soldiers can be conducted. JSP 539 defines soldiers based in UK and Northern Europe as 'un-acclimatised' in their base locations. Thus, 5 RIFLES were to be considered un-acclimatised. At heat stress index readings of 20°C or below it is considered that un-acclimatised soldiers can conduct "very high work rate" activities (Table 3 below). This allows TABing[27] at an AFT pace for an hour after which a 30 min break is required[28]. Taking such a break is clearly not in accordance with the AFT process, therefore there is an apparent disconnect between the policy set down in JSP 539 and the MATT 2 Protocol. 20 Armd Inf Bde disseminated a coloured chart showing a visual representation of the same JSP 539 information. This chart makes no mention of acclimatised or un-acclimatised personnel, but it classes any WBGT reading below 20°C as "Green" and not an impediment to physical training. The SI **observed** the only mention of soldiers in NW Europe not being acclimatised in JSP 539 is a single footnote, which is likely to be missed and the reference table is not easy to apply to military training, including the AFT.

Exhibit 118

Exhibit 46

Exhibit 46

Exhibit 55

Ser	Maximum Work Rate (not to be exceeded	WBGT Index Threshold Values	
		Acclimatised	Un-acclimatised
1	**Low.** For example , lying, guard duty.	34	32
2	**Medium.** For example, marching at 3.6 kph (2.3 mph) with a 30 kg load.	30	26
3	**High.** For example, marching at 5.6 kph (3.5 mph) with a 20 kg load, patrolling, digging, field assaults.	27	24
4	**Very High.** For example, marching at 8 kph (5 mph) with no load, marching at 5.6 kph (3.5 mph) with a 30 kg load.	25	20
5	**Extreme.** For example, running in sports kit; speed marching at 9.7 kph (6 mph) with a 15 kg load.	20	Max 30 mins at 20

[27] TAB is an acronym meaning Tactical Advance to Battle. This can be used as a noun or verb and is analogous to speed-march or yomp.

[28] JSP 539 Para 2A8 details the threshold values in Table 3 are the maximum permitted continuous work intensity for Service personnel at a given WBGT. They are valid for one hour exposures with a minimum of 30 minutes rest after the activity.

Table 3 - WBGT Index Threshold Value

(2) **WBGT Reading**. PTI 1 and Sldr Q took the initial WBGT reading at 0725 hrs. The reading was 12.8°C. At 1030 hrs Sldr Q took an additional reading of 19.1°C. Though close it remains within the threshold for the Very High work rates for un-acclimatised troops. Cross-referencing with the recorded data from the nearest weather station at Bad Lippspringe shows that these temperatures were consistent with those of the wider region (which ranged between 14.5°C and 17.4°C from 0400-1000 hrs). **PTI 1** **Soldier Q** **Exhibit 17** **Soldier P** **Soldier Q** **Exhibit 16**

(3) **Factors to be considered in conjunction with the WBGT reading**. JSP 539 states "*It must be remembered that the WBGT only forms part of the overall risk assessment and it must not be used in isolation.*" The WBGT reading should be considered in conjunction with various risk factors (eg overweight personnel, air travel in the last 24 hrs, lack of sleep, smoking, mild illness or being dressed in specialist protective clothing). The WBGT reading seems to have been used as the sole go/no go criterion. The SI examined other considerations on the day which, in accordance with JSP 539 should also have contributed to the assessment of risk: **Exhibit 46** **Exhibit 46** **Soldier Q**

(a) **Additional considerations**. Members of B Coy received a range of inoculations prior to deployment, dependent upon whether they were in date for the specific treatment. They were also issued anti-malarial prophylactics. The 5 RIFLES Regimental Medical Officer has examined the list of inoculations and other treatments given and is not aware of recommendations for the avoidance of physical activity after administration of the routine vaccines issued. It has been noted that the Coy contained personnel at varying levels of fitness (as do all units). There were smokers and some individuals with poor diets (PTI 1 offered an observation that a lot of people in the Coy go to the camp restaurant and eat burgers and chips as well as going to the camp shop and buy bottle of coke); however these were individual issues only and not something affecting the Coy as a whole. The troops would not be wearing helmets or additional layers of clothing and were not subjected to any other relevant factors as listed in JSP 539 **Exhibit 56** **PTI 1** **Soldier P** **Exhibit 13** **Exhibit 46**

(b) **Awareness of the issues**. PTI 2 joined the Coy on Mon 15 Jun 15 and as such would not necessarily have been aware of any individuals who might struggle during the AFT. During interview he confirmed that he played no part in the development of the Coy PT programme that had been followed prior to his joining but did observe the Coy PFA on 16 Jun 15. On the morning of 18 Jun 15 he signed on the Daily Risk Assessment Sheet (a dynamic RA completed immediately prior to the event) stating that he was using Generic Risk Assessment 09 (AFT). This involved him assessing his own ability, familiarity with running the activity, student ability, environmental conditions, local weather and activity choice to calculate a total score and risk grade. He rated his students as grade 1 (very competent), indicating he had confidence in their ability. **PTI 2** **Exhibit 15** **Exhibit 64**

Conclusion: The SI concluded that although PTI 2 had observed the PFA he was not in a position to conduct a comprehensive

dynamic RA, as he was not fully aware of the physical ability of the AFT participants nor was he party to their build up prior to the event, which could have a detrimental effect on the safe system of training that should be in place for this type of activity. Whilst not a factor in the death of Rfn Evans, if repeated in the future it could lead to an incident or accident and therefore the SI consider it to be an **Other Factor.**

(4) **Equipment Used**. The device in use at 5 RIFLES gymnasium on 18 Jun 15 was the MOD approved (Evidence JSP 539 Para 2A-6) QUESTemp 34 WBGT Monitor serial number TEE070005 manufactured by Quest technologies. It had last been calibrated on 13 Feb 15. The SI noted personnel had been topping up the device's reservoir with tap water and not distilled or de-ionised water as specified in the user manual. This can cause furring as dissolved salts and particles in suspension within tap water collect on the inside of the bulb. This in turn can lead to inaccuracies in the reading. The device was sent for testing at the Institute of Naval Medicine. It was tested alongside two other devices of known accuracy on 06 Jul 15. The results were within the tolerance of the device. Therefore the use of non-filtered water had not caused the readings to go out of tolerance for the device. According to the user manual the device should be set up at a height of 1.1 m for personnel who will be in the standing position during the activity. The SI observed during a visit to 5 RIFLES that the device was set up on a stool at about 0.6 m. The SI considered, with the WBGT working within tolerance and the benign weather on the day, these practices, whilst not in line with the manufacturer's instructions, would have had little or no impact on the readings taken.

Exhibit 58
Exhibit 57
Soldier P
Exhibit 59
Exhibit 59
Exhibit 58
Exhibit 59

1.4.38 **Summary**: The SI concluded that the AFT was fully compliant with the MATT 2 Protocol in most areas (nutrition and hydration, weight carried, distance and pace, instructor ratios). However, there is an apparent disconnect between JSP 539 and the requirements of the AFT.

1.4.39 **Recommendation. The SI recommends that**:

a. The Heat Injuries Working Group should provide guidance in JSP 539 on how the WBGT Threshold values may be used for activities lasting in excess of 1 hour.

b. The Heat Injuries Working Group should define "acclimatised" and "non-acclimatised" more fully to enable the benchmark to be established.

c. Director of Training (Army) should review training provided by Army School of Physical Training with regards to the operation of WBGT. A DSA urgent safety notice[29] was promulgated 6 Aug 15.

1.4.40 **Policy Non-Compliance**. The SI examined the conduct of the AFT which consists of the planning, preparation and running of the event. The following areas were highlighted as being non-compliant with the MATT 2 Protocol and/or other relevant policy.

[29] DSA/Exec/DG/Comms/Armed Forces dated 6 Aug 15 – Urgent Safety Advice – Climatic Illness and Injury Awareness and Prevention.

a. **Off-road section of the route**. The MATT 2 Protocol states "*at least 4.8km [is] to be off tarmac/metalled roads*". This allows some relief from the strain of marching on a hard surface and replicates battlefield conditions. Alanbrooke Barracks is located within a large town which does not lend itself to a local route with an off-road section, if an AFT is going to be commenced from inside the Barracks, therefore on the AFT route used on the day (and commonly used) there is no off-road section. The SI **observed** that this is not unique to 5 RIFLES.

Exhibit 13
PTI 2
Soldier P

Conclusion: The lack of an off-road section to the AFT was **not a factor** in the death of Rfn Evans. However, it is evident the MATT 2 Protocol was not being (and had not been (see para 1.4.55)) rigidly adhered to by the unit (see para 1.4.78.e (2)).

b. **Provision of a medic and medical equipment**. MATT 2 Protocol states there will be a First Aid Non Commissioned Officer (NCO) in support of the AFT. It goes on to say "*Ideally the First Aid NCO should be a CMT or equivalent. Subject to the RA, Team Medics may be used when CMTs are not available.*" It is also stated that the SV is to carry "*additional water and First Aid equipment*". PTI 1 says he tried to book a CMT earlier in the week but was told that there was not a medic available. The unit was at 50% manning for CMTs at the time and all but one of those were deployed away from the unit. This was an enduring situation such that the Unit Fitness Training Officer (UFTO) stated that people were just used to not having CMTs about. Sldr N was the only CMT in the barracks; however he was participating in a 4 mile loaded march with his Coy, as part of the fitness programme rather than as a CMT (the 4 mile march does not require a nominated medic) on the morning of 18 Jun 15 and could therefore have filled the CMT position on the AFT. PTI 1 assumed there would be many TMs present on the day (and there were) as after their recent Op HERRICK tour a significant portion of 5 RIFLES personnel were TM qualified. As it transpired on the day, none of the personnel who were with Rfn Evans when he collapsed and therefore provided initial treatment were qualified and current as a TM. No First Aid NCO was nominated and there was no mention of TM in the generic AFT RA. As a result no one was detailed to bring a medical kit with them. Furthermore the mandated extra water and safety equipment was not present in the SV (which according to Soldier W (who had completed numerous AFTs as the SV driver) was the norm).

