Witness 13. The two SP requested to gain access to the room of the SP. Witness 33 instructed Witness 32 to accompany the two SP to the SLA to permit controlled supervised access to the room via the master key. **F138**

1.4.141. Witness 32 took Witness 12 and Witness 13 to the SLA. Witness 32 knocked on the door, getting no reply he unlocked the door using the master key. On opening the door (approx 1000 hrs) Witness 12 and Witness 13 immediately saw and recognised the SP laying on the bed. **F142 F1/A5 T13/53/C-G T14/75/E**

Immediate Follow Up

1.4.142. Witness 32 closed the door and telephoned his immediate superior Witness 33. Witness 13 immediately called the emergency services (approx 1005 hrs). Witness 12 informed Witness 23 (approx 1005 hrs) who subsequently informed the 1 MI Bn Chain of Command. **F142 T14/75/G F1/A5**

1.4.143. The 1 MI Bn response and actions of the Chain of Command is covered in full detail under TOR 6. The 1 MI Bn TRiM support provided to the SP that discovered the SP is covered under TOR 4.

Emergency Services Response

1.4.144. North Yorkshire Ambulance Service attended the incident and at 1019 hrs, confirmed the SP was deceased. North Yorkshire Police attended the scene on 23 Jan 20 and subsequently conducted an investigation determining that the room was locked and secure with the key hung on a noticeboard, there were no signs of disturbance in the room and no suspicious circumstances present. **F165/39 F165/41-45**

Opinion

1.4.145. The Panel are of the opinion that the actions carried out by Witness 12 and Witness 13 were an effective and an appropriate response to the circumstances as they perceived them at the time. There are no Event Factors attributed to TOR 2.

Recommendations

1.4.146. There are no recommendations arising from TOR 2.

TOR 3. Determine The Procedures In Place Within 1 MI Bn For All Personnel Remaining Within SLA In Barracks During Stand Down Periods. How Are These Understood, Disseminated And Assured By 1 MI Bn.

Findings:

1 MI Bn Welfare Procedures in Place for All Personnel Remaining in Single Living Accommodation (SLA) in Barracks During Stand Down Periods

1.4.147. The Christmas 19 / New Year 20 stand down period was the first time that 1 MI Bn had put in place specific local welfare procedures to support SP remaining in SLA within barracks. There is no Army policy that mandates units to carry out welfare checks on SP under such circumstances, it was a local 1 MI Bn initiative directed by Witness 28.

T16/129/A
T31/216/D
T16/129/C
T31/211/G
F64

1.4.148. Witness 28 outlined his reasoning for the implementation of the procedure *"…concern that people on their own, particularly over Christmas stand down could be having a really miserable time and that the normal support network they've got of people who are in their unit, that they're gone as well. …. the check for the BDO was to almost just give those people some reassurance and a continued contact with other people in their unit, so if they were having a miserable time then that would be lifted a little bit…..clearly if someone was sick or in any kind of trouble or any difficulty then they also had someone contacting them to see if we could help them rather than have to reach out themselves*".

T31/216/D

1.4.149. 1 MI Bn had no specific SOI / SOP in place in Dec 19 to cover procedure for welfare support to SP remaining in SLA within barracks over stand down periods. Witness 15 took responsibility for implementing the procedure for the Christmas stand down period and briefing the duty staff.

T16/140/F-G

1 MI Bn Welfare Procedures in Place For SP Remaining in SLA in Barracks Over Christmas 19 / New Year 20 Stand Down Period

Identification of Those SP Remaining in SLA

1.4.150. On 12 Dec 19, Witness 15 was informed by Witness 22 that two HQ Coy SP would be remaining in SLA in Catterick during parts of the Christmas leave period. It was identified that the SP would be in the SLA from 26 Dec 19 until he returned to 77 Bde on 6 Jan 20. On 12 Dec 19, Witness 15 emailed those SP holding BDO appointments, over the leave period, informing them that two soldiers will be in the JNCO block sporadically over the stand down. The email also contained direction for the 1 MI Bn Welfare Dept to contact the two SP.

F64/1
F64/1-2

1 MI Bn Welfare Dept Engagement / Support

1.4.151. On 12 Dec 19, Witness 20 contacted the SP by text "*Afternoon* [the SP], *just checking if you will be in Catterick for the whole of the Christmas break. Also, should you need any support the following fact sheet can help you*". The fact sheet was entitled "*External Sources of Support and Self Help*", however the image of the fact sheet was not sent, and the image annotated "*not sent.* On 12 Dec 19 the SP replied to Witness 20 with the detail of his planned disposition over the Christmas leave period and the names of the SP he would be spending time with adding "*I'll be back in Catterick from the 26th and then Hermitage on the 6th Jan*".

F64/1
T22/263/A
F150
T22/263/A
T22/265/F
F150

1.4.152. On 12 Dec 19, Witness 20 produced a 1 MI Bn Christmas stand down period 2019 Welfare Support guide accompanied by an External Sources of Support and Self Help factsheet to be included in the BDO folder.

F149

1 MI Bn BDO Christmas 19 / New Year 20 Stand Down Period

1.4.153. 1 MI Bn had tasked four SP to conduct the role of BDO over the period 16 Dec 19 to 6 Jan 20, as follows: **F64/1** **F62**

a. 16 Dec to 23 Dec 19 – Witness 16.

b. 23 Dec to 27 Dec 19 – Witness 29.

c. 27 Dec to 30 Dec 19 – Witness 17.

d. 30 Dec 19 to 6 Jan 20 – Witness 18.

1 MI Bn Email Briefing BDO Christmas 19 / New Year 20 Stand Down Period

1.4.154. On 13 Dec 19 Witness 15 emailed those SP holding BDO appointments over the leave period, the mobile phone numbers for the two SP remaining in SLA and the dates of the "*vulnerable period*" for each. For the SP the period was stated by Witness 15 as "*27 Dec to 6 Jan 20*". Witness 15 clarified during Hearing 1 that his use of the word vulnerable was used "*in the context of this is an individual on their own in the block is vulnerable*". **F64/1** **T16/133/F**

1.4.155. Witness 15 directed the BDO as follows "*Can the BDO please contact them daily whilst they are on barracks to ensure they are safe and well*". There was no physical duty parade / brief conducted by Witness 15, he stated he relied on the individual BDO contacting him if they had any questions relating to understanding the email and the direction it contained. **F64/2** **T16/131/A** **T16/132/B**

1.4.156. Witness 15 specified in the email that he would "*auto-forward the duty mobile so it reaches all who are on duty*[21]" and "*on HOTO I will ring each individual to see if there have been any issues*". He took the 1 MI Bn duty BDO mobile phone with him on leave. **T16/130/C** **F64/2**

1.4.157. The email did not specify the means of contact. Witness 15 noted "*I left it open to interpretation as to whether that was physically in person, via text message or phone call…I didn't stipulate*". Witness 15 stated that BDOs were not briefed on what to do if they could not make daily contact with the SP. The email did not state the start time or finish time for each BDO duty period, the actions to be carried out if the BDO could not contact the SP, or any requirement to log / record the contact by the BDO. **T16/134/C** **F64/22**

1 MI Bn BDO Actions 16 Dec 19 to 7 Jan 20

BDO 16 Dec to 23 Dec 19

1.4.158. Witness 16 understood that the requirement was to contact SP daily that were remaining in the SLA and that no method of contact had been specified. He carried out the action (by text message) to contact daily a SP who was remaining in the SLA on specified dates. **T17/153/B**

[21] Within 1 MI Bn forwarding the BDO duty mobile phone was a normal daily practice, not one adopted purely for Christmas 19 / New Year 20 stand down Period.

1.4.159. On 23 Dec 19 Witness 15 sent a text message to Witness 16 to confirm that the BDO duty mobile phone had been redirected to the next BDO, there was no confirmation / assurance that the daily contact had been made with Witness 12. Witness 15 did not telephone the outgoing BDO.

F151
T16/134/E

BDO 23 Dec to 27 Dec 19

1.4.160. Witness 29 understood that the requirement was to contact SP daily by telephone that were remaining in the SLA. They carried out the action (by telephone, followed by texts) to contact the SP daily that was remaining in the SLA on 23 Dec 19 and 24 Dec 19. Details of the contact were not logged.

T32/255/A
T32/255/F
T32/256/D-F

1.4.161. On 27 Dec 19, Witness 15 contacted Witness 29 to confirm that the BDO duty mobile phone had been redirected to the next BDO. Witness 29 could not recall if they provided confirmation / assurance that daily contact had been made with Witness 12.

T32/257/D-F
T32/255/B

BDO 27 Dec to 30 Dec 19

1.4.162. Witness 17 understood that the requirement to contact SP in the SLA was to "*just to tie in with them and make sure you contact them while you're on that duty"* and that no method of communication was stated. He contacted the SP once by text on 27 Dec 19, establishing two way communications.

T18/161/E
T18/162/F
T18/163/D-G

1.4.163. On 27 Dec 19, the SP informed Witness 17 by text that he was going to visit friends over the next couple of days. Witness 17 decided that he would therefore not contact him if he was seeing friends and did not attempt to communicate with him on 28 Dec 19.

T18/163/D-G
T18/164/A

1.4.164. On 29 Dec 19, Witness 17 encountered the SP at the gym within Catterick Garrison. They had a five to ten minute conversation during which the SP appeared happy and content.

T18/164/B-C

1.4.165. On 30 Dec 19 (at approx 0908 hrs), Witness 17 contacted Witness 15 by text to ask whether "*the duty phone is getting transferred today or tomorrow*". During the message exchange Witness 17 confirmed that he had "*touched base*" with the SP and saw him in the gym.

F151

BDO 30 Dec 19 to 6 Jan 20

1.4.166. Witness 18 understanding of the requirement to contact SP in the SLA was "*to check in with the two personnel identified on a daily basis*" and that no method of contact had been specified. Witness 18 did not contact the SP over the period 30 Dec 19 to 5 Jan 20 inclusive.

T19/173/G
T19/174/G
T19/175/F-G
T19/176/A-C

1.4.167. Witness 18 had spoken to the SP on 20 Dec 19 by phone and told him that he was the BDO over the period 30 Dec to 6 Jan and that if there were any issues to contact him. Witness 18 explained the reason for not contacting the SP daily over the 7 day period, 30 Dec 19 to 6 Jan 20, as "*I spoke with [the SP] on the 20 Dec and as he was on leave we didn't have a good relationship outside of being professional, therefore I felt it would be intrusive to contact him every day and maybe set him back on mental health or just being very intrusive into his leave*".

T19/173/A
T19/176/D

1.4.168. On 6 Jan 20 Witness 29 carried out a BDO dismount of Witness 18 on conclusion of his period of BDO. Witness 29 did not confirm that Witness 18 had made daily contact with the SP over the period on 30 Dec 19 to 5 Jan 20 inclusive. Witness 29 asked him, as was their standard practice, only "*if there had been any issues or incidents*".

T32/257/G
T32/258/A-D
F220/9

BDO Assurance Process

1.4.169. Witness 15 stated that 1 MI Bn did not have an assurance process in place to confirm that the BDOs had contacted the SP in the SLA over the Christmas stand down period. He stated, "*My assumption was the fact that whenever I handed the phone over… and said if there's any issues contact me and I heard nothing, that there were no issues and that the orders had been carried out*". Witness 15 clarified that on return to work in Jan 20 there was no process to assure the BDO checks on the SP had been carried out as directed by him on 13 Dec 19.

T16/143/A
T16/143/E
T16/144/B
F64/2

BDO Folder[22] Christmas 19 / New Year 20 Stand Down Period

1.4.170. On completion of his duty the first BDO of the Christmas leave period left the BDO folder in his office within 1 MI Bn. Witness 17 stated he could not access the 1 MI Bn BDO folder over the period 27 to 30 Dec 19 whilst he was the BDO and that he did not know where the BDO Folder was located. Witness 18 stated "*I didn't have the BDO folder for the period I was on duty*" and when asked if an incident were to happen how would you know what to do without the BDO folder replied, "*I wouldn't be able to*". 1 MI Bn had not specified how the BDOs would be able to access the BDO folder whilst on duty during Christmas leave.

T17/158/D-E
T18/168/G
T18/169/B
T19/176/G
T32/260/G

1 MI Bn BDO Reports - Suspension

1.4.171. 1 MI Bn suspended the requirement for a BDO report to be completed by BDOs over Christmas leave. The suspension occurred as the routine checks usually conducted by a BDO (armoury, protectively marked documents) were not required over the stand down period.

T32/257/A
T32/258/F

Lessons Identified by 1 MI Bn

1.4.172. **BDO Email Brief - Lack of Clarity.** Witness 29 identified that the BDO briefing should have stated the start / finish time of the duty period. Witness 15 identified that he should have included actions on failure to establish communications with SP in the SLA.

T32/258/H
T16/137/E

1.4.173. **BDO Duty Brief.** Witness 29, Witness 15 and Witness 18 identified that a centralised BDO physical brief would have been more effective than an email brief. Witness 29 noted that this would have enabled confirmation that the BDO understood their duties. Witness 28 noted that in retrospect he "*could have got* [Witness 18] *and* [Witness 17] *in and given them my intent*".

T32/259/A-B
T19/178/E
T16/139/D
T32/259/F
T31/216/G

[22] The 1 MI Bn BDO Folder held the written orders for the BDO, including: BDO Log, Incident Management guidelines, operational activation plan along with the 1 MI Bn Christmas Stand down Period 2019 Welfare Support guide produced by the 1 MI Bn Welfare Dept.

1.4.174. **BDO Handover Process.** Witness 17, Witness 18 and Witness 29, identified that a more effective handover process would have occurred if the outgoing / incoming BDO met in person. Witness 15 identified that "*I should have phoned them on handover of the phone instead of texting. That might have brought out more information about whether or not they had conducted the checks I'd asked*" adding "*I used text message as opposed to calling and in hindsight,….I would ring them..*". Witness 28 noted that the handover "could have been clearer" and included "*five set questions*" as a "*forcing function*".	**T32/259/C** **T18/166/E** **T19/178/G** **T16/137/E** **T16/143/G** **T31/216/G**
1.4.175. **BDO Daily Reports.** Witness 29 identified that it would have been more effective if the BDO had logged their contact with the SP remaining in the SLA, potentially in daily BDO reports. Witness 16 noted that a sheet could have been used to record that the BDO had made contact with the SP.	**T32/259/C** **T17/154/F**
1.4.176. **BDO Dismounting.** Witness 29 identified that it would have been more effective for her to ask the outgoing BDO specifically whether they had spoken to the individual SP.	**T32/259/D**

Opinion

1.4.177. The Panel are of the opinion that 1 MI Bn effectively identified those SP expressing an intent to remain in their SLA during the Christmas 19 / New Year 20 stand down period. 1 MI Bn were innovative in their approach to supporting those SP and put in place a process that went beyond any Joint or Single Service mandated requirement.

1.4.178. It is the opinion of the Panel that the 1 MI Bn BDO briefing process (by email) rather than in person was not effective as it did not enable 1 MI Bn to assure that the BDO understood the requirements of their duty. The BDO briefing process did not contain any actions on / procedures to be carried out if the BDO could not contact the specified SP, nor did it specify the timing of the BDO duty period, or a requirement to log / record contact with the SP. The BDO Briefing email did not indicate how the BDO could access the 1 MI Bn BDO Folder in case an incident occurred. The Panel determined that the 1 MI Bn BDO briefing process for those BDOs on duty over the Christmas leave period was an Other Factor.

1.4.179. The Panel are of the opinion that 1 MI Bn the did not have in place an effective assurance process to assure that the intent for the BDO to contact the two SP daily whilst they were in SLA over the Christmas 19 / New Year 20 stand down period was carried out in accordance with the intentions of Witness 28. The Panel determined that the lack of an effective 1 MI Bn assurance process to assure that the BDOs contacted SP remaining in the SLA over the Christmas leave period was an Aggravating Factor in that it led to a delay in 1 MI Bn being aware that the BDO had not contacted the SP over the period 30 Dec 19 to 5 Jan 20 inclusive.

