

Ref: FOI2018/08466 ArmySec/07/02/80636

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31 July 2018

Dear

Thank you for your email of 26 June in which you requested the following information:

I would like to know statistically, how many fatalities are caused during training or on operations as a result of an undiagnosed or diagnosed Bicuspid Aortic Valve (BAV) heart malformation?

I am treating your correspondence as a request for information under the Freedom of Information Act (FOIA) 2000. A search for the information has now been completed within the Ministry of Defence, and I can confirm that since 1984 to present day, there have been no deaths (on training, operations, or indeed neither) recorded with this condition.

Under section 16 (advice and assistance) it might help if I explain how these statistics are recorded. Defence Statistics Health compiles the Department's authoritative deaths database for all UK Armed Forces personnel who died whilst in Service going back to 1984. Information is compiled from several internal and external sources from which we release a number of internal analyses and external National Statistics Notices.

Defence Statistics receive weekly notifications of all Regular Armed Forces deaths from the Joint Casualty and Compassionate Cell (formerly the single Service casualty cells). Defence Statistics also receive cause of death information from military medical sources in the single Services. At the end of each calendar year, Defence Statistics cross-reference the medical information it holds against publicly available death certificate information available from NHS Digital and The General Registrar's Office Scotland.

Defence Statistics regularly check all deaths for information on coroner's verdicts (England & Wales) and the results of investigations by the Procurator Fiscal for Scotland where possible. For Northern Ireland, Defence Statistics liaise with the Northern Ireland Statistics and Research Agency (NISRA) who handle the official information on behalf of the Northern Ireland Office.

Considerable validation is undertaken against military and public records to ensure that the information provided is complete and accurate. However, some causes of death require a Coroner's report before the cause of death can be formally classified and there is often a time lag between when the death occurred and when the Coroner's inquest takes place. This can result in final cause of death information not being timely and complete for recent years and can lead to revisions in the cause of death categories when these verdicts are returned.

If you have any queries regarding the content of this letter, please contact this office in the first instance. Following this, if you wish to complain about the handling of your request, or the content

of this response, you can request an independent internal review by contacting the Information Rights Compliance team, Ground Floor, MOD Main Building, Whitehall, SW1A 2HB (e-mail <u>CIO-FOI-IR@mod.uk</u>). Please note that any request for an internal review should be made within 40 working days of the date of this response.

If you remain dissatisfied following an internal review, you may raise your complaint directly to the Information Commissioner under the provisions of Section 50 of the Freedom of Information Act. Please note that the Information Commissioner will not normally investigate your case until the MOD internal review process has been completed. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF. Further details of the role and powers of the Information Commissioner can be found on the Commissioner's website at https://ico.org.uk/.

Yours sincerely,