Exhibit 13
PTI 1
Exhibit 62
Soldier V
Soldier N
Exhibit 63
PTI 1
Exhibit 63
PTI 2
Exhibit 64
PTI 1
Soldier W

Conclusion: There is no medical evidence to suggest that the lack of a nominated First Aid NCO and medical kit was a factor in the death of Rfn Evans; however it may have a bearing on future AFTs and their safety. It is, therefore, an **Other Factor.**

c. **Pre-AFT Briefings**. The MATT 2 Protocol includes separate briefings for Directing Staff and participants. From interviews conducted the SI learnt that the briefs given did not match the MATT 2 Protocol.

Exhibit 13
PTI 2
PTI 1
Soldier F
Soldier W
Soldier G

(1) **Safety Vehicle Driver**. PTI 1 delivered a brief to the SV Driver. The detail of the conversation is not recorded, but anecdotally it appears to have been along the lines of asking the SV driver if he was happy with the normal route. It did include swapping of phone numbers but not

PTI 2
PTI 1

confirmation of whether additional water was being carried. The driver had completed numerous AFTs as a SV driver and was content he knew the route. PTI 1 gave the driver his mobile number at this point by dialling it from the driver's personal mobile. **PTI 2** **Soldier W** **Soldier W**

(2) **Road Safety Personnel**. MATT 2 Protocol mandates the need for road safety personnel and a brief to be given explaining their duties. PTI 2 asked for volunteers and four personnel stepped forward, including Sldr A. Sldr A had missed a significant amount of PD prior to the AFT (due to attending courses) and consequently struggled on the day. ASPT teaches PTIs to select road safety personnel who they know will carry out their duties effectively. As noted in Para 1.4.37.g.(3).(b) PTI 2 had joined the Coy three days before the AFT, hence the selection of Sldr A. When PTI 2 briefed the road safety personnel he informed them that the AFT would follow the normal route and asked if everyone was content. The SI noted that this method of briefing appeared to be the norm within the unit. **Soldier A** **Exhibit 97** **Soldier Q** **Exhibit 97** **PTI 2** **PTI 2** **Soldier F**

(3) **Participants**. PTI 2 gave a brief to the participants as a whole. He acknowledges he did not read out the mandatory brief. He did mention the distance and time, hydration and the process for being removed from the test. He told the Coy it was the normal route. The SI assessed that the following elements of the participants brief were apparently not delivered in accordance with the MATT 2 Protocol: **Soldier G** **Soldier F** **PTI 2**

(a) **Safety vehicle**. Of those interviewees questioned no one recalled having the safety vehicle pointed out; the SV was on the other side of the building when the brief was given and so it would not have been visible to the participants. **Exhibit 13** **PTI 1**

(b) **Route**. Of those interviewees asked about the route brief, no one recalls being told the route in detail and there was confusion about where the AFT would end, with some expecting it to finish at the gym and others believing they would complete a loop inside camp before finishing. **Exhibit 13** **PTI 1**

(c) **First Aid NCO**. A First Aid NCO had not been nominated and therefore one could not be identified to the participants. The implication here is that should one of the participants start to feel unwell, he would not know who to turn to for medical assistance. **Exhibit 13**

(4) **Additional Points**. The following issues were also noted:

(a) **Chain of Command**. Neither the OC nor CSM were on parade with the Coy for the weigh-in or the brief. The SI noted that the brief is a vital component for the safe execution of the AFT and by being present the CoC reinforces the importance of this brief. **Soldier H** **Soldier R** **Soldier K**

(b) **Handover**. PTI 2 had taken over from PTI 1 on the morning of the event at around 0715 hrs. There is no evidence of a handover. Due to his familiarity with and experience in running AFTs and the structured nature of the activity, PTI 2 was content that he did not conduct a detailed handover with PTI 1. It is the SI's opinion that a proper handover would have involved a brief that covered the planning, immediate actions and exchange of DS phone numbers as a minimum. The SI could not determine why **PTI 1** **PTI 2** **PTI 2** **PTI 1**

this change of appointment took place at this time. PTI 1 went to work under the impression he would be running the AFT and even signed the risk register as such. PTI 2 was the senior in rank of the two men and in all likelihood took over as such. **PTI 1**

Conclusion: Whilst the pre-event briefs were not provided verbatim and the administration of the AFT did not include some of the elements taught and provided for in the policy they were **not a factor** in the death of Rfn Evans. However such briefs and administration are vital to the safety of personnel undertaking other similarly physically demanding events and therefore the SI consider it to be **an Other Factor**.

d. **Ability of the SV to follow the Main Body on this AFT Route**. The MATT 2 Protocol mandates that the AFT route must be accessible to the SV throughout. There were several points at which barriers blocked the SV's progress. These are highlighted in Figure 1.4.2 below. There were also two stretches of the route which the SV, under German Law, is not allowed to follow. It has become custom and practice, within 5 RIFLES for the SV to routinely box around obstacles and in doing so leapfrog the main body to wait for them further along the route. As such it is not with the main body for significant portions of the route and at some points can be as far as two miles away. The absence of the SV during these times creates two issues; firstly casualties cannot receive immediate assistance and secondly the DS cannot place soldiers who are unable to keep up on to the SV, which in turn can produce an extremely spread-out group, in turn making Command and Control more difficult. **Exhibit 13** **PTI 2** **Soldier F** **Soldier W** **Soldier W**

Conclusion: On this occasion the inability of the SV to access much of the route was **not a factor** in the death of Rfn Evans. However, the inability to provide support along the whole route was assessed to be **an Other Factor** that could compromise future AFTs at this location.

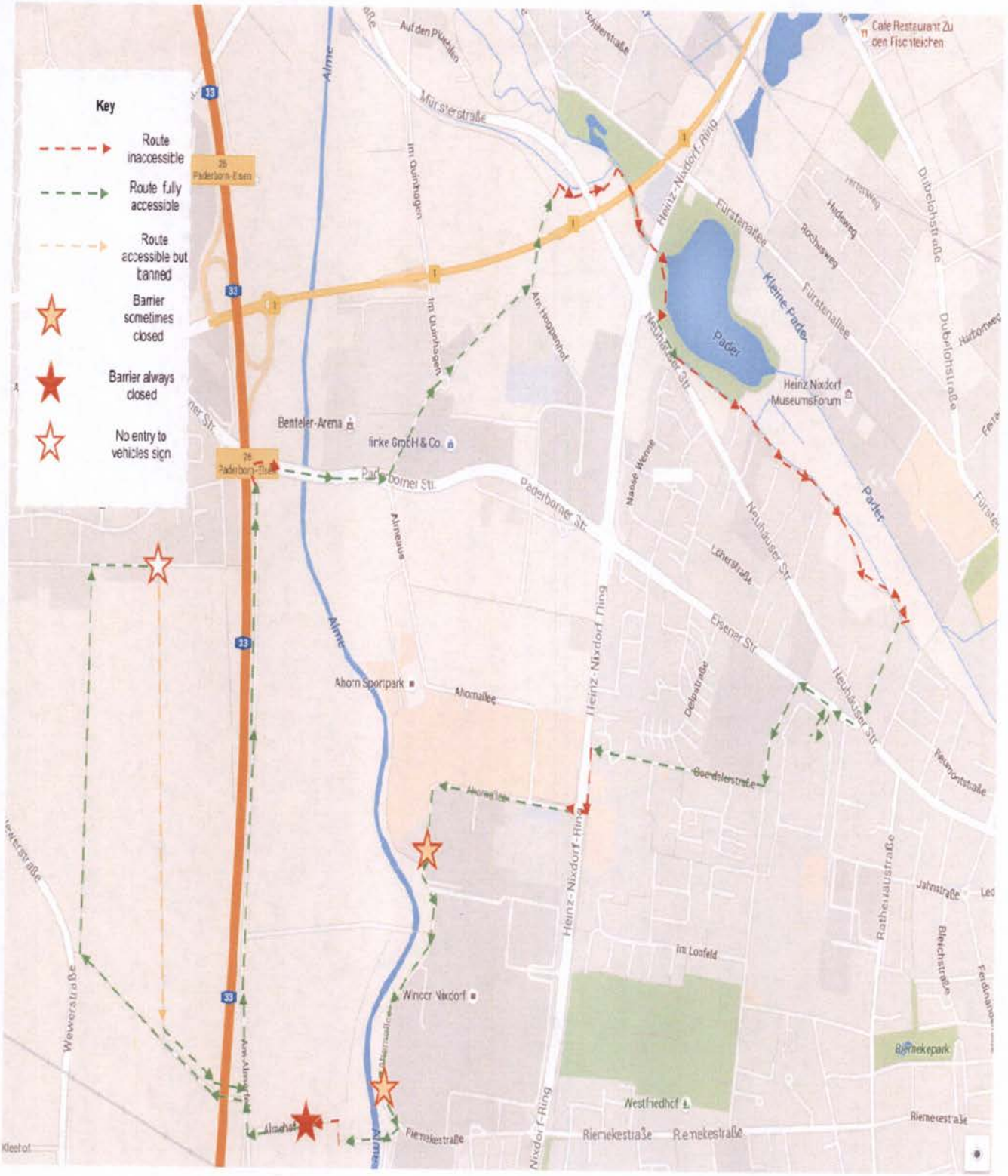

Fig 1.4.2 – Map showing SV accessibility on the AFT route

1.4.41 **Command and Control of the AFT**. The SI examined the command and control process and procedures that were in place on the day of the AFT.

a. **Communications**. The MATT 2 Protocol states, only, that "*communications means should be considered*". It does not require a communications plan. PTI 1 and the SV driver had mobile phones and had exchanged numbers indicating a degree of forward planning. However, PTI 2 did not have communications with PTI 1 or the driver throughout the AFT. There was no mitigation in place and it was not referred to in the RA. The SI concluded that an effective communications plan had not been developed.