1.4.180. The BDO handover process facilitated by Witness 15, and the BDO dismounting on 6 Jan 20 did not confirm that each BDO had contacted the two SP daily. Witness 15 deviated from the stated process to telephone each BDO on handover - takeover of duty and used text messages rather than verbal communication. The Panel are of the opinion that contact by text message was less conducive to effective communication than contact by voice. The Panel formed the opinion that the removal of the requirement to

complete a BDO report at the end of each duty period removed a well proven assurance mechanism where the BDO would have recorded the actions undertaken during their duty period. The Panel determined that the 1 MI Bn communication with BDO's on handover of duty by text rather than voice, the BDO dismounting process and removal of the requirement to complete a BDO report were an Other Factor.

1.4.181. The Panel are of the opinion that had the BDO carried out the task directed by Witness 15 to contact the SP daily during the required period that any lack of response from the SP may have caused 1 MI Bn to investigate further and that the SP may have been discovered earlier than 23 Jan 20. The Panel determined that the 1 MI Bn BDO not communicating daily with the SP as directed by Witness 15 was an Aggravating Factor.

1.4.182. It is the opinion of the Panel that recommending the Army adopt a directed / mandated policy to check on all SP remaining in SLA within barracks would be too prescriptive / draconian, is not required and would unnecessarily interfere with the privacy of SP. SP on individual leave have a right to privacy wherever they are located; within SLA, SFA, SSSA or private accommodation. The Panel are of the opinion that it should remain a CO unit level decision based on the knowledge of their SP to determine which SP are vulnerable and require support.

Recommendations

1.4.183. 1 MI Bn ensure that the requirement for Battalion Duty Officer's (BDO's) reports is not suspended / stopped during stand down periods as it removes the opportunity for a duty officer to formally record actions undertaken and incidents that occur during their duty period.

1.4.184. 1 MI Bn ensure that the Battalion Duty Officer's (BDO's) have access to the BDO Folder at all times, including during stand down periods, in order to react to incidents in a timely manner and in accordance with the Unit plan.

1.4.185. 1 MI Bn ensure that an effective Battalion Duty Officer (BDO) briefing process is conducted prior to each stand down period that includes: the start / finish times of each duty period and the actions to be carried out if a BDO is unable to contact a SP that has been identified as requiring a welfare check.

1.4.186. 1 MI Bn ensure that an effective Battalion Duty Officer (BDO) assurance process is in place following each stand down period to dismount from duty each BDO and to assure that any directed welfare checks have been conducted.

TOR 4: Determine the handover procedures in place at 1 MI Bn for their personnel on temporary assignment to other units. Examine how relevant policies, procedures, welfare practices and other provisions are applied, including but not limited to:

- **Establish what policies, procedures and regulations are in place both in the wider Army and within the 1 MI Bn for the provision of welfare support to a situation based on the facts of this matter. These include but are not limited to: Army**

General and Administrative Instructions (AGAIs) Volume 2 Chapter 57 (Health Committees); Volume 3 Chapters 81 (Army Welfare Policy); Volume 3 Chapter 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy); Army Command Standing Order (ACSO) 3217 (Trauma Risk Management (TRiM)): and Joint Service Publication (JSP) 751 (Joint Casualty and Compassionate Policy and Procedures). Determine the unit level of understanding in relation to these policies.	
• Establish any unit policies that were in place prior to the death of [the SP] with regard to alerting the Chain of Command of any welfare and medical concerns.	
Findings:	
1 MI Bn Handover Procedures in Place for SP on Temporary Assignment[23] / Detachment to Other Units	
1 MI Bn FRAGO Process	
1.4.187. The Ops Cell, 1 MI Bn, created a 1 MI Bn FRAGO for every deployment of SP from the Unit. This included those deploying on operations, exercise (UK or overseas) or detachment to another unit. 1 MI Bn did not have a specific SOI / SOP, or process covering the handover procedures for SP on temporary assignment / detachment to other units, it used the 1 MI Bn FRAGO process.	**F79D** **T8/70/F**
1.4.188. The aim of the 1 MI Bn FRAGO was to give SP deploying on detached duty clear direction and clear terms of reference. The FRAGO was an internal 1 MI Bn process and was not distributed to the receiving unit.	**F61** **T8/6/E** **T5/44/D-E**
1.4.189. The 1 MI Bn FRAGO tasked SP to report their safe arrival at the new location. Witness 5 confirmed that the safe arrival was not recorded by the Ops Cell and that the process was not routinely followed by deploying SP. There was not an Ops Cell assurance process in place, to assure that all SP had reported their safe arrival, nor any written actions on / procedures for the Ops Cell to follow if SP had not reported their arrival to the Ops Cell.	**T9/5/B-H** **F61** **T9/6/A**
1.4.190. Witness 28 had an understanding that in addition to "*just a force generation time and details*" 1 MI Bn made contact with a receiving unit, introducing a SP to the unit. Witness 28 expected *".....either the company or the Ops team to contact the receiving Chain of Command". He thought "as a matter of standard practice that conversation would happen……… That was my expectation*", adding "*my understanding and expectations of what was happening certainly wasn't met in this case*" Witness 28 had issued verbal direction in relation to the requirement to contact the receiving Chain of Command to handover a 1 MI Bn SP but no written direction in relation to his intent.	**T31/202/C** **T31/241/C** **T31/226/C** **T31/202/D-E** **T31/242/G** **T31/227/C** **T31/242/F**

[23] Temporary Assignment. For the purposes of the Service Inquiry the Panel have interpreted the term to incorporate any SP detached from their parent unit to another unit, via any authorised mechanism, with a defined start and end date.

1.4.191. The 1 MI Bn changes implemented to the handover procedures for SP on temporary assignment / detachment to other units is covered under TOR 6.

1 MI Bn - Requirement for a Handover of the SP to 77 Bde

1.4.192. 1 MI Bn personnel were unified in their view that the SP did not have any welfare circumstances that would have required a formal welfare handover to 77 Bde in Dec 19. Witness 18 did not believe that he had any welfare circumstances requiring handover. Witness 25 commented, "*I believe that when he deployed he'd been through the system and he was happy, in a great place, he'd been through the MO, he'd been through the PRU and he was ready to go. I don't think he had any outstanding welfare that would have affected his trawl at all, he seemed really happy to go*". Witness 14, commented *"……at the stage he went over to 77 Bde it was my view that he did not have what we would class as a welfare issue that was actionable*". **T20/208/A** **T28/156/A-C** **T15/103/G**

1.4.193. Witness 28 noted that the SP did not have any welfare circumstances present "*Not by the definitions in the AGAIs….. ..he didn't have any, he wasn't receiving any treatment, he wasn't asking for a change in his working hours, he didn't need particular different support in the workplace and there wasn't any foreseeable events in his personal life…... that was likely to present as being a stressor for him in the immediate future or for the duration of the trawl, noting it was nine months*". Neither Witness 19 nor Witness 20 believed that the SP had any welfare issues that required a formal welfare handover to 77 Bde in Dec 19. **T31/202/H** **T21/225/H** **T22/263/H**

1.4.194. 1 MI Bn had no communication with HQ 77 Bde or DCSU regarding the temporary assignment / attachment of the SP. **T9/11/E**

Opinion

1.4.195. The Panel are of the opinion that 1 MI Bn were effective in their approach to providing direction to SP deploying on detachment from the Unit by their implementation of a FRAGO process.

1.4.196. The Panel note that Witness 28 had an intent and understanding of what was occurring in terms of 1 MI Bn handing over SP to a receiving unit that differed from the reality of what was happening within 1 MI Bn. The Panel are of the opinion that had Witness 28 issued written direction, underpinned by an effective internal assurance process then it would have been very likely that his intent that SP were to be handed over / introduced to the receiving unit would have occurred.

1.4.197. The Panel are of the opinion that 1 MI Bn did not have in place an effective system to record when SP reported their safe arrival at a new location. There was no assurance process to assure that the deploying SP had reported their safe arrival at a new location. There was no effective process or procedure for 1 MI Bn to follow if a SP had not reported their arrival to the Ops Cell. The Panel determined that the lack of an effective system within 1 MI Bn to record when SP had reported their safe arrival at a new location and lack of process for the 1 MI Bn to follow if a SP did not report safe arrival at a new location was an Other Factor. The Panel noted that in the case of the SP he had not been directed to report his arrival at Hermitage on 7 Jan 20 following Christmas leave.

1.4.198. The Panel are of the opinion that the personal situation of the SP in Nov / Dec 19 did not cross a welfare threshold mandated by policy[24] which required 1 MI Bn to conduct a formal handover to 77 Bde / DCSU. However the Panel are of the opinion that the individual circumstances of the SP in Nov / Dec 19 should have generated a handover by 1 MI Bn. Namely the decision by 1 MI Bn to grant the SP permission to retain his SLA within Catterick Garrison and the fact that the SP was the victim and a witness in an ongoing RMP investigation into a serious assault which occurred in Nov 18. The Panel determined that the lack of handover of the SP by 1 MI Bn to 77 Bde / DCSU, although not mandated by policy was an Other Factor.

Recommendations

1.4.199. 1 MI Bn ensure that for SP deploying on a temporary detachment from the Unit (ie Temporary Employed Elsewhere, Authorised Elsewhere, Trawl etc), where unique ongoing individual circumstances remain (ie retention of SLA, SFA, welfare issues, or the SP is the victim / witness in ongoing disciplinary case) then a full handover to the receiving unit takes place.

1.4.200. 1 MI Bn ensure the Unit has in place an effective system in place to record when SP report their location / safe arrival as directed by a 1 MI Bn FRAGO and a process / procedure to follow if a SP fails to make contact as directed.

Examine how relevant policies, procedures, welfare practices and other provisions are applied and determine the unit level understanding in relation to these policies.

1 MI Bn Application / Understanding of AGAI Vol 2, Chap 57 - Health Committees[25]

1.4.201. 1 MI Bn held a combined Unit Health and Welfare Committee (UHWC). During Hearing 1, all personnel; Witness 1, Witness 14, Witness 15, Witness 19, Witness 20, Witness 22, Witness 24, Witness 28 and Witness 29 demonstrated a good understanding of the UHC process and their role within it. 1 MI Bn UHWC were divided into two parts: UHWC Part 1 - Unit Health Policy Review and UHWC Part 2 – Individual Case Conference. 1 MI Bn conducted ten combined UHWC 1 and UHWC Part 2 monthly meetings during 2019. The minimum requirement mandated by AGAI 57 – Health Committees is "*Part 2 UHC must be held at least every 28 days to comply with command duties……*" and that Part 1 is to be held quarterly.

F74, F75
T1/5/E,
T15/107/B
T21/232/F
T22/268/E
T24/42/G
T26/97/A
T27/120/D
T31/229/F
T32/267/G
F194/57.026

1.4.202. **Unit Health Committee Conduct / Attendance.** The 1 MI Bn UHWC were consistently chaired by Witness 28 with the required unit internal representation. The Nominated Medical Officer, or a substitute, was not present at six out of the ten 1 MI Bn UHWCs held during 2019. (Jan 19, Feb 19, Apr 19, May 19, Sep 19 and Oct 19). AGAI 57 – Health Committees directs that "*Attendance by the Nominated Medical Officer is mandatory for*

F75
F194/0.29

[24] JSP 770 – Tri-Service Operational and Non-Operational Welfare Policy. AGAI 81 – Army Welfare Policy, AGAI 110 – Army SVRM Policy.
[25] AGAI Vol 2, Chap 57 – Health Committees dated Sep 17 in force until replaced by version dated Apr 20.

Part 2 UHC. Where they are unavailable another suitably qualified informed and empowered member of the medical team must attend on their behalf'.

Opinion

1.4.203. The Panel are of the opinion that to be effective the UHC Part 2 Individual Case Conference should be held every 28 days and that the nominated medical representative or suitable representative must be in attendance in order to provide medical input. The Panel determined that 1 MI Bn not holding a UHC Part 2 Individual Case Conference every 28 days and holding UHC Part 2 without the nominated medical representative or suitable other medical representative deviated from policy and was an Other Factor.

Recommendation

1.4.204. 1 MI Bn ensure that UHC Part 2 Individual Case Conference (known from Apr 20 onwards as Commanders Monthly Case Review)[26] is held in accordance with AGAI 57 – Health Committees.

1 MI Bn Application / Understanding of AGAI Vol 3, Chap 81 - Army Welfare Policy[27]

1.4.205. **Unit Welfare Standing Orders.** 1 MI Bn held Unit Welfare Standing Orders as mandated by AGAI 81 - Army Welfare Policy which incorporated the CO's Welfare Statement and the 1 MI Bn Welfare Charter.

F195/A-1/2
F76
F195/005

1.4.206. **Unit Welfare Management Committee.** The combined UHWC held by 1 MI Bn covered both the requirements of the Unit Health Committee (mandated by AGAI 57 – Health Committees) and Welfare Management Committee (mandated by AGAI 81 – Army Welfare Policy). The 1 MI Bn UHWC were consistently chaired by Witness 28 with the required unit internal representation. 1 MI Bn conducted ten combined UHWC 1 and UHWC Part 2 monthly meetings during 2019. The minimum requirement mandated by AGAI 81 – Army Welfare Policy for the Welfare Management Committee is monthly.

F74/1
F75
F194/029
F195/D-1/3
F74/A-1

1.4.207. **Unit Application of the JPA Welfare Tool.** The JPA Welfare tool was in use within 1 MI Bn. 1 MI Bn used the UHWC meeting to discuss / identify SP that require to be flagged as having a welfare issue using the JPA Welfare Tool which was then communicated to Witness 24 to put the flag in place. Witness 24 did not check whether SP on arrival to the unit had a JPA Welfare Flag in place to identify any ongoing welfare issues. Witness 24 noted "*I probably should on arrival, but I've never been directed to*".

F76
T21/236/G
T26/103/G
T26/103/B

Opinion

1.4.208. The Panel are of the opinion that to be effective the Welfare Management Committee should be held monthly as required by AGAI 81 – Army Welfare Policy. The Panel determined that 1 MI Bn not holding a Welfare Management Committee monthly was an Other Factor.

---

[26] From Apr 20 onwards (AGAI 57 – Army Health Committees) refers to UHC Part 2 (Individual Case Conference) as Commanders Monthly Case Review.

[27] AGAI Vol 3, Chap 81 - Army Welfare Policy dated Mar 19 in force until replaced by version dated Jan 20.

1.4.209. The Panel are of the opinion that to be utilised effectively the JPA Welfare Tool should be checked for all SP on arrival to the unit by the RCMO in order to identify any SP arriving with an ongoing welfare issue and that information is then passed to the UWO / Chain of Command as appropriate. The Panel determined that 1 MI Bn not checking the JPA Welfare Flag for SP on arrival within the Unit was an Other Factor.

Recommendations

1.4.210. 1 MI Bn ensure that the Welfare Management Committee is held monthly as directed in AGAI 81 Army Welfare Policy.

1.4.211. 1 MI Bn ensure that the Unit comply with AGAI 81 Army Welfare Policy to check the JPA Welfare Tool / Flag for each SP on assignment into the Unit to ascertain if there are any ongoing welfare concerns that should be brought to the attention of the CoC / UWO.

1 MI Bn Application / Understanding of AGAI Vol 3, Chap 110 Army Suicide Vulnerability Risk Management (SVRM) Policy[28]

1.4.212. **Unit SVRM Process / Application.** The Unit lead within 1 MI Bn for SVRM was the Adjt. During Hearing 1 it was clear that it was well known amongst those Chain of Command witnesses who the Unit SVRM Lead was. Once a SP is identified at risk, 1 MI Bn conduct a SVRM Risk Conference at which the CO is the deciding authority as to whether the SP is placed onto the Unit SVRM Register (VRMIS). The Adjt allocates permissions on VRMIS giving the CO visibility and assigning access to the individual CAP Lead. Individuals on the Unit SVRM are reviewed monthly at the UHWC. As at Dec 19, 1 MI Bn had approx five SP on the Unit SVRM Register.

T1/6/F
T15/109/E
T21/238/F
T24/44/F
T27/122/B
T31/233/H
T32/270/E
T32/271/C/G
T32/272/E

1.4.213. **Transferring SP.** 1 MI Bn understood the requirement to transfer a VRMIS record with an open CAP when a SP is posted to a new unit.

T32/272/F-H
T31/237/H

Opinion

1.4.214. The Panel are of the opinion that 1 MI Bn understood and were effective in their application of AGAI 110 - Army SVRM Policy. The policy and the Management Information System VRMIS was in use, with a nominated and well known SVRM Lead, risk conferences with regular monthly reviews were in place with the CO as the deciding authority.

1 MI Bn Application / Understanding - LFSO 3217 Trauma Risk Management (TRiM)[29]

1.4.215. **Unit TRiM Policy.** 1 MI Bn had a TRiM Standing Order (including TRiM Management Plan and CO's TRiM Policy Letter) in place, dated 5 Mar 20, as mandated by LFSO 3217 - TRiM. However, 1 MI Bn were unable to supply a copy of the Unit Standing Order in place in Jan 20 (see TOR 7).

F78
F197
T29/175/D
F51/44

1.4.216. **Unit TRiM Qualified Personnel.** LFSO 3217 – TRiM states that the requirement for Major Units is five TRiM Coordinators and 20 TRiM Practitioners. The publication does not list the requirement for TRiM qualified

F197/7.C
F51/45

[28] AGAI 110 – Army Suicide Vulnerability Risk Management (SVRM Policy) dated Aug 12 in force.
[29] LFSO 3217 Trauma Risk Management (TRiM) dated Aug 11 in force.

personnel within a minor unit. In Jan 20, 1 MI Bn held seven TRiM Coordinators and 13 TRiM Practitioners.

1.4.217. **Unit TRiM Process / Application - Death of the SP (Delivery).** Following the discovery of the SP on 23 Jan 20 a TRiM initial planning meeting was held within approx 30 minutes of the incident and initial support provided within 60 minutes of the incident.

T29/173/A-D
F71

1.4.218. **Unit TRiM Process / Application - Death of the SP (Record Keeping).** 1 MI Bn created a TRiM Incident Log Book, but did not record the TRiM undertaken on JPA as directed by LFSO 3217 – TRiM. TRiM was offered to an additional SP, the SP declined. The offer and subsequent decline was not recorded as required in the TRiM Incident Logbook.

F71 /F71B
T29/175/C
F197/16/D
T29/175/C
T29/178/C

Opinion

1.4.219. The Panel are of the opinion that 1 MI Bn understood and were effective in their application of LFSO 3217 – TRiM. The Panel note that in response to the discovery of the SP on 23 Jan 20, 1 MI Bn put TRiM measures in place within 60 minutes. The Panel are of the opinion that recording the TRiM activity conducted on JPA is essential to ensure that the Army have an accessible and viewable record of SP that have undergone a traumatic incident in order that future support may be provided as required. The Panel determined that 1 MI Bn omission in not recording the TRiM activity conducted on JPA was an Other Factor.

Recommendations

1.4.220. 1 MI Bn ensure that the Unit comply with the requirement to record TRiM activity on JPA individual records in accordance with LFSO 3217 Trauma Risk Management.

1.4.221. 1 MI Bn ensure that when a SP declines to undertake TRiM it is recorded in the TRiM Incident Log Book relating to the incident.

1.4.222. Senior Health Advisor (Army) (SHA (A)), as owner of LFSO 3217 – Trauma Risk Management (TRiM) Policy, include within the publication guidance on the number of TRiM trained personnel to be held by a minor unit (currently only major unit figures are listed).

1.4.223. SHA (A), Army HQ update LFSO 3217 - Trauma Risk Management (TRiM) Policy at the next revision to contain the detail that the policy owner is Senior Health Advisor (Army), Army HQ, not Personnel Services Branch 4 (Army), a now defunct organisation.

1 MI Bn Application / Understanding of JSP 751 Joint Casualty and Compassionate Policy and Procedures

1.4.224. **Casualty Reporting Process (General) - Working Hours / Out of Hours.** Within 1 MI Bn, the Adjt is the Unit lead for reporting casualties via the Joint Casualty and Compassionate Centre (JCCC) during working hours. Outside normal working hours the BDO, 1 MI Bn is responsible for casualty reporting. 1 MI Bn BDO Orders contain a detailed flow chart covering the actions required by the BDO in the event of an out of hours casualty.

F198
T32/273/C
F51/49
T32/273/D
T31/238/G
F63

1.4.225. **Casualty Reporting Process (The SP).** 1 MI Bn raised a NOTICAS to JCCC on 23 Jan 20 (approx 1200 hrs). The NOTICAS speculated on the cause of death. The NOTICAS was followed up by a telephone call to JCCC. 1 MI Bn amended and reissued the NOTICAS on 23 Jan 20 (approx 1215 hrs). JSP 751 requires units "*must inform JCCC as soon as possible…where the situation allows, the JCCC must initially be alerted by telephone*". **F6 F1/17F F23 F24 F1/A-7 F198/5.1**

1.4.226. **Casualty Notification Officer (CNO) / Visiting Officer (VO) Process / Application.** 1 MI Bn held 17 CNO qualified personnel and two VO qualified personnel (Mar 20 figures). The Compendium of Mandated Course Trained Personnel states a requirement for a minor unit to hold eight CNO and three VO qualified personnel. 1 MI Bn were aware that they were one short of the minimum required number of VO qualified personnel. **F51/50 F51/51 F80 F200/10-11**

1.4.227. **Updating Next of Kin (NoK) / Emergency Contact (EC) Details.** Within 1 MI Bn SP are required to verify their NoK / EC contact details on JPA when they are assigned into the Unit during the Unit arrivals process. Additionally, verification takes place annually during the Unit Readiness Administration Checks. **F181 F159/31B F8**

Opinion

1.4.228. The Panel are of the opinion that 1 MI Bn understood and were effective in their application of JSP 751 Joint Casualty and Compassionate Policy and Procedures. The Panel are of the opinion that to speculate on the cause of death within an initial NOTICAS was unnecessary, can lead to misinformation and that a unit should only include the known facts on a NOTICAS. The Panel determined that 1 MI Bn speculating on the cause of death of the SP in the initial NOTICAS was an Other Factor.

Recommendations

1.4.229. 1 MI Bn ensure that when raising a NOTICAS following the death of a SP, the Unit must not speculate on the cause of death within the NOTICAS.

1.4.230. 1 MI Bn ensure that when raising a NOTICAS, where the situation allows, the Unit must initially alert JCCC by telephone as required by JSP 751 Joint Casualty and Compassionate Policy and Procedures, Part 1, Volume 1: Management of the Casualty.

Establish any unit policies that were in place prior to the death of the SP with regard to alerting the Chain of Command of any welfare and medical concerns.

1 MI Bn Policies / Process for Alerting the Chain of Command to any Welfare and Medical Concerns.

1.4.231. **1 MI Bn Welfare Standing Order No 1010.** The Standing Order contains full details on how SP may contact both Level 1 (Internal) and Level 2 (External) welfare support. The Welfare Charter sets out the rights of SP to access welfare services. The welfare responsibilities for all SP from the CO downwards are clearly articulated within the Standing Order. **F76**

1.4.232. **1 MI Bn UHWC Standing Order No 1013.** The Standing Order contains the details of how the Unit use the UHWC series of meetings to alert the Chain of Command to any welfare / medical concerns using the Sub-Unit Individual Case Conferences as part of the UHWC Part 2.	**F74**
1.4.233. **1 MI Bn CO's Directive / Interaction With Sub-Unit OCs.** The Directive highlights that; commanders at all levels are responsible for welfare, providing access to welfare support is a command responsibility and that the Chain of Command are responsible for identifying, advising and referring SP with welfare issues. In addition to the monthly UHWC the CO held a weekly VTC with Sub-Unit OCs and also received a weekly update email from them and that this was an additional mechanism for him to be alerted by the Chain of Command to any welfare or medical concerns.	**F159/31(k)** **T31/229/B**
1.4.234. **1 MI Bn Workplace Induction Programmes (WIP).** All SP on arrival at 1 MI Bn, and every three years thereafter, attend a 1 MI Bn WIP. Within the WIP the 1 MI Bn Welfare Dept deliver a Unit Welfare Brief which includes the details of how to access different levels of welfare support.	**F51/53** **F53** **T22/270/F**
1.4.235. **Chain of Command Understanding of the Process / Procedure to Alert the Higher Chain of Command to Welfare / Medical Concerns.** Witness 14 described the process for him to alert the Chain of Command "*I'd knock on his door and tell him straightaway…. I send an email every Friday so he can look on the company as well. We have Monday CO's to OC's O Group where we can discuss within the realms of confidentiality if we had a problem that we need to talk to him about, then we have the Unit Health Committees as well monthly where we talk about people health and medical in depth*".	**T15/106/H**
1.4.236. **SP Understanding of the Process / Procedure to Alert the Chain of Command to Welfare / Medical Concerns.** During Hearing 1, five junior SP gave evidence relating to their understanding / application of the process / procedure in place within 1 MI Bn for them to alert the Chain of Command to any welfare or medical concerns they had. They felt able to approach their Chain of Command directly with any personal welfare or medical concerns, or in relation to another SP. The SP were also aware of the 1 MI Bn Welfare Dept and how to access it.	**T10/15/F-H** **T11/26/B-F** **T12/37/A-G** **T13/55/A-F** **T14/81/D-H** **T14/82/A-D**
Opinion	
1.4.237. The Panel are of the opinion that within 1 MI Bn there was an effective process in place to alert the Chain of Command to any welfare and medical concerns. 1 MI Bn had in place a formal structure using the UHWC. Outside the rhythm of the UHWC there existed a well understood process where SP could raise issues to their Chain of Command directly and also where the Sub-Unit could raise issues to the Bn HQ as required. The five junior SP that gave evidence during Hearing 1 were unified in their comment that it was easy to approach the Chain of Command directly with any personal welfare or medical concerns, or in relation to another SP.	
TOR 5: Determine the takeover procedures in place at DCSU for personnel on temporary assignments to that unit. Examine how relevant policies, procedures, welfare practices and other provisions are applied, including but not limited to:	

• Establish what policies, procedures and regulations are in place both in the wider Army and within the establishment for the provision of welfare support to a situation based on the facts of this matter. These include but are not limited to: Army General and Administrative Instructions (AGAIs) Volume 2 Chapter 57 (Health Committees); Volume 3 Chapters 81 (Army Welfare Policy); Volume 3 Chapter 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy); Army Command Standing Order (ACSO) 3217 (Trauma Risk Management (TRiM)); and Joint Service Publication (JSP) 751 (Joint Casualty and Compassionate Policy and Procedures). Determine the unit level of understanding in relation to the policies.

• Establish any unit policies that were in place prior to the death of [the SP] in relation to assignment of temporary personnel, their arrival and proposed integration/induction with existing cells.

Findings:

DCSU Takeover Procedures in Place for Personnel on Temporary Assignment to that Unit

1.4.238. DCSU did not have any specific takeover procedures in place to takeover personnel on temporary assignment from a losing unit; (ie contact the losing unit). Witness 42 confirmed that "*We didn't have any procedures because this has never occurred…..we haven't had anyone on temporary assignment*". The TAA Uplift was the first time that DCSU had received personnel attached to DCSU for a temporary period.

T44/173/D-F
T44/175/F
T51/415/A
T51/405/D
T51/401/G
T51/406/B

1.4.239. In respect of the takeover from a losing unit Witness 48 noted *"…unless there was a reason to make contact with a losing unit on a normal standard assignment move….there was no....standard every single unit that was losing a person was contacted*". Witness 51 noted that contact with the losing unit was not routine business "*unless there's a specific issue unless something has been specifically raised…*". Witness 48 clarified that DCSU did not contact any of the parent units that the TAA Uplift personnel came from.

T51/407/F
T51/423/F
T54/516/F
T54/517/G-F
T51/424/C

1.4.240. DCSU had an arrival and induction process in place which is covered below; including the application of the arrival and induction process to the TAA Uplift personnel.

Opinion

1.4.241. The Panel are of the opinion that DCSU had no specific takeover procedures in place for SP joining the Unit on a temporary basis. The Unit did not have a process in place (nor were they mandated to have), which routinely established contact with the losing unit of SP that joined the unit, either on a temporary or permanent basis. The Panel determined DCSU not having any specific takeover procedures in place for SP joining the Unit on a temporary basis was an Other Factor.

Examine how relevant policies, procedures, welfare practices and other provisions are applied and determine the unit level understanding in relation to these policies.

DCSU Application / Understanding of AGAI Vol 2, Chap 57 - Health Committees[30]

1.4.242. During 2019 and early 2020, DCSU attended the RAF Henlow Station monthly Unit Health Committee (UHC) under a local Memorandum of Understanding (MoU). The UHC was co-ordinated and chaired by RAF Henlow not Witness 51.

F81/27-28
T51/418/A-H
T54/530/C

1.4.243. The RAF Henlow Station monthly UHC was a combined UHC Part 1 - Unit Health Policy Review and UHC Part 2 - Individual Case Conference. Witness 51 noted that from May 20 onwards DCSU now attend a separate UHC Part 1 Unit Health Committee and UHC Part 2 Individual Case Conference. Witness 51 commented *"…the Station* [RAF Henlow] *now understand that they don't…..cover everything the Army needs to cover…."*. During 2019 DCSU did not attend the RAF Henlow Station Monthly Unit Health Committee in Oct 19, Nov 19 or Dec 19.

T51/418/F
T54/530/A-H
F81A/28
T54/531/B

Opinion

1.4.244. The Panel are of the opinion that the DCSU application of AGAI Vol 2, Chap 57 - Health Committees prior to May 20 was not compliant with policy. The Panel are of the opinion that to be effective the UHC must be chaired by the Unit CO and the UHC held in accordance with the required policy timescales. The Panel determined that DCSU being not compliant with AGAI Vol 2, Chap 57 - Health Committees was an Other Factor.

Recommendation

1.4.245. DCSU ensure that UHC Part 1 (known from Apr 20 onwards as the Unit Quarterly Review) and UHC Part 2 Individual Case Conference (known from Apr 20 onwards as Commander's Monthly Case Review) are held in accordance with AGAI 57 – Health Committees.

DCSU Application / Understanding of AGAI Vol 3, Chap 81 - Army Welfare Policy[31]

F99

1.4.246. **Unit Welfare Standing Orders.** DCSU held a Welfare Standing Order (dated 27 Feb 20) as mandated by AGAI 81 – Army Welfare Policy incorporating the CO's Welfare Policy Statement. DCSU were not able to produce a copy of the Welfare Standing Order in force in Jan 20 (See TOR 7).

F81A
T51/419/H

1.4.247. **Unit Welfare Management Committee Conduct / Attendance.** DCSU did not hold a Unit Welfare Management Committee monthly as required by AGAI 81 – Army Welfare Policy. Witness 51 noted that from May 20 onwards DCSU now conduct a monthly Welfare Management Committee.

T51/421/D
T54/536/D
T54/536/C

1.4.248. **Unit Application of the JPA Welfare Tool.** The JPA Welfare Tool was in use in DCSU. DCSU had a process in place to check the JPA Welfare

T54/535/A-E

[30] AGAI Vol 2, Chap 57 – Health Committees dated Sep 17 in force until replaced by version dated Apr 20.
[31] AGAI Vol 3, Chap 81 - Army Welfare Policy dated Mar 19 in force until replaced by version dated Jan 20.