Exhibit 13

Soldier W
Soldier W
Exhibit 64

b. **Significance on the day**. Rfn Evans collapsed at approximately 0912. Sldr L was ordered to move forward to the Guardroom, call the emergency services and remain there to act as a guide. This call is logged as being from 09:14:29 to 09:17:42. PTI 1, who had been with the stragglers behind the main body, arrived at the incident location and phoned for a civilian ambulance. This call is logged as being from 09:14:09 to 09:15:52. The SI concluded there was no delay between it becoming clear Rfn Evans needed urgent medical attention and the calls being made.

Exhibit 21

Exhibit 21

c. **Emergency Response Plans**. British Forces Germany Health Services Information Booklet clearly states that "*in case of serious illness or injury occurring, whether to a military or civilian individual, the immediate response must always be to call the civilian emergency services on 112.*" During interviews the SI noted that 5 RIFLES soldiers did not know the names of the German streets on the route. PTI 1 had to tell the German Paramedics to meet him at the Alanbrooke Guardroom as it would have added extra time to explain by any other means. The SI noted that the Commando Training Centre Royal Marines (CTCRM) have a map of their training area with pre-designated Rendezvous locations for civilian emergency services. In the opinion of the SI, this is an example of best practice.

Exhibit 65

PTI 1
Exhibit 116

Conclusion: Although neither the communications plan nor the emergency response plan were as robust as they could have been, messages were sent to the emergency services as quickly as could reasonably be expected. Given the incident location, members of the Coy were able to guide the emergency services into the exact location without delay. The SI therefore concludes that they were **not a factor** in the death of Rfn Evans. On future AFTs the nature of the communications plan and emergency response plan might be significant and therefore the SI considers them to be **an Other Factor**.

d. **Spread of group**. The group started to spread out after the 2nd water stop, which is at the 4 mile point (see Fig 1.4.1) and by the time the Main Body crossed the road at the traffic lights Sldr A and PTI 1 were 250m behind (see Fig 1.4.3).

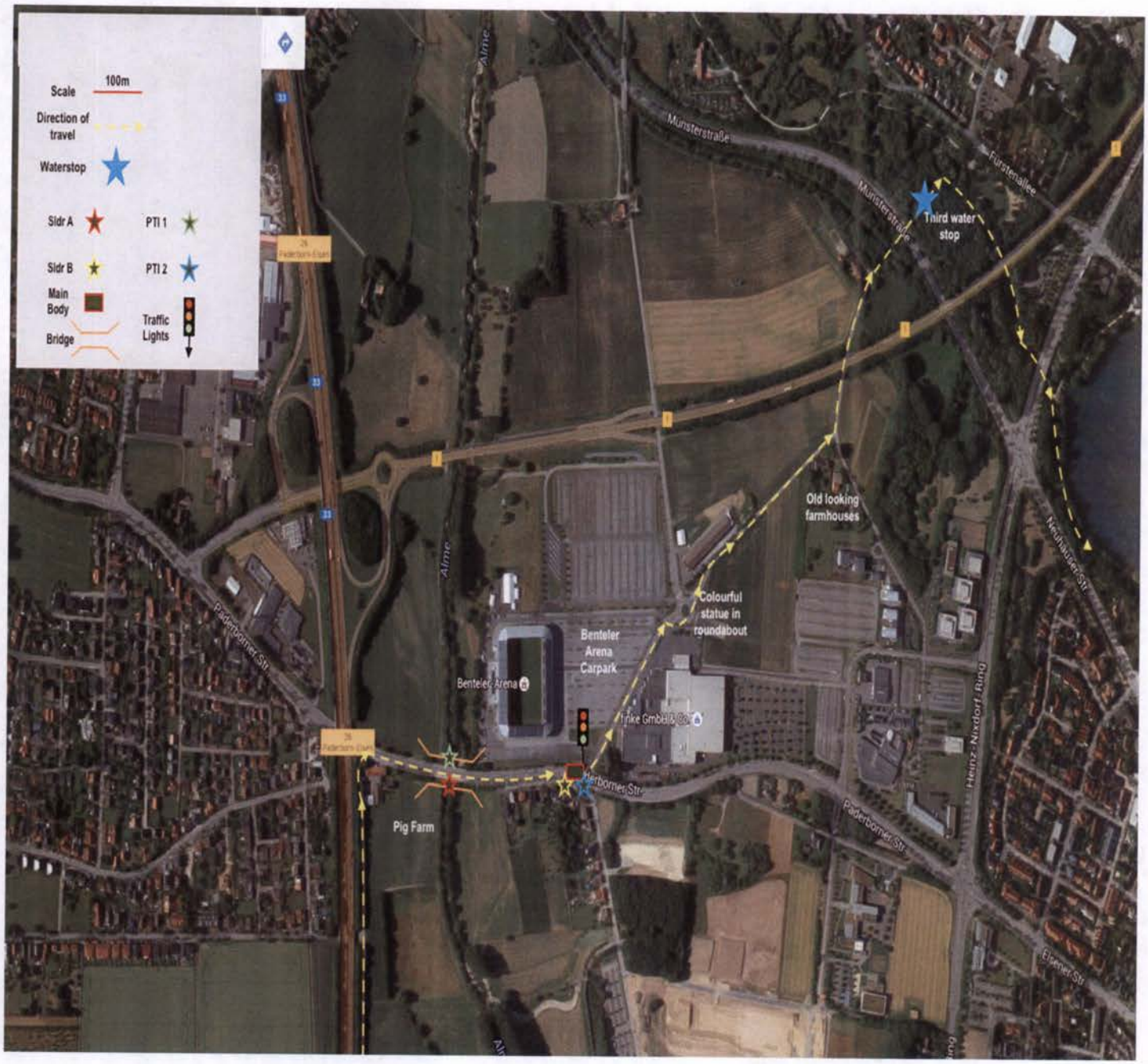

Fig 1.4.3 – Estimated position of PTI 1 and Sldr A when Main Body at Traffic lights.

Sldr B dropped out of the main body 100-150 m beyond the traffic lights and collapsed shortly afterwards. He was placed onto the SV at the point of collapse by Sldrs E and J. Neither Sldr A nor PTI 1 saw this occur, suggesting they had yet to reach the traffic lights (see Fig 1.4.4).

Soldier E
Soldier J

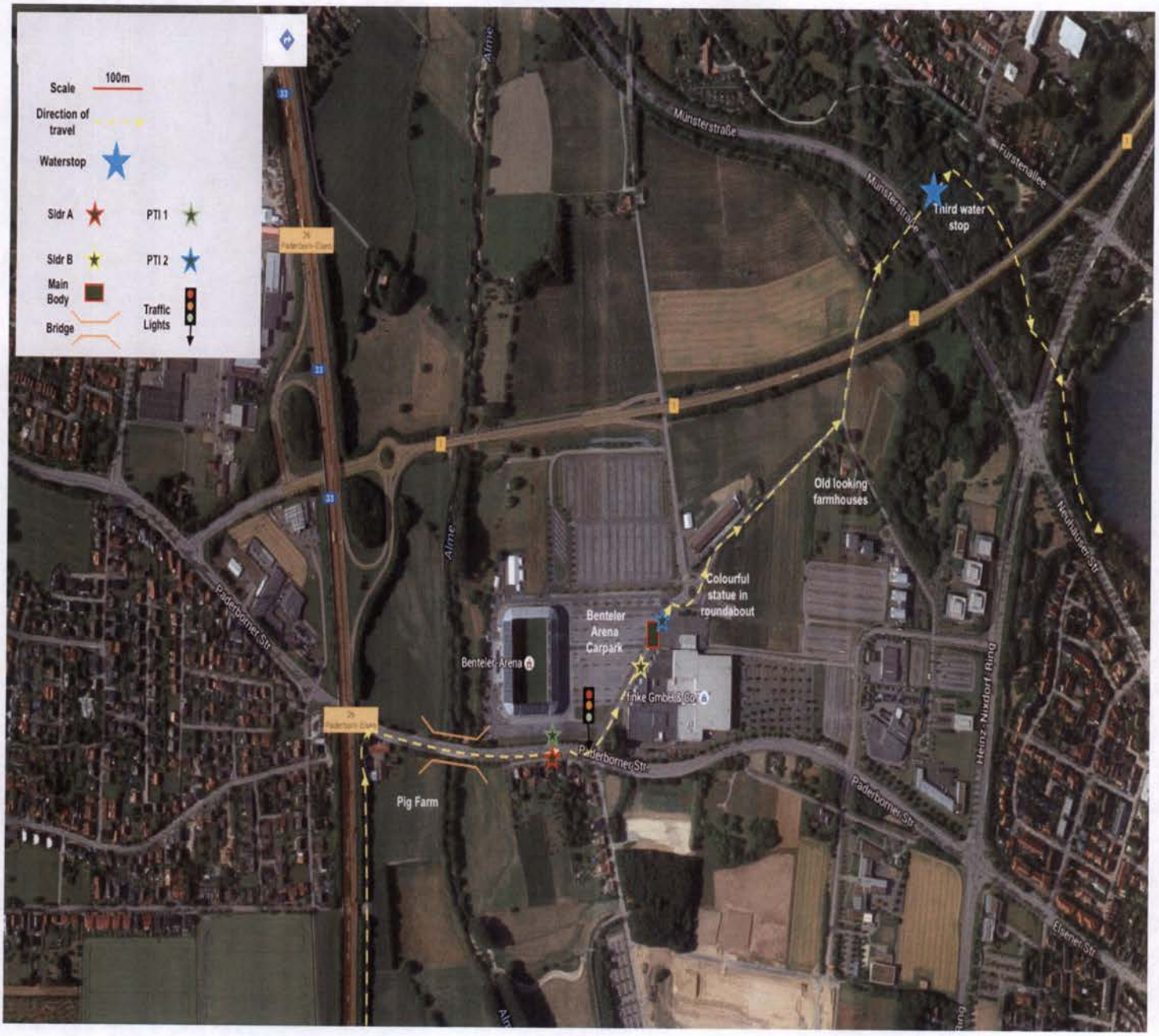

Fig 1.4.4 – Estimated position of PTI 1, Sldr A and Main Body when Sldr B collapses