Tool as a means of identifying individuals with welfare issues on arrival / departure to / from DCSU. **F99**

Opinion

1.4.249. The Panel are of the opinion that the DCSU application of AGAI 81 - Army Welfare Policy prior to May 20 was partially compliant with policy. The Panel are of the opinion that to be effective the Welfare Management Committee should be held monthly as required by AGAI 81 – Army Welfare Policy. The Panel determined the DCSU being partially not compliant with AGAI 81 - Army Welfare Policy was an Other Factor.

Recommendation

1.4.250. DCSU ensure that a Welfare Management Committee is held monthly as directed by AGAI 81 Army Welfare Policy and that the expected attendance / membership for the meeting is as per Annex D to AGAI 81 Army Welfare Policy.

DCSU Application / Understanding of AGAI Vol 3, Chap 110 Army Suicide Vulnerability Risk Management (SVRM) Policy[32]

1.4.251. **Unit SVRM Process / Application.** The DCSU lead for SVRM policy was the Adjt. Once a SP is identified at risk, DCSU conduct a SVRM Risk Conference, chaired by the CO at which he is the deciding authority as to whether the SP is placed onto the Unit SVRM Register (VRMIS). A CAP Lead is appointed by the CO and a CAP is produced relevant to the needs of the SP. The CAP is reviewed every 28 days by the CO as part of a formal review. As at Dec 19, DCSU had one SP on the Unit SVRM Register. **T51/424/E-F** **T51/382/D** **T54/538/C-H** **T54/539/A**

1.4.252. **Transferring SP.** DCSU understood the requirement to transfer a VRMIS record when an individual on the Unit SVRM register with an open or closed CAP is posted to a new unit. The CO also stated that he would conduct a CO to CO level handover. **T54/538/B-D**

Opinion

1.4.253. The Panel are of the opinion that DCSU understood and were effective in their application of AGAI 110 - Army SVRM Policy. The policy and the MIS system VRMIS was in use, with a nominated SVRM Lead, risk conferences with regular monthly reviews were in place with the CO as the deciding authority.

DCSU Application / Understanding - LFSO 3217 Trauma Risk Management (TRiM)[33]

1.4.254. **Unit TRiM Policy.** DCSU had a TRiM Standing Order dated 30 Jan 18 (including TRiM Action Plan) and CO's TRiM Policy Letter in place, dated Dec 19, as mandated by LFSO 3217 – TRiM. **F102** **F104**

1.4.255. **Unit TRiM Qualified Personnel.** LFSO 3217 – TRiM states that the requirement for Major Units is five TRiM Coordinators and 20 TRiM **F103** **T35/304/E**

---

[32] AGAI 110 – Army Suicide Vulnerability Risk Management (SVRM Policy) dated Aug 12 in force.
[33] LFSO 3217 Trauma Risk Management (TRiM) dated Aug 11 in place.

Practitioners; minor unit requirement is not listed. In Mar 20 DCSU held two TRiM Coordinators and one TRiM Practitioner. On 23 Jan 20, DCSU held only one TRiM Coordinator. DCSU had submitted applications for training for an additional TRiM Coordinator but had not been successful.	**F105C**
1.4.256. **Unit TRiM Process / Application - Death of The SP (Delivery).**	
a. The single DCSU qualified TRiM Coordinator was away from DCSU when the Unit became of aware of the death of the SP. He returned briefly but left on assignment on 31 Jan 20 leaving DCSU with no trained TRiM Coordinator to oversee the DCSU TRiM process. Witness 50, from HQ 77 Bde took charge of the coordination of TRiM for DCSU personnel, having already commenced the coordination of TRiM for HQ 77 Bde personnel on 24 Jan 20.	**T35/298/E** **T35/298/G** **T35/302/D** **F105C** **T53/467/F**
b. TRiM was formally offered to seven DCSU SP, of which three SP declined. Four DCSU SP underwent TRiM. The TRIM 72 hour Risk Assessments, required by LFSO 3217, were not conducted until 13 Feb 20 for three of the four DCSU SP and the One Month Risk Assessments were not conducted / completed for the same three DCSU SP due to Witness 50 deploying on a course and then being posted immediately afterwards.	**F95** **F183** **T39/58/G** **T53/469/A-C**
1.4.257. **Unit TRiM Process / Application - Death of the SP (Record Keeping).** Witness 50 created a TRiM Incident Log Book. The TRiM activity was not recorded on JPA as directed by LFSO 3217 – TRiM.	**F183** **T53/470/D**

Opinion

1.4.258. The Panel are of the opinion that DCSU were effective in meeting the requirement to have a Unit TRiM policy, however at the time immediately post incident did not have a DCSU TRiM Coordinator in post despite submitting course applications. The Panel view the support offered by HQ 77 Bde in the provision of TRiM support to DCSU SP as being only partially effective due to the delay in the provision of the TRIM 72 hour Risk Assessments for three DCSU SP and that the One Month Risk Assessments for same SP were not conducted. The Panel are of the opinion that recording the TRiM activity conducted on JPA is essential to ensure that the Army have an accessible / viewable record of SP that have undergone a traumatic incident in order that future support may be provided as required. The Panel determined that the HQ 77 Bde provision of TRiM support to DCSU SP being only partially effective was an Other Factor.

Recommendations

1.4.259. HQ 77 Bde, as the TRiM coordinating HQ for the incident, ensure that the TRiM activity undertaken by SP within 77 Bde has been recorded on JPA individual records in accordance with LFSO 3217 Trauma Risk Management.

1.4.260. HQ 77 Bde, when supporting units without TRiM trained personnel, ensure that TRiM is delivered in accordance with the required timescale directed in LFSO 3217 Trauma Risk Management.

DCSU Application / Understanding of JSP 751 Joint Casualty and Compassionate Policy and Procedures

1.4.261. **Casualty Reporting Process (General) - Working Hours / Out of Hours.** The Adjt was the lead for reporting casualties via JCCC during working hours. Outside working hours the DCSU Duty Field Officer (DFO) was responsible for casualty reporting. The DFO Orders contain a detailed flow chart covering the actions required by the DFO in the event of an out of hours casualty. DCSU had no involvement in the casualty reporting process following the death of the SP as all reporting was conducted by 1 MI Bn. **T54/539/F T54/540/C-D F193**

1.4.262. **Casualty Notification Officer (CNO) / Visiting Officer (VO) Process / Application.** DCSU had two SP that were both CNO and VO qualified. The Compendium of Mandated Course Trained Personnel states a requirement for a minor unit to hold eight CNO and three VO qualified personnel. DCSU were aware that they did not hold the minimum required number of CNO and VO qualified personnel. Witness 51 noted that DCSU do not currently contribute to any CNO / VO Duty Roster. **F107 F81/43 T54/541/A**

1.4.263. **Updating SP NoK / EC Contact Details.** Within DCSU SP are required to verify their NoK / EC contact details on JPA on arrival. Additionally, verification takes place annually and prior to any overseas deployment. SP are reminded via Unit Part One Orders. **T44/179/D T54/540/F**

Opinion

1.4.264. The Panel are of the opinion that DCSU understood and were effective in their application of JSP 751 Joint Casualty and Compassionate Policy and Procedures. The Panel are of the opinion that DCSU not holding the required number of CNO and VO trained personnel was as a result of them not being required to contribute to a CNO / VO Duty Roster.

DCSU policies that were in place prior to the death of [the SP] with regard to assignment of temporary personnel, their arrival and proposed integration/induction within existing cells.

1.4.265. DCSU did not have any specific policies in place for personnel on temporary assignment. DCSU had two Unit SOIs relating to the arrival and induction of SP into DCSU; SOI 1-001 DCSU Unit Induction SOI (dated 30 Jan 18) and SOI 1-002 DCSU Arrival and Departures SOI (dated 30 Jan 18). **T51/401/G T51/406/B F108 F110**

1.4.266. **SOI 1-001 DCSU Unit Induction.** The SOI outlined the formal induction programme covering the J1 to J7 requirements for new arrivals at DCSU. The SOI had the stated intent "*to ensure new arrivals are received to the unit, administered in the appropriate manner and subsequently prepared to meet their new responsibilities*". The example Main Events List contained in the SOI included a J1 Arrivals Procedure at the DCSU J1 Office. **F108**

1.4.267. **SOI 1-002 DCSU Arrival and Departures.** The SOI outlined the process to be followed by SP as they arrived and departed from DCSU. The procedure included completion of a DCSU Arrivals Certificate to be actioned within five days of arrival. Completion of the DCSU Arrivals Certificate entailed visiting different departments within DCSU and obtaining their signature. **F110**

1.4.268. **Application of DCSU Arrival and Induction SOIs to the TAA Uplift Personnel.** DCSU did not apply the Unit Induction and Unit Arrival SOIs / process to the TAA Uplift personnel. DCSU did not apply them to the TAA Uplift personnel as they were geographically located at Hermitage, rather than RAF Henlow. Witness 48 noted it "*was the first time we'd ever been assigned personnel who were not going to be located here* [RAF Henlow]".

T51/409/A
T51/412/H
T54/521/B
T54/520/B
T51/409/D
T45/231G

1.4.269. **DCSU Arrival / Induction Lessons Identified.** Witness 51 noted that DCSU had not spotted the requirement *"…..to ensure they come here and we see them and we talk to them…* adding *".. we should have incorporated the induction".* In relation to the application of the Arrivals SOI No 1-002 Witness 51 commented *"…..it was just missed as a key thing to do*". As a Lesson identified during Hearing 2 Witness 51 noted "*inductions arrivals at DCSU to be done*".

T54/520/H
T54/527/H
T54/541/C

Opinion

1.4.270. The Panel are of the opinion that DCSU were not effective in the application of the DCSU Unit Induction and Arrival SOIs / Process for the TAA Uplift personnel. The DCSU SOIs were Unit specific, not location specific however DCSU treated the process as being location specific in that the TAA Uplift personnel were not to be based at RAF Henlow they were not required to go through the DCSU Unit Induction and Arrival Process.

1.4.271. The Panel are of the opinion that if DCSU had applied the DCSU Unit Induction and Arrival SOIs / Process to the TAA Uplift personnel then it is likely that the absence of the SP would have been identified prior to 23 Jan 20. The Panel determined that ineffective application of the Unit Induction and Arrival SOIs / Process was an Aggravating Factor.

Recommendation

1.4.272. DCSU ensure that the Unit Induction and Arrivals process includes SP that are on temporary attachment to the Unit and also those DCSU SP that are not located at RAF Henlow.

Arrival and Accountability of DCSU TAA Uplift Personnel

DCSU TAA Uplift Personnel Arrival - 7 Jan 20

1.4.273. On 7 Jan 20 (approx 1000 hrs) the TAA Uplift personnel allocated to DCSU and the Mission Planners allocated to the BOC 77 Bde, assembled at a conference room in Hermitage. They were met by Witness 44 and Witness 45; the former introduced the latter as the Senior Representative for DCSU based at Hermitage.

T40/71/C
T46/244/A
T47/272/D
T47/274/C
T47/278/B

1.4.274. Witness 44 was present to meet the Mission Planners allocated to the BOC 77 Bde and accounted for the seven SP that were expected. After an initial brief Witness 44 took the Mission Planners through to the BOC, introducing them to their Team Leaders who then took control of them.

T46/250/F
T46/253/C-D

1.4.275. Witness 45 did not have a list of those TAA Uplift personnel allocated to DCSU and did not account that all nine TAA Uplift personnel listed by name in the 77 Bde Uplift Joining Instructions were present and had returned from leave. Witness 45 described the process as "*quite informal*"

T47/274/B-H
F93
F93A
T47/274/H

adding "*I didn't expect anybody to be missing…..they're adults that we're dealing with*" and *"….people had been told to report at 1000 hrs…I had no reason to expect they wouldn't*" adding "*it didn't even come into my thinking that people wouldn't turn up*". The absence of the SP was not noticed by DCSU on 7 Jan 20 during the arrival of the TAA Uplift. Witness 51 confirmed that there was no assurance process in place by DCSU to assure that all the TAA Uplift personnel had arrived and been accounted for on 7 Jan 20.

T47/280/F
T47/275/F
T54/491/F

1.4.276. Witness 45 could not recall being formally directed by HQ DCSU to meet the TAA Uplift personnel but thought it a "*logical assumption*" and "*an implied task*". Witness 43 recalled tasking Witness 45 by telephone on 16 Dec 19 to greet the TAA Uplift personnel on 7 Jan 20.

T47/273/B-C
T45/202/A-D

DCSU TAA Uplift Personnel Activity - 7 Jan 20 to 8 Jan 20

1.4.277. Witness 45 was not aware of any plan for the TAA Uplift personnel on 7 Jan and 8 Jan 20. The only timing, he was aware of, was a forthcoming brief by the CO DCSU on 9 Jan 20. Witness 45 noted his understanding at the time was *"… just to find activity to fill that gap until the CO DCSU was able to do his introduction and give direction and guidance*".

T47/276/F
T47/276/F
T47/275/G
T47/272/E

1.4.278. Witness 45 directed the TAA Uplift personnel to the BOC to get a feel for what was going on and to complete any outstanding admin. He noted that 8 Jan 20 was a Sports afternoon adding "*it was a slow start*". Witness 45 clarified "*as I didn't have anything written down or anything planned, it was thinking off the cuff*" adding "*it was essentially a holding pattern until CO DCSU brief on Thursday* [Thu 9 Jan 20]". There was no accountability of the TAA Uplift personnel conducted by DCSU on 7 Jan or 8 Jan 20. The TAA Uplift personnel were not allocated any specific desk space or allocated to any DCSU Team. The absence of the SP remained unnoticed by DCSU on 8 Jan 20.

T47/275/G
T47/276/A-G
T47/281/E
T47/281/H
T47/282/C
T40/71/F
T40/88/D

1.4.279. Witness 38 described the 7 Jan 20 as "*constant confusion"*. Each of the three TAA Uplift personnel interviewed during Hearing 2 (Witness 36, Witness 38 and Witness 39) had a different view on who was in charge of them on 7 Jan and 8 Jan 20.

T40/72/F
T38/20/A
T40/72/C
T41/98/E

CO DCSU Welcome Brief to TAA Uplift Personnel - 9 Jan 20

1.4.280. On 9 Jan 20 (approx 1000 hrs) CO DCSU conducted a welcome brief for the TAA personnel, including the TAA Uplift personnel, in a lecture theatre at Hermitage. The brief welcomed TAA personnel to DCSU, introduced key DCSU personnel including Team Leaders and allocated TAA Uplift personnel to teams. The SP was shown on an organisational chart used by Witness 51 as allocated to the DCSU ENDURA Team.

T54/500/C-D
T42/125/G
T54/501/B-D
T54/500/F
T54/501/D

1.4.281. As part of the brief the names of the TAA Uplift personnel were read out allocating them to DCSU Teams, an individual response was not required from SP as their name was read out. The SP was allocated to the DCSU ENDURA Team led by Witness 47 who was present at the brief. The welcome brief was the first occasion that the TAA Uplift personnel and Team Leaders became aware of who was allocated to which of the four teams within DCSU. DCSU did not take a nominal role before the brief to ensure that all TAA Uplift personnel were present and had arrived. The absence of the SP was not noticed when the SP was allocated to DCSU Team ENDURA.

T54/501/D
T49/343/C
T54/502/B-F
T54/502/D
T49/342/B

DCSU ENDURA Team Welcome Brief By Witness 47 - 9 Jan 20

1.4.282. Following the CO DCSU welcome brief, Witness 47 gathered together the ENDURA and INTORT Teams to conduct a Team welcome brief. Witness 47 did not conduct a roll call or take a head count, he noted that "*I assumed that the arrivals process would have highlighted any issues*". The absence of the SP was not noticed by DCSU when the TAA Uplift personnel were welcomed into the DCSU ENDURA Team.