By the time Sldr A reached the SV the Main Body was estimated to be 400-500m further along the route (see Fig 1.4.5). This gap occurred because stragglers could not be removed from the event in accordance with the protocol, as the SV could not access the entire route. According to the MATT 2 Protocol individuals who fall out of the squad during the march are to receive a warning. If they receive more than 2 warnings they are to be placed on the SV. Combined with poor communications, the spread ensured PTI 1 was unable to inform PTI 2 that he had placed Sldr A on the SV without running hundreds of metres to catch up.

PTI 1

Exhibit 13
Exhibit 13

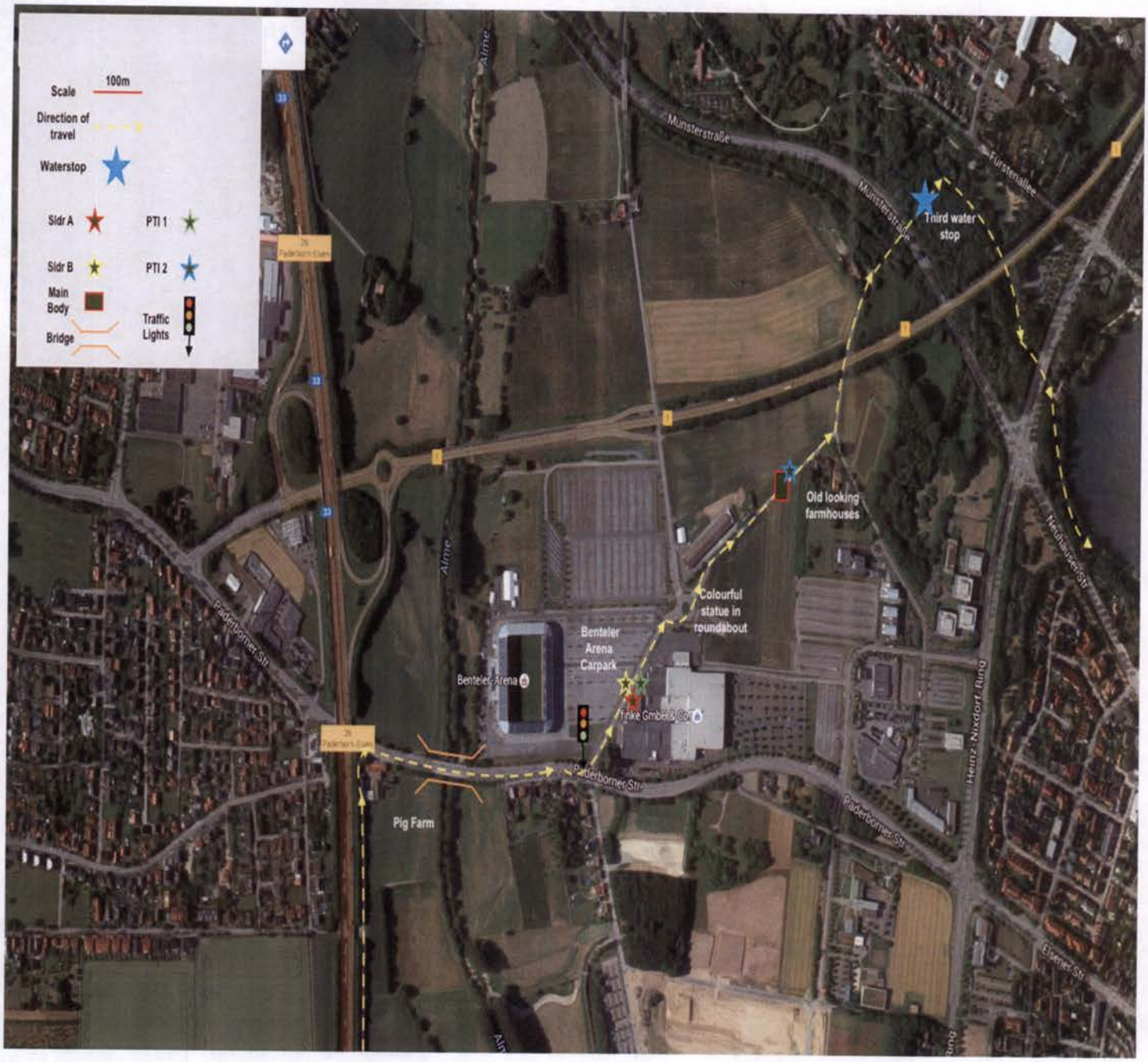

Fig 1.4.5 – Estimated position of the Main Body when PTI 1 arrives at Sldr B's collapse

The group became spread out again after the third water-stop (see Fig 1.4.5 above and Fig 1.4.6 below). At this point, the SI believes a serious safety issue had started to develop. **PTI 1**

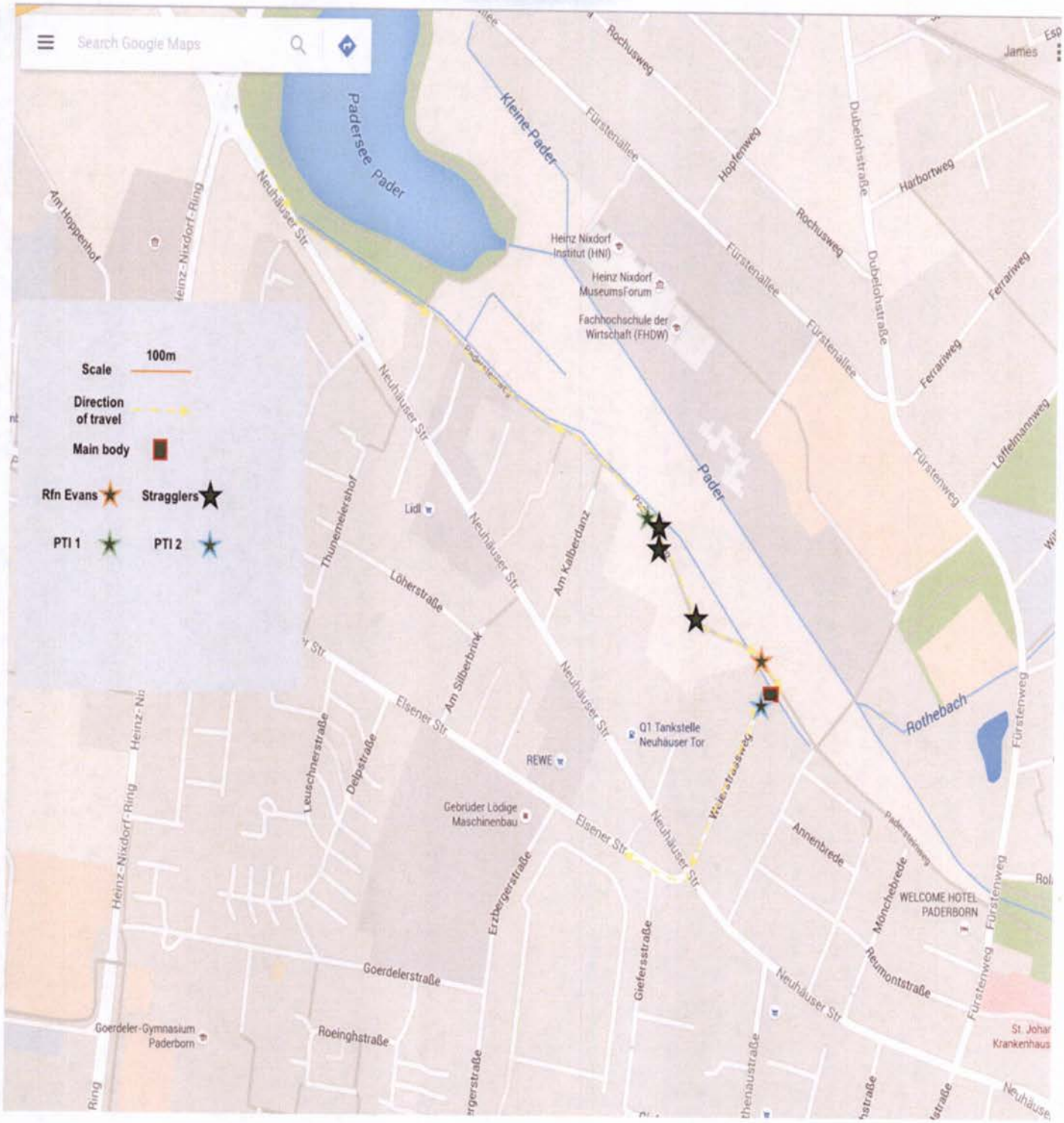

Fig 1.4.6 – Estimated spread of Main Body when Rfn Evans collapses.

Conclusion: The route selected for the AFT and the inability of the SV to follow troops at the correct distance, had an adverse effect on the command and control (getting emergency services to an incident, inability to place stragglers in the SV) of the AFT. In this instance however it was **not a factor** in the death of Rfn Evans. On future AFTs it might be significant and therefore the SI considers it to be an **Other Factor**.

1.4.42 **Division of responsibilities between OIC and OC B Coy**. When interviewed by the SI, it was noticeable that there was little agreement amongst

commanders as to their role in an AFT or similar event. PTI 2 believed that as the CO's representative he was solely in charge of the event. OC Fire Support Coy disagreed, as did B Coy CSM who believed that he was in charge of the men, whilst the PTI was is in charge of the test. Whilst everyone in the Chain of Command has a responsibility towards other individuals, under the Duty Holding principle the OIC has primacy during the event. The SI noted that CTCRM have a clear division of responsibility between the PTI and the March Commander. The former is responsible for running the event; the latter responsible for the men and making the decisions to remove those from the event who become injured or are unable to keep up. The SI could find no Army policy document detailing such a division.

PTI 2
Soldier V
Soldier K

Conclusion: There is a lack of clarity as to how responsibility is divided.

1.4.43 **Recommendation. The SI recommends that DTrg(A) should produce policy on the division of responsibility between a unit's chain of command who are participating in an event and the event OICs.**

1.4.44 **Dispatch of Safety Vehicle and continuation of march.** The SV was dispatched shortly after the main body passed the 5 ½ mile point. The decision to do so went through a number of stages.

PTI 1

a. **Soldier B Drops Out.** After crossing the main road at the traffic lights (see map Fig 1.4.4) and a brief shakeout run[30] at around the 5 ½ mile point Sldr B (who had by now been struggling for some time) was unable to keep up with the main body. He stopped and sat down against a fence. He was spoken to by Sldrs E and J, both of whom made the judgement call that Sldr B was not able to continue and loaded him into the SV. Sldr B is reported to have been relatively lucid at the point he went into the SV, but has no recollection of events between sitting down against the fence and becoming aware that he was in the SV. Sldr J then ran forward to rejoin the main body. Either simultaneously or very shortly after this (the witness recollections differ), PTI 1 and Sldr A reached the SV. By this stage Sldr B was dizzy and nauseous and appeared to be less than entirely conscious. At this stage Sldr B was showing signs of becoming a heat casualty.

Exhibit 66
Soldier E
Soldier B
Soldier J
Soldier E
Soldier E
Soldier B
PTI 1
Soldier A

b. **Withdrawal of Soldier A.** The MATT 2 Protocol states that "*The OIC is to withdraw personnel from the test under the following circumstances:*

Exhibit 46
Exhibit 13

(1) Where personnel show signs of illness or injury (on advice from the First Aid NCO).

(2) *Where personnel fail to maintain pace with the main body of troops (having received a maximum of two formal warnings to catch up)."* The protocol further states "*The Sweeper(s) is/are responsible for keeping the OIC and First Aid NCO informed of any casualties or stragglers who require assistance.*"

Exhibit 13

Due to the spread of the group and communication issues, it was not possible to keep the OIC informed contemporaneously of the withdrawal of Sldr's A and B, which was a sub-optimal situation. Whilst PTI 1 and Sldr J were not able to seek the views of the OIC with regards to withdrawing Sldr's A and B, it was nevertheless the correct decision. If the Coy had not been so spread out and/or

[30] Shakeout runs are short runs which allow the legs to move more freely. This helps break up the monotony of the TAB but more importantly is supposed to allow the body to get rid of lactic acid build up in the muscles.

had they had communications with the OIC, PTI 1 and Sldr J would have been able to involve him in the decision. In the circumstances this was not an option and (with little of the remaining route accessible to the SV) they had little time to make their decisions.

c. **Dispatch of Safety Vehicle**. On discovering Sldr B in the back of the SV, PTI 1 carried out a dynamic RA. He concluded that Sldr B needed medical assistance. He told Sldr A to look after Sldr B and dispatched the SV to the Sennelager Medical Centre. Although there is no explicit statement within the MATT 2 Protocol as to who can dispatch the SV, when taking into consideration the passages already quoted in the paragraph above and paragraph 12a of the MATT 2 Protocol "*The OIC is responsible for the administration and safety of the test*", it is clear that it would have been preferable had the OIC been involved in the decision. The same factors (spread of the group and communications) prevented PTI 1 from deferring this matter to the OIC as had prevented him from deferring the decision to place Sldr A on the SV. In the opinion of the SI, the OIC should have been involved in the decision to dispatch the SV. PTI 1 made a decision in a dynamic situation based on the information available to him under pressure and using his skills, qualifications and experience. The decision to dispatch the safety vehicle without the knowledge or agreement of the OIC was **not a factor** in the death of Rfn Evans. **PTI 1** **PTI 1** **Exhibit 13**

d. **Evacuation to Sennelager Medical Centre**. It was noted that when Sldr B was dispatched to Sennelager Medical Centre it was closed due to a power outage. This fact had been disseminated on BFBS radio and by email to units on the previous day. The SI confirmed that this information had been published on 5 RIFLES Part One Orders. The OIC and PTI 1 did not know that Sennelager Medical Centre was closed. Whilst this was **not a factor** in Rfn Evans death, in a similar situation it might increase the risk to others. Therefore the SI determines that the lack of knowledge of the availability of medical facilities to be **an Other Factor**. **Exhibit 67** **Exhibit 68** **Exhibit 98**

e. **Soldier B Diagnosis**. It was never established with certainty whether Sldr B had suffered a heat injury. When he was placed in the SV and subsequently seen by PTI 1, he was displaying some signs of being a heat casualty. His temperature was normal by the time he reached Barker Barracks which suggests otherwise, but is not conclusive. Significantly, the 510 accident reporting form compiled by PTI 1 describes him as a heat casualty and the RMO of 5 RIFLES advised that Sldr B should not deploy to the hot climate of Kenya as a result. Though it is not known for certain whether Sldr B did suffer a heat injury, at the point of collapse and afterwards he was displaying some signs of being a heat casualty and therefore a dynamic RA in accordance with JSP 539[31] should have been conducted. **PTI 1** **Exhibit 69** **Soldier B**

f. **The Coy Progress to the 6 Mile Water Stop**. The main body continued along the route until they halted for their third water stop. As the main body was preparing to move off PTI 1 arrived, having been running to catch up since dispatching the SV. He informed B Coy Commander and CSM that he had dispatched the SV. He briefed PTI 2 who recalls that he knew there were two casualties put on the SV at the 5 ½ mile point and that the SV had been dispatched. It is not clear whether he understood the reason for the SV being **PTI 1** **PTI 2**

[31] JSP 539 Para 219 states that a single case of heat illness is a warning that other personnel are at risk and the Commander is to carry out a dynamic RA of the activity, and is to consider other control measures including stopping the activity.

sent away. The following policies are apposite:

(1) **Paragraph 10.h of the MATT 2 Protocol**. "*The OIC is to halt the test if the Safety Vehicle is required to evacuate injured personnel to hospital. The test may recommence once the Safety Vehicle is present*". **Exhibit 13**

(2) **JSP HEAT 539 Para 219 b**. "*A single case is a warning that other personnel are at risk, the commander is to carry out a dynamic risk assessment of the activity, and is to consider other control measures including stopping the activity.*" In addition the document includes the following flowchart: **Exhibit 46**

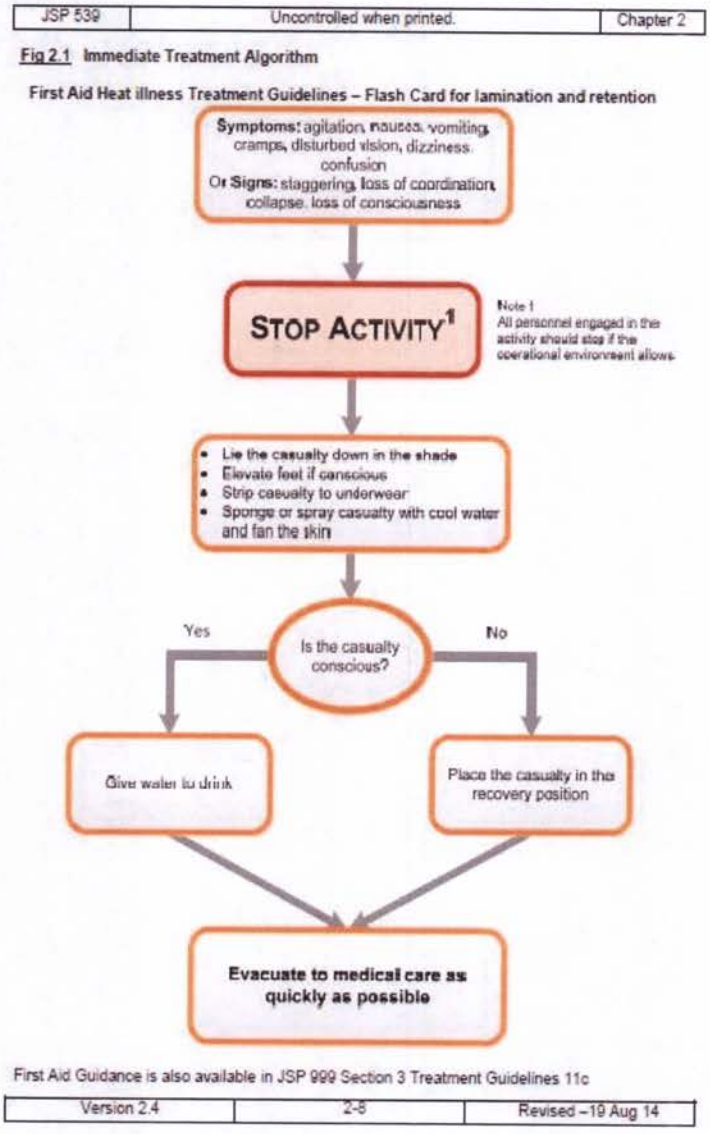

Fig 1.4.7 – Extract from JSP 539, First Aid Heat Illness treatment guidelines

g. **Decision to continue the test in the absence of a safety vehicle**. The AFT Protocol is clear that the OIC must stop the test if the SV is dispatched and PTI 2 was aware of this. However, the Coy would still have had to get back to camp. There were a number of courses of action available to the OIC. **PTI 2**

(1) Stop and call Alanbrooke Barracks for a pick up (though it is doubtful they could have got all the transport needed to lift the Coy).