T49/345/D-H
T49/348/C-D
T49/368/F
T49/346/A
T49/344/G

DCSU Staff Work Supporting the TAA Uplift Arrival Process

1.4.283. There was no single unifying piece of staff work, (ie written plan, FRAGO, admin instruction or coordination instruction) produced by DCSU to co-ordinate the arrival of the TAA Uplift personnel or activity during the W/C 6 Jan 20. Witness 45 noted "*I think it was potentially missed or overlooked because the information was already elsewhere in email chains…... We had the names, …….. there was a small window….7th to the 9th January 2020 that is potentially unaccounted for…., I don't think was accounted for in any written instruction, any written order..*".

T45/191/C
T47/268/C

TAA Uplift Arrival Process Lessons Identified

1.4.284. **DCSU Written Plan.** Witness 46 noted "*there should have been a formal admin instruction or something similar giving orders for what the requirements would be…..what the plan was, and then clear responsibilities and tasks for who was responsible for what*". Witness 45 identified "*We probably could have had a ….. coordinating instruction for those first few days after Christmas leave, accounting for that time between the 7th and the 9th* [Jan 20]" adding *"... [a] more comprehensive coordinating instruction for those first few days....with clear timelines of who is responsible for the individual at each stage in the process*".

T48/320/A
T47/287/C-F

1.4.285. **DCSU Roll Call / Nominal Rolls.** Witness 43 identified that "*there wasn't a definitive head check against the nominal on the first day back"*. Witness 45 noted *"..the nominal roll…. should have been taken.."* Witness 47 noted he could have done a roll call as part of his welcome brief on 9 Jan 20. Witness 51 identified *"… a nominal to be taken on the 7th January, a nominal to be taken on the 9th January*".

T45/235/B
T47/287/C
T49/365/C
T54/540/E

1.4.286. **DCSU Assumptions Vs Assurance.** Witness 43 noted there were a series of assumptions that were made *"There was an assumption at .. headquarter level that … everyone was being accounted for and administered and managed. There was an assumption … after the 9th from the headquarters,…. that there'd been a handover and then it was…. Line Managers accounting for their people……, so it was a number of assumptions rather than clarity and clear concise facts that probably led to the oversight at all levels…..*". Witness 51 identified that there was no DCSU assurance process in place to assure that all the TAA Uplift personnel had arrived as expected on the 7 Jan 20 and were accounted for.

T45/235/B-D
T54/491/E-G

Opinion

1.4.287. The Panel are of the opinion that DCSU were not effective in receiving the TAA Uplift personnel on 7 Jan 20 and their subsequent oversight

and accountability over the period 7 to 9 Jan 20. The Panel determine that the omission of DCSU to account for the TAA Uplift personnel on arrival on 7 Jan 20, or during the period 7 and 8 Jan 20 was an Aggravating Factor.

1.4.288. The Panel note there was no single unifying piece of staff work by DCSU (coordinating instruction / admin instruction or written plan) covering the arrival of the TAA Uplift personnel, responsibility for meeting them on 7 Jan 20, accountability and their subsequent allocation to teams. The Panel are of the opinion that a lack of a written instruction caused a significant lack of clarity. The Panel determine that the lack of DCSU coordinating instruction / written plan covering the arrival of the TAA Uplift personnel in Jan 20 was an Aggravating Factor.

DCSU ENDURA Team TAA Leadership Structure

1.4.289. Witness 47 did not allocate a direct Line Manager for any of the three TAA Uplift personnel joining the DCSU ENDURA Team (Witness 39, Witness 36 and the SP). Witness 47 commented *"I did not allocate one directly to them".* There was no NCO appointed by Witness 47 to be in charge of the TAA personnel based at Hermitage. Witness 47 noted *"I did not place anybody directly in charge. I did not say to somebody you're now in charge"* adding *"I assumed it'd be the Senior NCO in charge of the ENDURA Team".*

T49/338/C-E
T49/354/B
T49/351/A
T49/351/F

DCSU ENDURA Team TAA Accountability Process

1.4.290. There was no accountability process put in place for the DCSU ENDURA Team TAA Uplift personnel based at Hermitage. Witness 47 noted "*I didn't put anything in place… I personally didn't say to anybody 'I want you to do this*". He assumed that a SNCO would account for personnel but had not briefed a SNCO to be in charge of the ENDURA Team TAA Uplift personnel. Witness 40 and Witness 41 had not been given a list of names by Witness 47 of the TAA Uplift personnel allocated to the DCSU ENDURA Team.

T49/341/D
T49/353/A
T49/363/E
T49/370/G
T42/131/A-E
T43/148/C

Opinion

1.4.291. The Panel are of the opinion that there was no effective leadership structure or accountability process within the DCSU ENDURA Team. The Panel note that there was an assumption made rather than a positive assurance control action or measure put in place. The Panel are of the opinion that no SNCO in the DCSU ENDURA Team based at Hermitage had been given responsibility from 9 Jan 20 onwards for the TAA Uplift personnel, including the SP. Nor had they been provided with a list of names for the TAA Uplift personnel, therefore no one noticed the SP was missing as they had not been provided with his name. The Panel determined that the ineffective provision of a leadership structure and accountability process within the DCSU ENDURA Team from 9 Jan 20 onwards was an Aggravating Factor.

Recommendation

1.4.292. DCSU ensure that a Unit personnel accountability system is in place to assure that all SP are accounted for, commencing from the start date of any temporary attachment / assignment to the Unit.

TOR 6. Investigate what actions were taken by the Chain of Command following the death of [the SP] and any immediate recommendations made by both 1 MI Bn and DCSU.

Findings:

1 MI Bn Chain of Command Actions Following the Death of the SP

1 MI Bn Reporting / Investigation

1.4.293. **NOTICAS / INCREP.** 1 MI Bn raised a series of NOTICAS on 23 Jan 20. The details of NOTICAS, along with SI Panel Opinion and recommendations are contained within TOR 4. On 23 Jan 20 1 MI Bn raised an initial INCREP followed by a series of updates. **F1/A7-A8 F23/F24 F32**

1.4.294. **RMP Reporting.** On 23 Jan 20 (approx 1042 hrs), Witness 29 reported the incident to the RMP. They arrived on the scene at approx 1110 hrs and confirmed that North Yorkshire Police had also arrived at the incident. **F33**

1.4.295. **Unit Level Investigation.** 1 MI Bn conducted a Unit Level Investigation submitting a Learning Account to HQ 1 ISR Bde on 31 Jan 20. **F1**

Witness 28 - 1 MI Bn Unit Address

1.4.296. On 23 Jan 20 (approx 1045 hrs) Witness 28 made an address to those 1 MI Bn SP based at Catterick informing them of the death of the SP. The address contained incorrect information which speculated on the cause of death. On 23 Jan 20 (approx 1600 hrs) Witness 28 made a second addresses which corrected the earlier briefing. Witness 28 also briefed the assembled SP about the requirement for operational security relating to the incident in order that the family were informed via the appropriate means. **F1/A6 T31/219/C-F T27/116/F T31/219/C-F T31/221/A**

Opinion

1.4.297. The Panel are of the opinion that 1 MI Bn carried out timely reporting of the discovery of the SP on 23 Jan 20. The Panel are of the opinion that for Witness 28 to speculate on the cause of death in his address was unnecessary, could lead to misinformation and that a unit briefing should only include the known facts. The Panel determine that 1 MI Bn speculating on the cause of death of the SP in the brief to the Unit was an Other Factor.

Recommendation

1.4.298. 1 MI Bn ensure that when briefing Unit personnel following the death of a SP, the Unit must not speculate on the cause of death within the address.

1 MI Bn Learning Account Immediate Recommendations Following the Death of the SP - Update

1.4.299. **1 MI Bn Unit Recommendation 1.** CO 1 MI Bn to instigate an assured handover takeover protocol for BDO on duty over block leave periods NLT 1 Mar 20. **F1/17a(5)**

1.4.300. **1 MI Bn Unit Recommendation 2.** 1 MI Bn Ops [Cell] implements a new process in which the Ops Team will telephone all receiving units / formations to confirm the safe arrival of individual augmentees on the expected reporting for duty date, with immediate effect. **F1/17b(5)**

1.4.301. **1 MI Bn Unit Recommendation 3.** CO 1 MI Bn to ensure a coordination meeting takes place between 1 MI Bn Ops, the individual augmentees Coy CoC, and the receiving unit / formation prior to the deployment of an individual augmentee. This can address any pertinent G1 matters as well as the soldiers ongoing professional objectives for the reporting year. **F1/17b(6)**

a. **Update On Recommendations 1 to 3.** During Hearing 1 Witness 28 confirmed that the recommendations had been implemented. **T31/221/D T31/221/E T31/221/G**

1.4.302. **1 MI Bn Unit Recommendation 4.** Chief of Staff HQ 6 (UK) Div to consider implementing a standardised process of cross-formation co-ordination and assurance. **F1/17b(7)**

a. **Update.** HQ 6 (UK) Div confirmed that they had implemented the recommendation and amended Div SOIs. **T31/222/B F204**

1.4.303. **1 MI Bn Unit Recommendation 5.** Army HQ conducts a review of longstanding external commitments levied against Land ISR liability with a view to re-apportioning back to single service or JFC. **F1/17c(4)**

1.4.304. **1 MI Bn Unit Recommendation 6.** Army HQ considers that any trawls for tasks that will last more than three months should become an assignment. **F1/17c(5)**

1.4.305. **1 MI Bn Unit Recommendation 7.** Army HQ consider that external operations such as Op TORAL, TRAMAL and AMALTAS go back to become OCE filled or float between MI battalions based on the regular tasking relationship between combat formation and supporting MI battalion. **F1/17c(6)**

a. **Update On Recommendations 5 to 7.** HQ 1 ISR Bde informed the SI Panel this recommendation sat with the Lessons Team, HQ APSG. The Lessons Team, Pers Svcs Br, APSG provided an update in which they noted the recommendations raised by 1 MI Bn but had found insufficient evidence presented by the Unit within the Learning Account to find that the Force Generation process contributed to the incident. They found there is not a thematic issue relating to the Force Generation process in the HQ APSG Lessons database. Lessons Team, Pers Svcs Br, APSG noted that the outcome of the SI may find additional evidence to support this recommendation and therefore final judgement was reserved until the production of the SI Report. **T31/223/F F204B F204C**

1.4.306. **1 MI Bn Unit Recommendation 8.** Witness 28, 1 MI Bn to ensure unit NOTICAS SOPs are updated with the stipulation that cause and date of death are not to be commented on until a professional opinion is supplied by emergency services. **F1/17f(5)**

a. During Hearing 1 Witness 28 confirmed that the unit had implemented the recommendation. **T31/224/E**

1.4.307. **1 MI Bn Unit Recommendation 9.** This example be used as a serial for Ex GREEN LEADER and Ex GREEN PRUSSIAN, 1 MI Bn's leadership development training for Junior Officers and Company Commanders respectively. **F1/17f(6)**

a. During Hearing 1 Witness 28 confirmed that the recommendation had yet to be implemented fully due to COVID 19 limiting the gathering of personnel. However, the Unit had conducted a series of on-line seminars and that the recommendation will be handed over to his successor. **T31/224/F-H**

Opinion

1.4.308. The Panel are of the opinion that 1 MI Bn created and implemented appropriate effective Unit level recommendations in a timely manner. Where the Unit was unable to implement Recommendation 9 due to COVID 19, Witness 28 has a clear plan to handover the implementation to the incoming CO. The Panel are of the opinion that a search of the lessons database by the Lessons Team, Pers Svcs Br, APSG has effectively established that that the force generation process is currently not a thematic issue. The force generation process for the TAA Uplift is further examined in TOR 7.

DCSU Reporting / Investigation

1.4.309. **Reporting.** All reporting for the incident was carried out by 1 MI Bn as the unit discovering the SP on 23 Jan 20 and the unit responsible for coordinating the military funeral of the SP on 20 Feb 20. **F2**

1.4.310. **Unit Level Investigation.** DCSU conducted a Unit Level Investigation submitting a Learning Account to HQ 77 Bde dated 3 Feb 20. **F2**

Witness 51 - DCSU Unit Address

1.4.311. On 23 Jan 20 (approx 1700 hrs) Witness 51 made an address to those DCSU personnel based at RAF Henlow. He informed them that the SP had been found dead. He instructed them that no information was to be placed on social media as the NoK were yet to be informed. He did not elaborate on the circumstances surrounding the death. **T54/524/A- H**

1.4.312. Those members of DCSU based at Hermitage were informed via a central address delivered by the Bde Comd, 77 Bde, based at Hermitage in two stages initially on 23 Jan 20 when the name of the SP was not announced and then subsequently when they were informed that it was the SP that had been found dead. It was made clear to personnel that the circumstances of death at that stage was undetermined. **T39/57/F-G T39/58/A-D T41/115/A-D**

DCSU Learning Account Immediate Recommendations Following the Death of The SP - Update

1.4.313. **DCSU Unit Recommendation 1.** As an additional layer of assurance, DCSU should develop a return to work Standard Operating **F2/19d**

Procedure by 7 Feb 20, that requires all Sub-Units, particularly those dislocated from RAF Henlow, to formally notify the unit HQ that all personnel have been accounted for on return from leave.

a. **Update.** During Hearing 2 Witness 51 confirmed that the recommendation had been implemented. **T54/526/E**

1.4.314. **DCSU Unit Recommendation 2.** DCSU should deliver a duty of care plus education package to officers, Warrant Officers and Senior Non Commissioned Officers within the unit by 28 Feb 20. **F2/20d**

a. **Update.** During Hearing 2 Witness 51 confirmed that the recommendation had been completed by DCSU by 3 Mar 20 and that SP on arrival to the unit now automatically get the Presentation. **T54/526/F T54/527/A-C**

1.4.315. **DCSU Unit Recommendation 3.** DCSU should deliver an education package to soldiers and Junior Non Commissioned Officers within the unit by 28 Feb 20. **F2/21d**

a. **Update.** During Hearing 2 Witness 51 confirmed that the recommendation had been completed by DCSU by 20 Feb 20. **T54/527/C-D**

1.4.316. **DCSU Unit Recommendation 4.** The sending unit for Witness 39, Witness 38 and Witness 27 should conduct the same education package described in DCSU Unit recommendations 2 and 3. **F2/21e**

a. **Update.** HQ 77 Bde confirmed that this recommendation had been completed. **T54/527/E-F F204A**

Opinion

1.4.317. The Panel are of the opinion that DCSU carried out a timely investigation and production of a Unit Learning Account upon being informed of the discovery of the SP on 23 Jan 20. The Panel are of the opinion that DCSU created and implemented appropriate effective unit level recommendations in a timely manner supported by HQ 77 Bde based on the information they were aware of at the time.

TOR 7. Consider any other matters relevant to the Inquiry and, based on the evidence, make such findings and express opinions as are appropriate to support recommendations in order to prevent recurrence.

Findings:

The SP's Hire Car Collection 6 Jan 20

1.4.318. On 21 Nov 19, the SP submitted a FMT 1000 Transport request form for a one way hire vehicle to be collected by him on 6 Jan 20 (1200 hrs). **F66 F1/16c** The vehicle was booked by the MT Dept, 1 MI Bn and a hire vehicle allocated by the Authorised Demanding Officer within the White Fleet Management Team to be collected from a hire company based in Catterick Garrison on 6 Jan 20 (1200 hrs). **F66** The SP did not collect the hire vehicle on 6 Jan 20. 1 MI Bn were not made aware that the SP had not collected the hire vehicle.

1.4.319. The Standing Order for White Fleet Control, Management and Operation dated 13 Jun 16 does not contain any direction that units are to be informed following the non-collection or non-return of hire vehicles by SP. **F66B**

Opinion

1.4.320. The Panel are of the opinion that where a SP does not either collect or return a prearranged hire car that the unit should be made aware for duty of care / welfare reasons. The Panel are of the opinion that if 1 MI Bn been made aware that the SP had not collected the hire car on the 6 Jan 20 that on the balance of probabilities the unit may have tried to contact him, and that the SP may have been discovered earlier than 23 Jan 20. The Panel determine that 1 MI Bn not being made aware that the SP had not collected his hire car on 6 Jan 20 was an Other Factor.