(2) Wait for the return of the SV before continuing the test in accordance with MATT 2 Protocol (which would have taken an estimated minimum of 45 mins, by which point the temperature would have risen).

(3) Walk back to Alanbrooke Barracks following the easiest route, which is that of the AFT route.

With option 3 chosen the question then becomes should they have walked in at a relaxed pace or maintained their pace and continued with the test. If the OIC had chosen the former then the test would have to be abandoned (and as such everyone would have failed). The SI noted there was significant pressure to complete the test as the Coy understood they would not be able to deploy unless they passed the AFT. Additionally, the remaining part of the route was almost completely inaccessible to a SV and it was accepted procedure within the unit to continue the test from this point onwards without an SV. This underpins the understandable rationale for the decision to continue the test at AFT pace and without the SV. **PTI 2** **PTI 1** **Soldier R**

h. **Decision to continue the test after a suspected heat casualty**. According to JSP 539, one heat casualty is a warning that other personnel may be at risk. As such the SI would expect the OIC to satisfy himself that his remaining personnel were not displaying similar symptoms before continuing; there is no evidence of this occurring. Had the OIC conducted a dynamic RA and removed those individuals who caused him concern, Rfn Evans would have been amongst those who continued. In accordance with (JSP 539 and MATT 2 Protocol), the test should have been halted as a result of the potential heat casualty and the lack of a SV. The decision to continue was not countermanded by the most senior soldiers present (the OC and CSM). Under present arrangements the OIC is responsible for safety throughout the test. However, the OC, by dint of his rank and role is in a position to stop a test if he feels is becoming unsafe. In the opinion of the SI it is a distinct possibility both the OC and OIC believed the other man had made the decision to continue and deferred to that judgement. There is no medical evidence or opinion which supports the notion that stopping the event at this stage would have saved Rfn Evans. As such it is the view of the SI that the decision to continue with the test was **not a factor** in Rfn Evans death. Should, in the future, OICs not consider the guidance and requirements laid down in the MATT 2 Protocol and JSP 539 when deciding whether to stop or continue with the test there is the possibility of an incident or accident and therefore the SI considers it to be **an Other Factor.** **Exhibit 46**

1.4.45 **Summary on the execution of the AFT**: The SI's overall conclusion is the AFT was not conducted in strict accordance with the instruction received by all PTIs during their qualifying courses at ASPT. However, this must be taken in the context of the enduring attitude towards physical training events within the unit and wider Army. It was clear throughout the interview process that soldiers did not regard the AFT as a potentially hazardous activity. The conduct of the AFT had been normalised and breaches of the MATT 2 Protocol had become accepted as the norm. The two PTIs responsible for this particular event had not designed the route. Various soldiers confirmed that the route was the one that was always used. No one seemed to feel that it was unsuitable. As a result of these conclusions the SI felt it was appropriate to investigate the wider management of PD within the Bn. **Soldier AA** **Soldier AA**

1.4.46 **Recommendation. The SI recommends that CO 5 RIFLES should ensure that AFT policy and procedures are fully understood and implemented**

by his PD Staff. This should include a review of the route used, safety communications, employment of the SV, emergency response plan and availability of medical facilities. Where risk is identified and mitigation used it should be reflected in the AFT RA.

Situation of 5 RIFLES Jan - Jun 15

1.4.47 **Post Operation HERRICK 20**. Elements of 5 RIFLES had deployed on Op HERRICK 20 from May to Nov 14. These elements had been part of the security force closing down CAMP BASTION. B Coy had been part of that force and was the last to leave theatre in Nov 15.

AGAI Volume 1 Chapter 7 states that:

> *"When returning from periods of inactivity, care should be taken to ensure that training is resumed at an appropriate level and built up progressively. Individuals are more susceptible to re-injury if they re-join full activity too soon after recovery, appropriate reconditioning in accordance with Para 2 will be the key to avoiding unnecessary injuries."*

Exhibit 42

Typical periods of inactivity include:

- Post Operational Tour Leave (POTL).
- Annual Leave.
- Sedentary Courses or Employment.
- Sick Leave or Maternity Leave.
- Light Duties.

Exhibit 42

The A2020 FORM Fitness Doctrine (A2020 FFD) reinforces this by mandating a period of 'active rest' after operations to mentally and physically recuperate, during which COs should '*avoid programming mandatory fitness tests/assessments before a period of reconditioning had been undertaken'*. Those soldiers who had deployed added a period of POTL to their Christmas Leave. As such it is reasonable to assume a significant proportion of B Coy soldiers who had deployed on the tour were not fully fit when they returned to Bn duties in the New Year. The Coy training programme for the early part of the year was structured to progressively build the Coy's fitness towards the PFA. Additionally, there were soldiers returning to the Bn from external postings and soldiers (including Sldr A) committed to vehicle courses either as instructors or students who had missed organised PD. Though the unit declared it had had a rehabilitation/remedial organisation ('Salamanca Platoon') for integrating/reintegrating those personnel who had not been conducting mainstream PD in the Bn, the SI noted that it was in a nascent stage of development in Jun 15. 5 RIFLES was at the stage anticipated by the A2020 FFD as the lowest point for fitness during its three year cycle. Due to varied commitments some members of the Coy were likely to be at a lower level of fitness than others.

Exhibit 70
Soldier X
Soldier A
Soldier Y
Soldier P
Soldier AA

1.4.48 **Manning Issues**. 5 RIFLES overall manning was good at around 95%. However, the unit was experiencing a shortage of junior officers, which was putting a strain on the Chain of Command. Commanders at all levels were required to assume the responsibilities of higher ranks to mitigate shortages. To provide continuity during their Op HERRICK deployment the structure of the Bn was fixed at the beginning of

Soldier Y
Soldier Y
Soldier H

2014. As a result several key posts, including the CO and Second-in-Command, changed over immediately after the Bn's return from Afghanistan. The SI **observed** this resulted in issues being missed (partially due to a lack of information push from Superior HQ's) or overlooked as individuals took time to become familiar with their new roles. It is likely that this created an environment where information could be missed and the unit forced to prioritise some issues at the expense of others. Examples of this being the priority afforded to Warrior Training (see para 1.4.50), the lack of knowledge of the policy on MATTs currency being changed (see para 1.4.76 b) and the allocation of the CMT on 18 Jun 15 (see para 1.4.40 b). **Soldier Y** **Exhibit 5** **Soldier AA**

1.4.49 **Restructuring**. On their return from Afghanistan the outgoing CO ordered a restructuring of the Bn. This involved the re-allocation of manpower between the sub-units in the Bn, with priority given to HQ and Fire Support Coys and was to occur before the Bn went on Christmas Leave. In practice this resulted in a significant number of personnel in the Bn moving between Coys in late 2014. There was also an inflow of fresh manpower from the Infantry Training Centre at Catterick. The combined effects were to create turbulence and unfamiliarity within Coys. **Exhibit 71** **Soldier Y** **Soldier E**

1.4.50 **Training Targets for 2015**. 5 RIFLES had retained their role as Armoured Infantry despite deploying on Op HERRICK in a different infantry role. The consequence of which was on their return the unit needed to conduct an extensive package of training on the Warrior Armoured Fighting Vehicle. This resulted in many personnel being pulled away from their Coys either as students or instructors. The aim was to achieve CT1 by 30 Nov 15. This could only be done by staggering the Coys' training, as the Bn HQ sought to manage scarce resources and the shortage of junior officers. This effort was greatly frustrated by a mechanical issue with the Warrior that resulted in all but 2 of the entire fleet in Germany being taken off the road. These Warriors had to be shared with another Bn, thus placing strain on the training pipeline and posing a threat to 5 RIFLES being ready to deploy on exercises and operations in 2016 and 2017 respectively, with 'associated risks' from inadequate training. **Exhibit 72** **Soldier V** **Soldier Y** **Exhibit 8** **Exhibit 72**

Conclusion: 5 RIFLES had a tight schedule to achieve a substantial amount of training. There were a number of conflicting priorities pulling individuals and sub-units in a number of directions.