Recommendation

1.4.321. Logistic Support Branch, HQ Regional Command amend Standing Order for White Fleet Control, Management and Operation to include direction that where a SP fails to either collect or return a pre arranged hire car booking that the unit be made aware for duty of care / welfare reasons.

SLA Booking In / Out Procedure

1.4.322. The Army policy covering the routine to be applied within SLA is AGAI Vol 2, Chapter 53 - Barrack Regimes and Living Out by Single Personnel (dated Aug 18). AGAI 53 directs at Para 53.020 "*Booking In and Out. It is essential that as a matter of routine, an effective management system is in place in order to determine whether personnel, both civilian and military, are within barracks and whether SLA is occupied in the event of an emergency. This requirement ensures a CO meets health & safety requirements and fulfils their duty of care obligations.* **F205**

1.4.323. The SLA occupied by the SP was managed / allocated by HQ Catterick Garrison. The block was of mixed occupancy, housing SP from minor units within the Garrison, including 1 MI Bn. Witness 33, confirmed that there were no booking in / out procedures for the SLA block. Witness 9 noted that "*..you don't really book out of the block…*" adding "*there's no really booking in or out*", this was also confirmed by Witness 10. 1 MI Bn confirmed that the only booking in / out procedures in place related to booking out of the barracks when leaving post 2000 hrs. **F180** **F51/7** **T10/18/F-G** **T11/31F**

1.4.324. Whilst the SLA is controlled by HQ Catterick Garrison it is the CO's of the units occupying the SLA that have responsibility to control the SP living in the accommodation. A Memorandum of Understanding (MoU) exists between HQ Catterick Garrison as the originator of the MoU and the CO's of units occupying the accommodation, delineating the responsibilities to comply with policy and allocating the responsibilities where no one unit is the sole occupier of a SLA block. **F221**

1.4.325. HQ Catterick Garrison noted that in reviewing, post incident, the requirement for booking in and out procedures contained within AGAI 53 there was a lack of clarity in the publication as to the actual requirement / definition of the required effective management system, to determine whether personnel are in barracks and whether SLA is occupied. HQ Catterick **F221**

Garrison, in consultation with Garrison units noted, it was unclear what the requirement was and what effect the policy was trying to achieve. HQ Catterick Garrison noted that without clarity of the requirement it is not possible to implement an effective management system.

Opinion

1.4.326. The Panel are of the opinion that there was not an effective management system in place within the SLA in order to determine whether personnel were within barracks and if the SLA was currently occupied. The Panel are of the opinion that it is not possible to determine if an effective booking in / out system had been in place in the SLA block, whether any SP would have made reference to it to determine if the SP had booked out. The Panel determine that the lack of an effective management system in place within the SLA, Catterick in order to determine whether personnel were within barracks and if the SLA was currently occupied was an Other Factor.

1.4.327. The Panel share the view of HQ Catterick Garrison, that AGAI 53 lacks clarity (para 53.020) as to the requirement for the mandated effective management system for booking in / out. The Panel determine that the lack of clarity within AGAI 53 was an Other Factor. The Panel are of the opinion that Personnel Services Branch, Directorate of Personnel, HQ Army should review and clarify the procedure within AGAI 53 and that the input / view of HQ Fd Army and HQ Home Command be sought during the review.

Recommendations

1.4.328. Personnel Services Branch, Directorate of Personnel, HQ Army review and clarify the requirement for the mandated effective management system contained within AGAI Vol 2, Chap 53 Barrack Regimes and Living Out By Single Personnel.

1.4.329. HQ Catterick Garrison incorporate into the existing MoU between HQ Catterick Garrison and the CO's of units occupying GSU (Garrison Support Unit) controlled accommodation a requirement / reminder to ensure that each CO complies with (and has an effective unit assurance process) AGAI Vol 2, Chapter 53 - Barrack Regimes and Living Out by Single Personnel, in that each unit is to have an effective management system in place in order to determine whether unit personnel, both civilian and military, are within barracks and whether SLA is occupied in the event of an emergency. In cases where SP from different units share an SLA block, HQ Catterick Garrison MoU will appoint a named lead Unit.

Retention of Information

1.4.330. The Joint Policy on the retention of information is JSP 441 - Managing Information in Defence. The time period directed within the retention schedule within JSP 441 for unit orders, instructions and policy is 15 years. The Army policy on the retention of information is ACSO 1811 - Army Information Management Professionals Ways of Working (dated Feb 16). The time period directed within the retention schedule within ACSO 1811 for policy documents is 15 years.

F207
F206

1.4.331. 1 MI Bn were unable to produce the version of Standing Order 1026 Unit TRiM Management Plan that was in place in Jan 20. DCSU were not able to produce a copy of the Welfare Standing Order in place in Jan 20. **F51/44 F81A T51/419/G**

Opinion

1.4.332. The Panel note that both 1 MI Bn and DCSU did not have an effective information management system in place to archive previous versions of standing orders for the minimum mandated period set out by Joint and Single Service Policy. The Panel assess that the lack of awareness of the requirement to retain information for a set period was the reason why the units did not retain information. The Panel determine that the lack of an effective information management system within 1 MI Bn and DCSU to archive previous versions of standing orders for the minimum mandated period set out by Joint and Single Service Policy was an Other Factor.

Recommendation

1.4.333. HQ Fd Army and HQ Home Command regularly remind units that Unit Standing Orders are to be declared as a record and that the retention period for Unit Standing Orders is 15 years from date of publication in accordance with JSP 441 - Managing Information in Defence and ACSO 1811 - Army Information Management Professionals Ways Of Working.

TAA Uplift Force Generation Process

1.4.334. **6 (UK) Div FGenO.** On 17 Oct 19, HQ 6 (UK) Div issued a FGenO to generate 77 Bde capability including within the area of BOC Mission Teams, TAA, and Web Operations. The FGenO directed 1 ISR Bde to generate ten SP with the remaining personnel being drawn from others Bdes. **F35**

1.4.335. **1 ISR Bde Trawl.** On 18 Oct 19, HQ 1 ISR Bde issued a trawl to 1 ISR Bde units to identify volunteers for the ten posts they were required to fill. **F60**

1.4.336. **1 MI Bn Trawl.** On 18 Oct 19, the Ops Cell, 1 MI Bn issued a trawl to 1 MI Bn Sub-Units requesting they nominate volunteers by 22 Oct 19. On 21 Oct 19, HQ Coy nominated the SP and one other SP as volunteers for the trawl and the SP was subsequently put forward to HQ 1 ISR Bde as part of the unit submission by the Ops Cell 1 MI Bn as a supported volunteer. **F60**

1.4.337. **Trawl Selection.** On 28 Oct 19, the Ops Cell, 1 MI Bn informed HQ Coy that the SP had been selected by HQ 1 ISR Bde as a TAA. **F60**

1.4.338. **HQ 77 Bde Joining Instructions / 1 MI Bn FRAGO.** On 22 Nov 19, HQ 77 Bde issued detailed Joining Instructions for the Uplift personnel. The Joining Instructions were cascaded down by HQ 1 ISR Bde to the Ops Cell, 1 MI Bn on 22 Nov 19. 1 MI Bn Ops Cell subsequently produced and issued to the SP a bespoke FRAGO (56/19 - 77 Bde Uplift) on 27 Nov 19 covering his temporary attachment. **F93 F61**

Opinion

1.4.339. The Panel are of the opinion that the SP was a volunteer to become a TAA and received sufficient notification of his temporary attachment

to 77 Bde. The Panel are of the opinion that the Force Generation process for the 77 Bde Uplift was effective and not a factor in the incident.

1 MI Bn Publication of Helpline Contact Details On Unit Routine Orders

1.4.340. **Speak Out.** Speak Out is an impartial, confidential Army helpline, independent of the Chain of Command (CoC), that exists to improve the lived experience of Army personnel. The Unacceptable Behaviour Team, within Pers Svcs Br, APSG are responsible for the helpline. **F209** **F208**

1.4.341. **Speak Out Publicity on Unit Routine Orders.** The Unacceptable Behaviour Team, Pers Svcs Br, APSG confirmed that the requirement to publish the contact details of Speak Out on Unit Routine Orders is set at fortnightly and is contained within the Directorate of Personnel, Compendium of Standing Orders. In addition, Army Briefing Note 106/19 contained direction to units to publish the contact details of Speak Out on Unit Routine Orders. **F210** **F209**

1.4.342. **1 MI Bn Speak Out Publicity on Unit Routine Orders.** During 2019, 1 MI Bn did not publish the contact details for the Speak Out help line on their Unit Routine Orders. 1 MI Bn did not offer an explanation as to why the contact details had not been published on Unit Routine Orders. Although Witness 15 confirmed that Sub Units had G1 notice boards which included up to date Speak Out helpline posters (with contact details). **F162/4** **F220/10**

1.4.343. **Army Bulling Harassment and Discrimination (BHD) Guidelines.** AGAI 75, Vol 2, Chap 75, Respect For Others – Diversity and Inclusion (D & I) Policy guidance and Instructions directs that an extract from the publication covering the Army Policy on BHD is published every six months in order to ensure that personnel are reminded of Army policy on BHD and made aware of what constitutes unacceptable behaviour. **F208**

1.4.344. **1 MI Bn Publication on Unit Routine Orders of Bullying, Harassment and Discrimination Army (BHD) Policy.** During 2019 1 MI Bn published an extract on their Unit Routine Orders covering the Army Policy on BHD in Sep 19. 1 MI Bn also provided an extract that was published on their Unit Routine Orders in Mar 20. However, the extract from AGAI 75 was significantly out of date on both entries and included an incorrect telephone number for a BHD helpline and an incorrect telephone number for the Service Complaints Commissioner[34]. **F162** **F211**

Opinion

1.4.345. The Panel are of the opinion that 1 MI Bn were not policy compliant in the publication of the Army Speak Out helpline and the Army Policy on BHD on their Unit Routine Orders. The Panel are of the opinion that it is essential to make SP aware of the Army policy on BHD on a regular basis via Unit Routine Orders and also of the contact details for the independent and impartial means for SP to raise their issues and concerns. The Panel determine 1 MI Bn not complying with Policy in the publication of the Army Speak Out helpline and the Army Policy on BHD on their Unit Routine Order was an Other Factor.

Recommendations

[34] Service Complaints Commissioner is now known as the Service Complaints Ombudsman.

1.4.346. 1 MI Bn publish the contact details of the Speak Out helpline on Unit Routine Orders at the frequency directed within the Directorate of Personnel, Compendium of Standing Orders.

1.4.347. 1 MI Bn publish the Army Policy on bullying, harassment and discrimination on Unit Routine Orders with the contents and frequency directed by AGAI Vol 2, Chap 75 - Inclusive Behaviours - Diversity, Inclusion and Behaviours Policy, Guidance and Instructions.

1.4.348. Personnel Policy Branch, Directorate of Personnel, Army HQ request confirmation that a Unit is publishing the contact details for the Speak Out helpline on their Unit Routine Orders at the frequency required by AGAI 75 is included within the G1 Audit Question Set.

1 MI Bn Currency of Information Publicised on Unit Routine Orders

1.4.349. During the Service Inquiry the Panel obtained several editions of 1 MI Bn Unit Routine Orders during 2019 and 2020 as evidence. Within those editions were a number of references to policy that were out of date. A total of seven Part One Orders were submitted by 1 MI Bn to the SI Panel, all seven contained at least one out of date reference to policy. **F162** **F163** **F205** **F212**

Opinion

1.4.350. The Panel were of the opinion that 1 MI Bn were not effective in their communication of information to SP via Routine Orders in that it did not contain up to date information. The Panel are of the opinion that unit daily Routine Orders are the primary method of communication of both Joint and Single Service policy updates and Chain of Command information and that is essential that the information contained is update. The Panel determined that the 1 MI Bn lack of effective communication of policy to SP via Routine Orders information was an Other Factor.

Recommendation

1.4.351. 1 MI Bn publish Unit Routine Order updates (Part One Orders) at the frequency and contents contained within the Directorate of Personnel, Compendium of Standing Orders.

The SP's Nomination of NoK on JPA

1.4.352. Bereavement and Aftercare Support (BAS), Pers Svcs Br, APSG confirmed that the SP had not listed his wife on JPA as his Next of Kin, listing two other family members instead as Primary Emergency Contact (EC) and Next of Kin (NoK). This led to a significant delay informing his wife as the NoK. She was not informed of the death of the SP until 26 Jan 20 (approx 1550 hrs), three days after the discovery of the SP on 23 Jan 20. The address details contained on JPA for the two other family members as Primary EC and NoK were also incorrect. **F213** **F1**

1.4.353. The Unit Administration Manual gives direction under Chap 2 – Personnel Documentation, Section 6, Para 02.0603.c on the requirement for EC and NoK for SP that are married but not yet divorced "*If married or separated (but not divorced), the nomination will be the Service Person's* **F214**

spouse/civil partner". Additional direction is provided within JSP 751, Joint Casualty and Compassionate Policy and Procedures, Part 1 Volume 1: Management of the Casualty which directs "*All Service persons are to provide details of their NOK. If married or separated (but not divorced), this will be their spouse/civil partner*". **F215**

1.4.354. As outlined in TOR 1 the SP had formally confirmed during a 1 MI Bn RAC on 28 Nov 19 and during the arrivals process for the Uplift personnel facilitated by 77 Bde on 16 Dec 19 that he had updated his EC / NoK details. **F61** **F178/4** **F8**

Opinion

1.4.355. The Panel are of the opinion that the NoK and EC details for the SP were not effectively recorded on JPA and kept up to date. This led to a delay the NoK being informed of the discovery of the SP. The Panel note that the SP had formally signed to acknowledge his NoK and EC details were correct twice in the two months preceding 23 Jan 20. The Panel determined that the lack of effective NoK and EC details for the SP on JPA was an Other Factor.

Recommendations

1.4.356. HQ Fd Army and HQ Home Command regularly remind units that the NoK listed on JPA for SP that are married but not yet divorced should be the SP's spouse / civil partner in accordance with the Unit Administrative Manual and JSP 751, Joint Casualty and Compassionate Policy and Procedures, Part 1 Volume 1: Management of the Casualty.

1.4.357. The Lessons Team, Pers Svcs Br, APSG monitor SI Reports and Unit Learning Accounts for a period of 12 months to determine if the non-effective recording of EC and NoK details on JPA by SP provides a sufficient body of evidence to necessitate review of the process.

The SP's Move and Track

1.4.358. The Unit Administration Manual directs under Chap 3 – Move and Track, Section 2, Para 0.3.0200, that "*All arrivals at a new unit / organisation or location, for periods of 24 hours or more, must be recorded on JPA*". **F216**

1.4.359. During the Service Inquiry the Panel determined there was an instance when 1 MI Bn had not correctly move and tracked the SP on JPA. Thus, his JPA records listed him in one place and the local Sub-Unit records and TAFMIS / Course records listed him in another place. **F5/14-16** **F6** **F192/7**

Opinion

1.4.360. The Panel are of the opinion that the move and track of the SP conducted by 1 MI Bn was effective with the exception of the one occasion. The Panel are of the opinion that one instance of ineffective move and track on JPA was an isolated incident. The Panel determine that single instance of 1 MI Bn not being effective in the implementation of the JPA Move and Track policy was an Other Factor.