1.4.51 **Other Tasks Year**. 5 RIFLES was in its 'other tasks year' the first year of a 3 year cycle. The main policy document covering the A-FORM Cycle from DTrg(A) is the A2020 Training Narrative. It describes the Other Tasks Year thus: **Exhibit 73**

> ***Other Tasks Year***. *In the Other Tasks Year, units will support the training of others but nevertheless, they will conduct individual training, a CT1 dismounted training event and all AFV crews will conduct their live fire Annual Crew Test (ACT). Training support for those RF units that are in the Training Year will include meeting the Land Warfare Centre (LWC) battlegroup commitment to support Phase 2-3 training and CT3-4 events on SPTA. Other training support includes BATUS[32] COEFOR and BATUS temporary staff and RAAT tasks.*

20 Armd Inf Bde described the other tasks year in their 2015 Directive as: **Exhibit 8**

> ***The Other Tasks Year***. *20 Armd Inf Bde are responsible for providing*

[32] BATUS is the British Army Training Unit Suffield, which is located in Canada.

troops for HQ 3 (UK) Div training, 3 (UK) Div RAAT tasks as well as quality training support with efficient delivery that is accountable to identifiable people for the 1 Armd Inf Bde training year. 20 Armd Inf Bde Units and their affiliated 101 Log Bde units in their other tasks year will train to CT1 using available resources in order to build on the adaptive foundation core curriculum.

The Bn was tasked with providing troops and equipment to the Regular Army Assistance Table (RAAT). These tasks are varied and included providing enemy and support to major exercises in the UK and Canada. They were continually providing small teams of men for tasks outside the scope of RAAT (such as BFG commitments) and individuals trawled to fulfil a range of operational commitments. Combined with the extant training objectives for the year, 5 RIFLES was running at or very near to capacity. **Exhibit 80**

1.4.52 **Summary of the Situation of 5 RIFLES**. The overall effect of factors both internal and external was that the Bn was 'running hot'. It lacked spare capacity to take on any tasks above and beyond those already allocated and there was a risk that some issues deemed low priorities would not be fully addressed. It was also inevitable that some issues would not receive the appropriate level of scrutiny and rigorous staff work to ensure that detail was not missed or overlooked.

Legacy Physical Development Issues

1.4.53 **Introduction**. The SI has identified a number of legacy issues within and external to 5 RIFLES which merit analysis in order to prevent possible incidents in the future and which provide mitigation for some of the short-comings found in the conduct of the AFT on 18 Jun 15.

1.4.54 **Historical**. Alanbrooke Barracks is located in the centre of Paderborn and has acted as a British Military Barracks since the end of the Second World War. 1st Bn Light Infantry moved into the barracks in 2002. They became 5 RIFLES in 2007 and therefore it is likely that some of the current personnel stationed in Alanbrooke Barracks have been posted there numerous times in their military careers.

1.4.55 **The AFT Route**. The AFT route is displayed on an aerial photograph in the gymnasium. It was produced by 20 Armd Inf Bde and dated 3 Nov 09. From interviews conducted and during an SI reconnaissance of the route it became clear that there were differences between the published route and the one followed on 18 Jun 15. As previously noted, significant parts of the route are inaccessible to an SV and the route has no formal start and finish points. When interviewing the RAPTCI it was clear that he was not familiar with either the publicised route or that deviation to the route were being made by conducting OICs. The SI concluded that neither external nor internal PD assurance systems identified the fact that the AFT route did not comply with the MATT 2 Protocol. **Exhibit 74** **PTI 1** **PTI 2** **Soldier Q** **PTI 1** **Soldier P** **Soldier V**

1.4.56 **Previous Incidents and the alternate AFT route**. The SI identified that since 2013 there had been three AFT related incidents. The first on 17 Jul 13 resulted in two Rfn collapsing through exhaustion inside the barracks at the end of the AFT. The second on 25 Jul 13 resulted in one Rfn collapsing with heat exhaustion 300m outside of the barracks. The third on 2 Aug 13 resulted in a JNCO collapsing inside the barracks having completed the AFT. The learning accounts produced for the first 2 incidents recommended: making an early breakfast compulsory, maintaining a database of the build-up training prior to the AFT, scheduling the AFT to start earlier (when the temperature is cooler) and where this is not possible provide an additional **Exhibit 45** **Exhibit 75** **Exhibit 76** **Exhibit 75** **Exhibit 76**

hot weather brief. The third incident resulted in a learning account and a LAIT investigation as the casualty was listed as Very Seriously Injured. The third AFT took account of the recommendations from the learning accounts of the first two incidents and, in addition, the route was changed to ensure that at least half was in the shade. The learning account for this incident identified the Bn practice of having a CMT in attendance as best practice, only 1 issue top should be worn and that the revised route had worked well. The LAIT report concurred with these learning account recommendations. The SI noted similarities between the incidents on 2 Aug 13 and 18 Jun 15, in relation to the route and procedures use. In the opinion of the SI, lessons identified following the 2 Aug 13 incident had been largely forgotten by the time of the AFT on 18 Jun 15.

1.4.57 **Risk Assessments**. 5 RIFLES PD staff had produced a series of generic RAs for standard PD activities. PT staff were required to sign a register to say they have read the relevant RA prior to commencing the activity. In addition they were required to conduct their own dynamic RA prior to the activity. This RA covered environmental factors, instructor SQEP[33] and ability levels. The SI analysed the AFT RA that was in use on 18 Jun 15. It noted that the RA was on a form dated 2001 (which has been revised several times and last re-issued in Land Force Standing Order (LFSO) 3216) and that it contained errors (data entered on wrong lines, existing and additional controls not relevant or coherent with the associated risk, repetition of the same risk). The RA was reviewed on 2 Feb 15 and there is no indication that it had been changed from the previous iteration(s). It did not contain any information relevant to the local conditions (non-availability of medic, inability of SV to follow the route, communication plan, instructor ratios, extremes of weather). The SI also analysed a sample of other RAs and found them to have similar issues. **Exhibit 64** **Exhibit 15** **Exhibit 15** **Exhibit 99** **Exhibit 64** **Exhibit 100**

Conclusion. The SI **observed** that the compilation of PD RAs within 5 RIFLES was sub-optimal at the time of the incident, and further noted that this problem was not identified by internal and/or external PD assurance. The SI has sighted the recent (10 Nov 15) PD Inspection for 5 RIFLES which comments on the appropriateness and suitability of their revised RAs.

1.4.58 **Recommendation. The SI recommends that CO 5 RIFLES should review PD RAs to ensure they are fit for purpose and establish a robust management system to monitor and review them periodically. The SI understands that this process is underway.**

Assurance

1.4.59 **Internal PD Assurance**. A Bn CO, as the Delivery Duty Holder (DDH) exercises PD assurance within the Bn via the Unit Fitness Training Officer (UFTO) to the RAPTCI and down to the AAPTIs. 5 RIFLES deployed on Op HERRICK 20 in May 14. This deployment included Bn HQ, Fire Support Coy and B Coy, which accounted for the CO, UFTO and RAPTCI. However, as elements of the unit were left in Germany, management of PD in Alanbrooke Barracks was temporarily assigned to a Lance Corporal (LCpl) AAPTI. The RAPTCI returned from Op HERRICK in Aug 14 to discover that his relief had joined the unit and had immediately deployed to BATUK as an augmentee. With an onward assignment the RAPTCI formally handed over the PD facilities and management to the LCpl in the presence of the 20 Armd Inf Bde Senior Physical Training Instructor. The unit returned from Op HERRICK in Nov 14 **Soldier Q**

[33] Suitably qualified and experienced person – a subject matter expert with the correct training, qualifications and experience.

and underwent an extensive manpower and staff turnover (CO, 2IC and UFTO all changed). PD continued to be managed by the LCpl. The new RAPTCI returned from BATUK in Feb 15 and took over from the LCpl. The SI further noted that the RAPTCI TORs do not reflect the requirement for the post to deliver mentoring and assurance to the AAPTIs and that he did not see it as a personal responsibility to assure or develop Coy AAPTIs. **Exhibit 77 Soldier P**

Conclusion. The SI **observed** that the SME responsible for internal PD assurance was missing from 5 RIFLES for the best part of a year preceding the death of Rfn Evans. This situation was exacerbated by the staff churn (see paras 1.4.48 and 1.4.49) and the belief that PD is a safe activity and therefore the Command focus was directed towards those activities (such as Finance, Warrior Training, Equipment Care and Live Firing) that carry greater risk to life or unit reputation. **Soldier AA**

1.4.60 **Recommendation. The SI recommends**:

a. CO 5 RIFLES should amend RAPTCI TORs to include coaching and mentoring AAPTIs.

b. CO 5 RIFLES should establish a robust assurance process to ensure that the delivery of PD is in accordance with AGAI Volume 1, Chapter 7.

1.4.61 **External PD Assurance**. External assurance of PD is provided to 5 RIFLES by 20 Armd Inf Bde Senior Physical Training Instructor and BFG PD Subject Matter Expert. Their program is driven by the guidance received from the Divisional HQ. 5 RIFLES received their last PD Inspection in Dec 13 when they were part of 1 (UK) Div. They achieved a satisfactory pass with a recommendation for a follow up advisory visit in the following 6 -9 months. Under extant policy, units warned for operations have the requirement for inspections suspended for 6 months prior to deployment until 6 months after they return. In 5 RIFLES case this was from Jan 14 to Jun 15 and meant that the follow up visit did not take place. During this timeframe 20 Armd Inf Bde transferred from being under the command of 1 (UK) Div to being under command 3 (UK) Division and the 20 Armd Inf Bde Senior Physical Training Instructor changing three times. The 20 Armd Inf Bde Senior Physical Training Instructor who attended the handover in Alanbrooke in Sept 13 left the Army shortly afterwards. **Exhibit 92 Exhibit 99**

Conclusion. The SI **observed** that the lengthy gap between external PD Inspections, the turnover of 20 Armd Inf Bde Senior Physical Training Instructor and the transfer of 20 Armd Inf Bde from 1 (UK) Div to 3 (UK) Division all contributed to the failure to identify issues (see para 1.4.55) with the governance and delivery of PD within 5 RIFLES.