Recommendation

1.4.361. 1 MI Bn ensure that SP deploying to a new unit / organisation or location, for periods of 24 hours or more, must be recorded on JPA via move and track in accordance with the Unit Administration Manual.	
The SP's Off Duty Assault / Victim Updates / Victim Liaison Officer	
1.4.362. **The SP's Off Duty Assault.** On 9 Nov 18, (approx 0235 hrs) the SP was assaulted whilst off duty in Catterick. The incident was initially investigated by North Yorkshire Police until ceded to the Service Police, (Cyprus Joint Police Unit (CJPU)), in Mar 19. CJPU investigated the incident from Mar 19 until Jun 20 when a Service Police Case Referral was submitted by CJPU to the Service Prosecuting Authority on 02 Jun 20.	**F72** **F72C/D** **T11/29/E-H** **F72D** **F72F**
1.4.363. **Service Police Initial Report.** CJPU produced a Service Police Initial Report on 18 Mar 19; distribution addresses included 1 MI Bn and the CO's of the two SP (two separate units) that were alleged to have committed the assault.	**F72** **F217**
1.4.364. **VLO Role.** JSP 839, Victims Services, Section 1 – states "*Victim Liaison Officer (VLO's) appointed by the CO to keep the victim informed of the various events as the case progresses through the Service Justice System*" and Section 3 lists the duties of a Commanding Officer to the Victim stating, "*You must appoint a VLO to the victim within 3 working days of the incident occurring*".	**F217/1.3c** **F217/3.9**
1.4.365. **Responsibility for Appointing a VLO.** JSP 839 and AGAI 62 – Discipline Policy outline that the VLO will be appointed by the CO of the person suspected of committing the crime.	**F217/2.7** **F217/4.1** **F218/62.038**
1.4.366. **VLO Responsibilities.** JSP 839, outlines in the responsibilities of the VLO ".. *primary role is the provision of information to victims*" and "*You should ensure that you agree a means of contacting with the victim and always provide information to the victim without unnecessary delay, especially if the victim is a victim of the most serious crime".*	**F217/4.3**
1.4.367. **The SP's VLO.** 2 MERICAN appointed Witness 55 as the VLO to the SP on 18 Mar 19. Witness 55 confirmed that he did not contact the SP. Witness 55 stated when fulfilling the duty of VLO he always communicated via the Chain of Command of the victim rather than directly to the victim. In this case Witness 55 did not recall communicating with 1 MI Bn, as he was aware the Unit were in receipt of the same Monthly Service Police Progress Reports that he was, and he had no additional information to give the SP.	**F219A**
1.4.368. **1 MI Bn Understanding of the VLO Requirement for the SP.** Witness 29 understood that a VLO had not been appointed for the SP and noted her understanding as "….*Victim Liaison Officer, that's not a …concept that I am familiar with*". Witness 28 was not aware a VLO was in place, noting "…...*I wasn't aware that was a requirement*".	**T32/277/C** **T33/281/B-C**
1.4.369. **Enhanced Victim Support / Victim Support Officer (VSO).** JSP 839, contains guidance to CO's when dealing with allegations of serious criminal offences. The JSP lists the offence types that trigger the need for a victim to require enhanced support. The offence type / matter under investigation listed by CJPU on the monthly Service Police Progress Reports did not precisely match any of the offence types in JSP 839, that would have	**F217/Annex B** **F72D** **F217/Annex B**

triggered enhanced victim support. JSP 839 also contains the following guidance that in addition to the listed offence types "…*a Commanding Officer may exercise his / her discretion and offer enhanced support……. to any victim depending upon the individual's circumstances and the impact that the crime has had on them".* The appointment of a VSO is part of the enhanced support that may be offered to a SP.

1.4.370. **Responsibility for Appointing a VSO.** JSP 839, B states who the VSO will be appointed by at Step 8 "*As part of your ongoing responsibilities to the personnel under your command you are to appoint a Victim Support Officer to all victims of serious offences"*. Therefore 1 MI Bn had the responsibility for considering the requirement for enhanced victim support including considering the requirement for a VSO to be appointed. **F217/Annex B**

1.4.371. **Role of the VSO.** The role / duties of the VSO are covered in JSP 839, and include: provision of moral support, ensuring the victim is not being intimidated and ensuring the victim has information about the internal and external organisations which can provide them with support. **F217/Annex B**

1.4.372. **1 MI Bn Understanding of the VSO Requirement for the SP.** Witness 28 confirmed that a VSO was not offered to the SP noting "*I wasn't aware of that specific task in the JSP* [JSP 839]" adding "*I wasn't aware of a requirement for a VSO…."*. Witness 29 confirmed that a VSO was not offered to the SP noting they were "*unfamiliar with the concept".* **T33/281/A-B** **T32/277/D-G**

1.4.373. **CJPU Production of Monthly Service Police Progress Reports.** During the period May 19 to Jan 20[35] CJPU produced monthly Service Police Progress Reports. The distribution addresses for the monthly Progress Reports included 1 MI Bn and the Units of the two SP that were alleged to have committed the assault. Except Oct 19 and Nov 19 when CJPU only distributed the Progress Report to units of the suspected offenders and not the victim. HQ Provost Marshal (Army) confirmed that Military Police Investigative Doctrine (MPID) directs that it is not mandated that the unit of the victim receives Progress Reports. **F72D** **F72E**

Opinion

1.4.374. The Panel are of the opinion that the victim support provided to the SP following the investigation of the assault in Nov 18 being ceded to the Service Police in Mar 19 was not effective. There was no assurance process in place in 1 MI Bn to assure that the SP had been appointed a VLO. 1 MI Bn at BHQ level were not aware of the VLO process and therefore did not confirm that the SP was being supported by a VLO. The appointed VLO did not ever contact the SP. The Panel were unable to determine if the SP was aware that he had been appointed a VLO.

1.4.375. 1 MI Bn at BHQ level were not aware of the VSO procedure and therefore could not consider the requirement for enhanced victim support to the SP, or consider the opportunity that the CO may exercise their discretion to offer enhanced victim support to the SP.

[35] CJPU continued to issue Service Police Progress Reports post Jan 20 however the SI covered only the Service Police Progress Reports issued up until the discovery of the SP on 23 Jan 20.

1.4.376. The Panel determined that the provision of ineffective victim support to the SP during the investigation of the assault which occurred in Nov 18 was an Other Factor.

Recommendations

1.4.377. PM (A) request that at the next revise of Military Police Investigative Doctrine (MPID) be amended to reflect a requirement to include the CO of the victim's unit in the distribution of the Monthly Service Police Progress Reports.

1.4.378. PM (A) direct a case review of the CJPU investigation into the assault of the SP on Fri 9 Nov 18 in order to establish whether it was conducted in a timely and effective manner.

1.4.379. 1 MI Bn ensure the Unit are aware of the requirement to appoint a Victim Liaison Officer (VLO), that the CO's duties and VLO duties are contained within JSP 839 – Victims' Services.

1.4.380. 1 MI Bn ensure the Unit are aware of the requirement to appoint a Victim Support Officer (VSO) and the requirement to consider the need for enhanced victim support in accordance with JSP 839 – Victims' Services.

1.4.381. Professional Development Branch, Personnel Policy Branch, Directorate of Personnel, HQ Army review the effectiveness of the training delivery during the All Arms Adjts Course of the requirement contained within JSP 839 – Victims' Services to appoint a Victim Liaison Officer (VLO) and a Victim Support Officer (VSO) to a SP that has been the victim of a Service Crime.

1.4.382. Professional Development Branch, Personnel Policy Branch, Directorate of Personnel, HQ Army review the effectiveness of the training delivery during the CO Designate Course of the requirement contained within JSP 839 – Victim' Services for a CO to appoint a Victim Liaison Officer (VLO) and a Victim Support Officer (VSO) to a SP that has been the victim of a Service Crime.

PART 1.5

RECOMMENDATIONS

PART 1.5 – RECOMMENDATIONS	Analysis Reference
1.5.1. Introduction. The Panel recommends the following:	
1.5.2. TOR 1	
Recommendation 1. 11 (RSS) Sig Regt ensure that all incidents of self-harm are reported to the RMP in accordance with AGAI 110 - Army VRM Policy.	1.4.29
Recommendation 2. 11 (RSS) Sig Regt ensure that the Unit comply with the requirement contained within AGAI 110 – Vulnerability Risk Management to handover a closed CAP when a SP is assigned to a new unit.	1.4.44
Recommendation 3. Professional Development Branch, Directorate of Personnel, Army HQ review the effectiveness of the training delivery during the All Arms Adjts Course of the requirement contained within AGAI 110 – Vulnerability Risk Management to handover a closed CAP when a SP is assigned to a new unit is covered during the course	1.4.45
Recommendation 4. 1 MI Bn follow the direction in JSP 763 MOD Bullying and Harassment Complaints Procedure when investigating allegations of mistreatment.	1.4.73
Recommendation 5. 1 MI Bn follow the direction in 1 MI Bn Diversity and Inclusion Standing Order 1016 when investigating allegations of mistreatment.	1.4.74
Recommendation 6. Bereavement and Aftercare Support (BAS), Pers Svcs Br, HQ APSG inform the NoK of [the SP] that JSP 831, Redress of Individual Grievances: Service Complaints, Part 2 Guidance, Chapter 11 gives guidance relating to bereaved families identifying potential complaints after a SP has died, including alleged mistreatment.	1.4.75
Recommendation 7. Defence Primary Healthcare (DPHC) remind medical teams to record all significant communication regarding the health / employment suitability of a SP with the Chain of Command, within the SPs DMICP record.	1.4.83
Recommendation 8. 1 MI Bn advise all unit personnel that the Unit VRM Lead must be made aware of any disclosure of previous suicide attempts or expressions of suicidal ideation by SP in order that an Individual Case Conference can be held in accordance with AGAI 110 – Army VRM Policy to formally consider risk.	1.4.91
Recommendation 9. Defence Primary Healthcare (DPHC) remind all staff to consider risk to the patient when issuing safety critical Light Duties proforma (ie unfit weapon handling) and where a medical concern exists relating to patient safety they are to contact the Chain of Command directly to ensure that the SP has presented the Light Duties proforma and to discuss the risk mitigation measures / patient safety; the interaction is to be recorded on the SPs DMICP record.	1.4.100
Recommendation 10. Defence Primary Healthcare (DPHC) should adopt clear policies that, wherever possible, DCMH Multidisciplinary Team meeting (MDT) decisions should be communicated in person, either directly, by video consultation or by phone and that only after several attempts have been made	1.4.116

to contact the patient in person should discharge decisions be communicated by email or letter.

1.5.3. TOR 2

No recommendations

1.5.4. TOR 3

Recommendation 11. 1 MI Bn ensure that the requirement for Battalion Duty Officer's (BDO) reports is not suspended / stopped during stand down periods as it removes the opportunity for a duty officer to formally record actions undertaken and incidents that occur during their duty period.	1.4.183
Recommendation 12. 1 MI Bn ensure that the Battalion Duty Officer's (BDO's) have access to the BDO Folder at all times, including during stand down periods, in order to react to incidents in a timely manner and in accordance with the Unit plan.	1.4.184
Recommendation 13. 1 MI Bn ensure that an effective Battalion Duty Officer (BDO) briefing process is conducted prior to each stand down period that includes: the start / finish times of each duty period and the actions to be carried out if a BDO is unable to contact a SP that has been identified as requiring a Welfare Check.	1.4.185
Recommendation 14. 1 MI Bn ensure that an effective Battalion Duty Officer (BDO) assurance process is in place following each stand down period to dismount from duty each BDO and to assure that any directed welfare checks have been conducted.	1.4.186

1.5.5. TOR 4

Recommendation 15. 1 MI Bn ensure that for SP deploying on a temporary detachment from the Unit (ie Temporary Employed Elsewhere, Authorised Elsewhere, Trawl etc), where unique ongoing individual circumstances remain (ie retention of SLA, SFA, welfare issues, or the SP is the victim / witness in ongoing disciplinary case) then a full handover to the receiving unit takes place.	1.4.199
Recommendation 16. 1 MI Bn ensure the Unit has in place an effective system in place to record when SP report their location / safe arrival as directed by a 1 MI Bn FRAGO and a process / procedure to follow if a SP fails to make contact as directed.	1.4.200
Recommendation 17. 1 MI Bn ensure that the UHC Part 2 Individual Case Conference (known from Apr 20 onwards as Commander's Monthly Case Review) is held in accordance with AGAI 57 – Health Committees.	1.4.204
Recommendation 18. 1 MI Bn ensure that the Welfare Management Committee is held monthly as directed in AGAI 81 Army Welfare Policy.	1.4.210
Recommendation 19. 1 MI Bn ensure that the Unit comply with AGAI 81 Army Welfare Policy to check the JPA Welfare Tool / Flag for each SP on assignment into the Unit to ascertain if there are any ongoing welfare concerns that should be brought to the attention of the CoC / UWO.	1.4.211

Recommendation 20. 1 MI Bn ensure that the Unit comply with the requirement to record TRiM activity on JPA individual records in accordance with LFSO 3217 Trauma Risk Management.	1.4.220
Recommendation 21. 1 MI Bn ensure that when a SP declines to undertake TRiM it is recorded in the TRiM Incident Log Book relating to the incident.	1.4.221
Recommendation 22. SHA (A), as owner of LFSO 3217 – Trauma Risk Management (TRiM) Policy, include within the publication guidance on the number of TRiM trained personnel to be held by a minor unit (currently only major unit figures are listed).	1.4.222
Recommendation 23. SHA (A), Army HQ update LFSO 3217 - Trauma Risk Management (TRiM) Policy at the next revision to contain the detail that the policy owner is Senior Health Advisor (Army), Army HQ, not Personnel Services Branch 4 (Army), a now defunct organisation.	1.4.223
Recommendation 24. 1 MI Bn ensure that when raising a NOTICAS following the death of a SP, the Unit must not speculate on the cause of death within the NOTICAS.	1.4.229
Recommendation 25. 1 MI Bn ensure that when raising a NOTICAS, where the situation allows, the Unit must initially alert JCCC by telephone as required by JSP 751 Joint Casualty and Compassionate Policy and Procedures, Part 1, Volume 1: Management of the Casualty.	1.4.230
1.5.6. TOR 5	
Recommendation 26. DCSU ensure that UHC Part 1 (known from Apr 20 onwards as the Unit Quarterly Review) and UHC Part 2 Individual Case Conference (known from Apr 20 onwards as Commanders Monthly Case Review) are held in accordance with AGAI 57 – Health Committees.	1.4.245
Recommendation 27. DCSU ensure that a Welfare Management Committee is held monthly as directed by AGAI 81 Army Welfare Policy and that the expected attendance / membership for the meeting is as per Annex D to AGAI 81 Army Welfare Policy.	1.4.250
Recommendation 28. HQ 77 Bde, as the TRiM coordinating HQ for the incident, ensure that the TRiM activity undertaken by SP within 77 Bde has been recorded on JPA individual records in accordance with LFSO 3217 Trauma Risk Management.	1.4.259
Recommendation 29. HQ 77 Bde, when supporting units without TRiM trained personnel, ensure that TRiM is delivered in accordance with the required timescale directed in LFSO 3217 Trauma Risk Management.	1.4.260
Recommendation 30. DCSU ensure that the Unit Induction and Arrivals process includes SP that are on temporary attachment to the Unit and also those DCSU SP that are not located at RAF Henlow	1.4.272
Recommendation 31. DCSU ensure that a Unit personnel accountability system is in place to assure that all SP are accounted for, commencing from the start date of any temporary attachment / assignment to the Unit.	1.4.292

1.5.7. TOR 6

Recommendation 32. 1 MI Bn ensure that when briefing Unit personnel following the death of a SP, the Unit must not speculate on the cause of death within the address.	1.4.298

1.5.8. TOR 7

Recommendation 33. Logistic Support Branch, HQ Regional Command amend Standing Order for White Fleet Control, Management and Operation to include direction that where a SP fails to either collect or return a prearranged hire car booking that the unit be made aware for duty of care / welfare reasons.	1.4.321
Recommendation 34. Personnel Services Branch, Directorate of Personnel, HQ Army review and clarify the requirement for the mandated effective management system contained within AGAI Vol 2, Chap 53 Barrack Regimes and Living Out by Single Personnel.	1.4.328
Recommendation 35. HQ Catterick Garrison incorporate into the existing MoU between HQ Catterick Garrison and the CO's of units occupying GSU (Garrison Support Unit) controlled accommodation a requirement / reminder to ensure that each CO complies with (and has an effective unit assurance process) AGAI Vol 2, Chapter 53 - Barrack Regimes and Living Out by Single Personnel, in that each unit is to have an effective management system in place in order to determine whether unit personnel, both civilian and military, are within barracks and whether SLA is occupied in the event of an emergency. In cases where SP from different units share a SLA block, HQ Catterick Garrison MoU will appoint a named lead Unit.	1.4.329
Recommendation 36. HQ Fd Army and HQ Home Command regularly remind units that Unit Standing Orders are to be declared as a record and that the retention period for Unit Standing Orders is 15 years from date of publication in accordance with JSP 441 - Managing Information in Defence and ACSO 1811 - Army Information Management Professionals Ways of Working.	1.4.333
Recommendation 37. 1 MI Bn publish the contact details of the Speak Out helpline on Unit Routine Orders at the frequency directed within the Directorate of Personnel, Compendium of Standing Orders.	1.4.346
Recommendation 38. 1 MI Bn publish the Army Policy on bullying, harassment and discrimination on Unit Routine Orders with the contents and frequency directed by AGAI Vol 2, Chap 75 - Inclusive Behaviours - Diversity, Inclusion and Behaviours Policy, Guidance and Instructions.	1.4.347
Recommendation 39. Personnel Policy Branch, Directorate of Personnel, Army HQ request confirmation that a Unit is publishing the contact details for the Speak Out helpline on their Unit Routine Orders at the frequency required by AGAI 75 is included within the G1 Audit Question Set.	1.4.348
Recommendation 40. 1 MI Bn publish Unit Routine Order updates (Part One Orders) at the frequency and contents contained within the Directorate of Personnel, Compendium of Standing Orders.	1.4.351

Recommendation 41. HQ Fd Army and HQ Home Command regularly remind units that the NoK listed on JPA for SP that are married but not yet divorced should be the SP's spouse / civil partner in accordance with the Unit Administrative Manual and JSP 751, Joint Casualty and Compassionate Policy and Procedures, Part 1 Volume 1: Management of the Casualty.	1.4.356
Recommendation 42. The Lessons Team, Pers Svcs Br, APSG monitor SI Reports and Unit Learning Accounts for a period of 12 months to determine if the non-effective recording of EC and NOK details on JPA by SP provides a sufficient body of evidence to necessitate review of the process.	1.4.357
Recommendation 43. 1 MI Bn ensure that SP deploying to a new unit / organisation or location, for periods of 24 hours or more, must be recorded on JPA via move and track in accordance with the Unit Administration Manual.	1.4.361
Recommendation 44. PM (A) request that at the next revise of Military Police Investigative Doctrine (MPID) be amended to reflect a requirement to include the CO of the victim's unit in the distribution of the Monthly Service Police Progress Reports.	1.4.377
Recommendation 45. PM (A) direct a case review of the CJPU investigation into the assault of [the SP] on Fri 9 Nov 18 in order to establish whether it was conducted in a timely and effective manner.	1.4.378
Recommendation 46. 1 MI Bn ensure the Unit are aware of the requirement to appoint a Victim Liaison Officer (VLO), that the CO's Duties and VLO duties are contained within JSP 839 – Victims' Services.	1.4.379
Recommendation 47. 1 MI Bn ensure the Unit are aware of the requirement to appoint a Victim Support Officer (VSO) and the requirement to consider the need for enhanced victim support in accordance with JSP 839 – Victims' Services.	1.4.380
Recommendation 48. Professional Development Branch, Personnel Policy Branch, Directorate of Personnel, Army HQ review the effectiveness of the training delivery during the All Arms Adjts Course of the requirement contained within JSP 839 – Victim' Services to appoint a Victim Liaison Officer (VLO) and a Victim Support Officer (VSO) to a SP that has been the victim of a Service Crime.	1.4.381
Recommendation 49. Professional Development Branch, Personnel Policy Branch, Directorate of Personnel, Army HQ review the effectiveness of the training delivery during the CO Designate Course of the requirement contained within JSP 839 – Victims' Services for a CO to appoint a Victim Liaison Officer (VLO) and a Victim Support Officer (VSO) to a SP that has been the victim of a Service Crime.	1.4.382

PART 1.6

CONVENING AUTHORITY COMMENTS ON THE SERVICE INQUIRY INTO THE DEATH OF A SP IN HIS SINGLE LIVING ACCOMMODATION IN CATTERICK GARRISON ON 23 JANUARY 2020

1.6.1 **Convening Headquarters**. Headquarters 1st (United Kingdom) Division.

1.6.2 **Commander**.

1.6.2.1. The General Officer Commanding the Division at the commencement of the Service Inquiry was Major General CRJ Weir DSO MBE.

1.6.2.2. The current General Officer Commanding, and the author of these comments is Major General CS Collins DSO OBE.

1.6.3. **Timelines.**

1.6.3.1. Date of Occurrence. SP discovered in his Single Living Accommodation (SLA) at Bourlon Barracks on 23 Jan 20.

1.6.3.2. The Army Personnel Services Group (APSG) is requested to liaise with the Defence Inquest Unit (DIU), MOD in order to identify when a date for the Coroner's Inquest has been scheduled.

1.6.4. **Affected Persons.** 18 witnesses were identified as Potentially Affected Persons. They were treated in accordance with Joint Service Publication 832. This Service Inquiry has not identified any other affected persons or organisations through implication.

1.6.5. **Evidence from Foreign Sources.** There is no evidence from Foreign Sources.

1.6.6. **Conduct of Panel**. The Panel dealt with a range of witnesses (55 in total). The Panel was not constrained by any factors and it has been thorough and effective. It has met the Terms of Reference (TOR) of the Service Inquiry.

1.6.7. **Findings of the Inquiry**. The Service Inquiry fully addressed the following Terms of Reference:

1.6.7.1. **TOR 1**. Establish the facts of [redacted] military career history up to the time of his death.

1.6.7.2. **TOR 2**. Present the facts surrounding [redacted] being discovered in his SLA on 23 Jan 20.

1.6.7.3. **TOR 3**. Determine the procedures in place within 1 MI Bn for all personnel remaining within SLA in barracks during stand down periods. How are these understood, disseminated and assured by 1 MI Bn.

1.6.7.4. **TOR 4**. Determine the handover procedures in place at 1 MI Bn for their personnel on temporary assignment to other units. Examine how relevant policies,

procedures, welfare practices and other provisions are applied, including but not limited to:

1.6.7.4.1. Establish what policies, procedures and regulations are in place both in the wider Army and within the 1 MI Bn for the provision of welfare support to a situation based on the facts of this matter. These include but are not limited to: Army General and Administrative Instructions (AGAIs) Volume 2 Chapter 57 (Health Committees); Volume 3 Chapters 81 (Army Welfare Policy); Volume 3 Chapter 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy); Army Command Standing Order (ACSO) 3217 (Trauma Risk Management (TRiM)): and Joint Service Publication (JSP) 751 (Joint Casualty and Compassionate Policy and Procedures). Determine the unit level of understanding in relation to these policies.

1.6.7.4.2. Establish any unit policies that were in place prior to the death of [redacted] with regard to alerting the Chain of Command of any welfare and medical concerns.

1.6.7.5. **TOR 5.** Determine the takeover procedures in place at DCSU for personnel on temporary assignments to that unit. Examine how relevant policies, procedures, welfare practices and other provisions are applied, including but not limited to:

1.6.7.5.1. Establish what policies, procedures and regulations are in place both in the wider Army and within the establishment for the provision of welfare support to a situation based on the facts of this matter. These include but are not limited to: Army General and Administrative Instructions (AGAIs) Volume 2 Chapter 57 (Health Committees); Volume 3 Chapters 81 (Army Welfare Policy); Volume 3 Chapter 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy); Army Command Standing Order (ACSO) 3217 (Trauma Risk Management (TRiM)); and Joint Service Publication (JSP) 751 (Joint Casualty and Compassionate Policy and Procedures). Determine the unit level of understanding in relation to the policies.

1.6.7.5.2. Establish any unit policies that were in place prior to the death of [redacted] in relation to assignment of temporary personnel, their arrival and proposed integration/induction with existing cells.

1.6.7.6. **TOR 6.** Investigate what actions were taken by the Chain of Command following the death of [redacted] and any immediate recommendations made by both 1 MI Bn and DCSU.

1.6.7.7. **TOR 7.** Consider any other matters relevant to the Inquiry and, based on the evidence, make such findings and express opinions as are appropriate to support recommendations in order to prevent recurrence.

1.6.8. **Recommendations of the Inquiry**. The Convening Authority endorses the 49 recommendations made by the panel, consolidated within Sect 1.5. These recommendations are made across 6 of the 7 TORs. The Army Personnel Services Group (APSG) is requested to conduct a Military Judgement Panel (MJP) with the relevant stakeholders and to track the progress of the recommendations to closure.

Summary

1.6.9. I am grateful to the Service Inquiry panel for the detailed and thorough execution of this inquiry.

1.6.10. The cause of death is not yet known, and the Terms of Reference did not ask for any investigation into the cause of death. The Service Inquiry therefore rightly focuses on learning points which are driven by the TORs and are very clear; particularly around the delay in discovering the SP. It also highlights a number of other issues which are important and might well have been more central and explored in greater detail if the cause of death was known.

1.6.11. The Service Inquiry panel identified no causal or contributory factors in their report. The six aggravating factors the team identified centred on the checking of SP in SLA over stand down periods, and the accounting of personnel when temporarily assigned between units. These are the two key issues that served to worsen the outcome of this tragic event.

1.6.12. 1 MI Bn was noted as being "innovative in their approach to supporting" personnel remaining in SLA over the Christmas period. Sadly, it appears from this inquiry that the plan had not been communicated and implemented as effectively as it should have. Had it been, may have been discovered earlier than 23 Jan 20. For good reasons, the panel did not judge it necessary to recommend the Army mandates in policy that SP remaining in SLA over stand down periods are regularly checked upon (1.4.182). I believe, however, that 1 MI Bn's intended approach should be viewed as best practice. I therefore recommend that Army, D Pers, consider prompting, in policy, commanding officers and heads of establishment to consider putting in place measures, specific to their own circumstances, to check upon those remaining in SLA over stand down periods. APSG is requested to consider this, via an MJP, alongside the other recommendations.

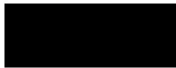
1.6.13. DCSU failed to account for the personnel returning from Christmas leave that had temporarily been assigned to the unit. The SP had initially reported to Hermitage on 16 Dec 19, and received an arrival interview. It is therefore distressing that the non-arrival of the SP after Christmas leave on 7 Jan 20 was not noticed by the units involved. I note the opinion that 'there was no effective leadership structure, accountability or assurance process within the DCSU ENDURA Team' (1.4.291). These are process failings at unit level which could have been avoided and can be in the future if the recommendations made in this report are acted upon. Had an effective accountability process been in place at either unit, particularly DCSU where he was due to report for duty, the SP might have been discovered earlier.

1.6.14. The panel determined that the absence of takeover procedures in DCSU for temporarily assigned personnel was an "Other Factor" (1.4.241). Whilst DCSU was not mandated to have such procedures, I feel that this omission worsened the outcome of this tragic event, and therefore should be considered as an "Aggravating Factor". I am, however, content that all the recommendations that can be drawn out of this factor have been made elsewhere within the report. I would also urge that this lesson is learned beyond DCSU.

1.6.15. I note the many "Other Factors" identified in this report. Whilst they had no bearing on this specific event, they are noteworthy and mark, in some cases, disappointing deviations from policies that are designed to protect our personnel.

1.6.16. The report makes for sobering reading. My conclusion is that failings in the proper management of personnel led to the delay in the discovery of . If the units involved had registered and acted upon the SP's non-arrival on 7 Jan 20, or the BDO had a direct connection daily throughout the leave period, he would have been found sooner.

1.6.17. On behalf of the Army I offer my sincere condolences to family, friends and loved ones.



CS Collins DSO OBE
Major General
1st (UNITED KINGDOM) DIVISION

30 Apr 21

PART 1.7

REVIEWING AUTHORITY COMMENTS ON THE SERVICE INQUIRY INTO THE DEATH OF A SP IN HIS SINGLE LIVING ACCOMMODATION IN CATTERICK GARRISON ON 23 JANUARY 2020

1.7.1 On 14 February 2020 my predecessor directed a Service Inquiry to investigate the tragic death of a Service Person found in their Single Living Accommodation at Catterick Garrison on 23 January 2020. General Officer Commanding 1st United Kingdom Division was appointed as The Convening Authority for this Service Inquiry and Convened it on 20 February 2020.

1.7.2 The Service Inquiry panel submitted their report to Headquarters Army Personnel Service Group on 18 March 2021. Completion of the Inquiry was unavoidably delayed by Covid-19. Whilst not desirable, the thoroughness and quality of The Inquiry has not been diminished.

1.7.3 On 24 March 2021, Deputy Assistant Chief of Staff, Army Personnel Service Group submitted the draft report to the Convening Authority for their review. The Convening Authority review was signed off on 30 April 2021 and the General Officer Commanding 1st United Kingdom Division's comments were inserted into Part 1.6 of this report. As the Reviewing Authority, I received the report on 5 May 2021.

1.7.4 **Conduct of the Panel**. I am grateful to the President and their Panel for the thoroughness of their Inquiry and am satisfied that the Terms of Reference were appropriately pursued and met. I am content that the panel correctly afforded several Service Personnel Regulation 18 status, and that those individuals were treated in accordance with the requirements of Joint Service Publication 832.

1.7.5 **Findings of the Service Inquiry.** The Service Inquiry has been comprehensive and thorough. The recommendations are appropriate and meet the requirements of the Terms of Reference. The shortcomings that have been highlighted by the panel, notably assurance procedures during stand down periods, handover procedures (specifically when a gaining unit becomes responsible for the arriving Service Person) and issues relating to the Victim Liaison Officer and their understanding of the role – are well judged, as are the recommendations to prevent recurrence.

1.7.6. **Recommendations of the Inquiry**. Several unit specific issues were identified, and changes implemented, immediately following the death on 23 January 2020. I endorse all the panel's 49 recommendations, which can be found at Part 1.5 of this report. Prior to finalisation of the report, but after completion of the Inquiry, a recommendation endorsement meeting was held with key stakeholders on 26 January 2021 at which each recommendation was agreed and allocated a Senior Point of Authority and a Subject Action Manager. Following the Convening Authority's endorsement of the Inquiry findings, I now formally endorse the Inquiry's recommendations, and will ensure they are logged onto the Defence Lessons Identified Management System and are monitored until implemented and closed.

1.7.7. **Summary.** I am satisfied that the tragic death of the Service Person has been fully investigated, the findings appropriately analysed and reported on thoroughly. Some of the immediate findings have been implemented and the 49 Inquiry recommendations have been endorsed and tasked for implementation.

1.7.8 The deceased’s Next of Kin will receive a copy of the report, and the Inquiry President will offer a briefing to explain the findings and answer any questions that may arise. Headquarters Army Personnel Services Group will furnish the Defence Inquest Unit with a copy of the report for provision to Her Majesty Coroner as part of the yet to be scheduled Coronial Inquest.

1.7.9 On behalf of the Army, I offer my sincere condolences to the family, friends and colleagues of the Service Person and hope that the Service Inquiry has provided the information which will enable them to reach some peace and closure.

[redacted]

E J R Chamberlain
14 May 21
Brigadier
Head Army Personnel Services Group and
Single Service Inquiries Coordinator (Army)