1.4.62 **Recommendation. The SI recommends that DTrg(A) should consider amending the policy of suspending assurance visits due to operational commitments in order to take into account that units deployed will always leave a rear party behind at their base locations.**

1.4.63 **RA Training Best Practice**. To ensure that Health and Safety in the military work place is compliant with the Health and Safety at Work Act 1974, funding and resources are allocated to ensure personnel are given timely and appropriate training. Training is mandated and tied to specific posts within the organisation. British Forces Germany Safety, Health and Safety, Environmental Protection and Fire Safety (BFG SHE) Department delivers Health and Safety Trg for personnel based in Germany and this includes work place RA training. In comparison, PD RA Trg is briefly covered in

Command Leadership and Management courses and at the ASPT. The training is based on work place RA and not PD activities and there is no mandate to conduct refresher training on taking up a new post.

Conclusion. The SI **observed** the priority afforded to PD and other non health and safety related RA Training was inadequate, especially when PD is now seen as a RtL activity.

1.4.64 **Recommendation. The SI recommends that:**

a. DTrg(A) reviews and revises delivery of PD and other non health and safety related RA training in order to ensure a safe system of training.

b. DTrg(A) attaches to the UFTO and RAPTCI positions (or equivalent in smaller units) a requirement for a PD RA competency in the same way that the Quartermaster position is labelled as the Unit Safety Advisor.

1.4.65 **Inspection Best Practice**. The BFG SHE Department conducts SHE inspections as part of the 3 (UK) Div inspection week. BFG SHE reviews the work place RAs, comparing them against the actual activity. This ensures that the written RA reflects the demands and risks associated with the activities being undertaken. The SI felt this was an example of best practice and should be commended to the PD assurance team.

1.4.66 **Recommendation. The SI recommends that DTrg(A) reviews and revises the protocol for PD inspections to ensure RA are reviewed against actual activity, which is considered good practice.**

B Company's Tasking To Provide Troops To BATUK

1.4.67 **Introduction**. B Coy was tasked to provide the COEFOR for the British Army Training Unit Kenya (BATUK) at very short notice. The SI investigated this decision in detail to see whether it had any impact on the death of Rfn Evans.

1.4.68 **What was the tasking?** The original task was to provide two platoons to bolster the Grenadier Guards when they deployed to BATUK to undertake their CT 3[34] training exercise.

1.4.69 **Tasking Chain**. Under A2020, Adaptable Force (AF) units (in this case the Grenadier Guards) are not fully manned during peacetime and rely upon the Army reserve to make up the shortfall in time of need, i.e. Operations. However AF units are still required to undertake CT 3 level training during peacetime and as such need to bolster their manpower in order to achieve it. The Grenadier Guards higher HQ, London District (LONDIST) was warned of this and other manpower requirements (including provision of the COEFOR) in Aug 14. In Apr 15 LONDIST notified Army HQ that they were unable to meet the requirements. Army HQ in turn looked for solutions, not only for bolstering the Grenadier Guards but also the provision of the COEFOR for BATUK. **Exhibit 78** **Exhibit 82** **Exhibit 79** **Exhibit 81**

1.4.70 **How feasible was this tasking?** Army HQ consulted both 1 and 3 (UK) Div. 3 (UK) Div passed it down to 20 Armd Inf Bde who narrowed down the trawl to 5 RIFLES, who in turn narrowed it down to B Coy; however B Coy could not take on the task of providing two platoons and still achieve CT 1 status as mandated by 20 Armd **Exhibit 8**

[34] Platoon size sub-units working together to deliver an operationally effective Coy size sub-unit.

Inf Bde.

1.4.71 **Solution to the conflicting priorities**. 5 RIFLES suggested that they could provide a whole Coy to fill the COEFOR requirement if they could exercise to CT1 in the margins of the main exercise. This option also served to protect the cohesion of B Coy. Both the BATUK staff and Army HQ were happy with this offer. **Soldier AA** **Exhibit 81**

1.4.72 **Results of this tasking**. On 13 May 15 B Coy was formally committed to deploying to BATUK beginning 24 Jun 15. This gave them five weeks, during which they were to meet the deployment requirements including, as they thought they had to, the completion of all MATTs and beginning a course of anti-malarials. **Exhibit 81**

Conclusion. A2020 FORM cycle is designed to deliver operationally effective units through a progressive cycle of training. Tasking a Coy at the very beginning of the training cycle to deploy overseas with 5 weeks' notice, having achieved all start state requirements, runs counter to this policy.

Conclusion to the tasking of 5 RIFLES. The Coy was tasked at short notice for a standing task, which should have been scheduled and allocated earlier. This had no bearing on Rfn Evans' death. Nonetheless, such short notice trawls requiring a rapid build-up of fitness concurrently with courses of medication and issue of approved environmental clothing and equipment may present risk in the future and therefore the SI considers it to be **an Other Factor**.

1.4.73 **Recommendation. The SI recommends that ADOC should establish a process by which the implications of deploying overseas a unit outwith its readiness state are assessed and the accompanying risk registered at the appropriate level.**

Training

1.4.74 **B Coy PD Training Programme**. B Coy, in accordance with 5 RIFLES policy, conducted PT sessions on a Mon, Tues, Thu and Fri each week between Christmas and Easter leave. The emphasis was mainly on circuits and non-booted runs in order to prepare for the Personal Fitness Assessment[35] (PFA). From interviews the SI has learnt that the PFA had priority with very little training in boots carrying weight. Nonetheless on 6 Mar 15 thirty one members of B Coy (including Rfn Evans) conducted an AFT which thirty of them (including Rfn Evans) passed. The SI has determined that the most likely rationale for completing this AFT was to ensure the highest percentage of AFT passes before the end of the MATTs reporting period[36], which was 31 Mar 15. **Exhibit 83** **Exhibit 11** **Soldier G** **PTI 1** **Soldier B** **Soldier E** **Soldier Z**

1.4.75 **Changes to the B Coy Training Programme**. When it received the BATUK tasking, the Coy had an extant training programme which contained little TABing, Battle-PT or weighted and booted runs. Clearly the Coy now had a shift in objective with regards to its entire programme including the PD element. This shift was required to meet the BATUK start states and the direction provided in JSP 539 with regards to pre-deployment training. One soldier detected a slight shift in the training programme, whilst others detected no change at all. The AFT protocol requires a structured and progressive training programme to build up to the AFT. Examination of the training programme shows 2 booted runs in the 5 weeks prior to the AFT. It **Exhibit 12** **Exhibit 46** **Soldier J** **PTI 1** **Soldier E**

[35] Personal Fitness Assessment comprises a run (not in boots), sit ups and press-ups.
[36] Number of passes is a performance indicator used by superior HQs to determine the operational effectiveness of a unit.

should be noted that moving up and down rifle ranges with kit would contribute to soldiers' overall ability to operate in boots with weight, so the 2 runs should not be taken in isolation; however members of B Coy were relatively clear there was no progression. The SI detected a culture within certain areas of 5 RIFLES that an AFT should be achievable by all with no notice or preparation, which is neither realistic nor in line with Army policy. B Coy was at a mixed standard of fitness and the PD program was not sufficiently structured to establish a baseline level for all the Coy, from which to move forward. The SI's view was that the nature and quantity of the training was well within accepted norms for infantry soldiers and was not likely to lead to fatigue within members of B Coy. **Soldier G** **Exhibit 19** **Exhibit 42** **Soldier F** **PTI 1** **Soldier B**

1.4.76 **Decision to Conduct the AFT**. The decision to mount the AFT was (or should have been) influenced by several factors.

a. **White Book Requirements**. All units deploying to Kenya receive the BATUK White Book. This gives a range of advice on training in Kenya and specifies the requirements to be met by all exercising troops deploying to BATUK. One start state requirement is that they have completed MATTs 1-7 in the previous 6 months. This includes the AFT. The SI noted that the White Book is an amalgam of multiple documents, is poorly indexed and that the start state requirements listed within were the same for all personnel deploying to BATUK regardless of role. **Exhibit 12**

b. **Currency of B Coy Personnel**. The unit was unaware of the policy change detailed in 2015DIN07-081, which was that from 1 Apr 15 MATTs currency was to be recorded on a rolling basis. The unit was still working on the principle that MATTs went out of date at midnight 31 Mar each year. As such it appears they believed that personnel were out of date for all MATTs. There is potential to infer a conflict between the White Book Requirement (that personnel have completed their MATTs in the last six months) and the older annual currency. There is no evidence of the Coy or Bn having sought clarification on this issue. **Exhibit 84** **PTI 1** **Soldier V**

c. **Post-tour currency**. Personnel returning from tour are considered current for their MATTs for 6 months after their return, however this would not negate the requirement in the White Book to complete the test within 6 months of deploying to BATUK. **Exhibit 84**

d. **Start State Waiver**. The Bn were not aware of the contents of an email from HQ 3(UK) Div to HQ 20 Armd Inf Bde, which stated "Please note that it is understood that complete BATUK start states may not be achieved in time for the Ex. We are to meet start states as best we can, but note what we will not achieve." The Bn 2IC has no recollection of seeing the email and can find no record of it in his email account and soldiers within the Coy were convinced they had to pass the AFT in order to deploy. **Exhibit 85** **Exhibit 86** **PTI 1**

Conclusion. The requirement to conduct the AFT was misunderstood by 5 RIFLES. **Soldier AA**

1.4.77 **Who needed to complete the AFT?** As outlined above, the unit was under the impression all soldiers deploying to Kenya needed to pass the test as their currency was out of date after 31 Mar 15. In fact at least 15 ranks of B Coy who attempted the AFT on 18 Jun 15 (including Rfn Evans) were in date by virtue of having completed an AFT on the 6 Mar 15. The SI identified a number of reasons why the chain of command might still require them to attempt the AFT, with unit **PTI 1** **Soldier V**

