Defence
Safety
Authority

Service Inquiry

Road Traffic Accident

Al Asad Air Base, Iraq

31 January 2018

Defence Safety Authority

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PART 1.1

Covering Note and Glossary

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PART 1.1 – COVERING NOTE

DSA/SI/01/18/3SCOTS

26 Mar 19

DG DSA

SERVICE INQUIRY INVESTIGATION INTO THE FATALITY THAT OCCURRED IN AL ASAD AIR BASE, AL ANBAR PROVINCE, IRAQ ON 31 JANUARY 2018.

1. The Service Inquiry Panel formally convened at Ministry of Defence Main Building, Whitehall, London at 1500hr on Monday 26 February 2018 by order of the DG DSA for the purpose of investigating an accident involving Captain Dean Sprouting of The Black Watch, 3rd Battalion The Royal Regiment of Scotland on 31 Jan 18 and to make recommendations in order to prevent reoccurrence. The Panel has concluded its inquiries and submits the finalised report for the Convening Authority's consideration.

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]

[redacted]
Wing Commander Royal Air Force
President
3SCOTS AAAB SI

MEMBERS

[Signature]

[redacted]
Lieutenant Commander Royal Navy
Royal Navy Member
3SCOTS AAAB SI

[Signature]

[redacted]
Warrant Officer Class 2
Army Member
3SCOTS AAAB SI

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PART 1.1 – GLOSSARY

Serial (a)	Acronym / Abbreviation (b)	Definition (c)
1	1 (UK) Div	1 (United Kingdom) Division
2	2IC	Second in Command
3	2 RIFLES	2nd Battalion, The Rifles
4	2 SCOTS	Royal Highland Fusiliers, 2nd Battalion The Royal Regiment of Scotland
5	3 SCOTS	The Black Watch, 3rd Battalion The Royal Regiment of Scotland
6	51 Inf Bde	51 Infantry Brigade
7	AAAB	Al Asad Air Base
8	Adjt	Adjutant
9	AED	Automatic Electronic Defibrillator
10	AES	Armoured Engineer Squadron
11	AFT	Annual Fitness Test
12	AGC	Adjutant General's Corps
13	AO	Assignment Order
14	ALARP	As Low As Reasonably Practicable
15	ARB	All Ranks Brief
16	ASB	Aviation Support Battalion
17	BAS	Base Aid Station
18	Bde	Brigade
19	BDOC	Base Defence Operations Centre
20	BHQ	Battalion Headquarters
21	BME JMI	Broader Middle East Joint Mounting Instructions
22	Bn	Battalion
23	BOS-I	Base Operating Systems - Integration
24	BPC	Building Partner Capacity
25	CAB	Combat Aviation Brigade
26	Capt	Captain
27	CESO	Chief Environmental and Safety Officer
28	CID	Criminal Investigation Department
29	CJO	Chief Joint Operations
30	CJTF	Combined Joint Task Force
31	CJTF-OIR	Combined Joint Task Force-Operation Inherent Resolve
32	CO	Commanding Officer
33	CoC	Chain of Command
34	COMBRITFOR(L)	Commander British Forces (Land)
35	Coy	Company
36	Cpl	Corporal
37	CPR	Cardio Pulmonary Resuscitation
38	CQC	Care Quality Commission
39	CSM	Coy Sergeant Major
40	DAIB	Defence Accident Investigation Branch
41	DANPOL	Danish Military Police
42	Det Comd	Detachment Commander
43	DBS	Defence Business Services
44	DDH	Delivery Duty Holder
45	DFAC	Dining Facility
46	DH	Duty Holding
47	DoC	Duty of Care
48	ERM	Equipment Registration Mark (Military Vehicle Registration Number)
49	FD	Fire Department
50	FF	Firefighter
51	FGenO	Force Generation Order

Serial (a)	Acronym / Abbreviation (b)	Definition (c)
52	FHPI	Force Health Protection Instructions
53	FLT	Forklift Truck
54	FRAGO	Fragmentary Order
55	Fwd	Forward
56	HOTO	Hand Over / Take Over
57	HQ Coy	Head Quarter Company
58	IA	Individual Augmentee
59	JOA	Joint Operational Area
60	JPA	Joint Personnel Administration
61	JFC	Joint Force Command
62	KBR	Kellogg, Brown and Root
63	LCpl	Lance Corporal
64	Lt	Lieutenant
65	Lt Col	Lieutenant Colonel
66	Maj	Major
67	OC	Officer Commanding
68	ODH	Operating Duty Holder
69	ODR	Operational Deployment Record
70	OM	Occupational Medicine
71	OPCON	Operational Control
72	Ops Offr	Operations Officer
73	OSAT	Operational Safety Action Tracker
74	OSMS	Operational Safety Management System
75	OST	Operational Safety Team
76	MATTs	Military Annual Training Tests
77	MCF	Military Construction Force
78	MES	Medical Employment Standard
79	MFD	Medically Fully Deployable
80	MLD	Medically Limited Deployable
81	MLD(P)	MLD (Permanent)
82	MLD(T)	MLD (Temporary)
83	MO	Medical Officer
84	MOD	Ministry of Defence
85	MRA	Medical Risk Assessment
86	MRX	Mission Rehearsal Exercise
87	MTMC	Mission Training and Mobilisation Centre
88	MTV	Medium Tactical Vehicle
89	PAP	PULHHEEMS Administrative Pamphlet
90	PAPMIS	PULHHEEMS Administrative Pamphlet Management Information System
91	PFA	Physical Fitness Assessment
92	PJHQ	Permanent Joint Headquarters
93	PPE	Personal Protective Equipment
94	PT	Physical Training
95	RAC	Readinesss Administration Check
96	RAO	Regimental Administration Officer
97	RiP	Relief-in-Place
98	ROG	Rear Operations Group
99	ROHT	Regional Occupational Health Team
100	RMB	Risk Management Board
101	RMP	Royal Military Police
102	RSOI	Reception, Staging, Onward Movement and Integration
103	RTA	Road Traffic Accident
104	RtL	Risk to Life
105	SSA	Supply Support Activity
106	SECFOR	Security Force

Serial (a)	Acronym / Abbreviation (b)	Definition (c)
107	Sgt	Sergeant
108	SSgt	Staff Sergeant
109	SI	Service Inquiry
110	SIB	Special Investigation Branch
111	SOP	Standard Operating Procedure
112	SPS	Staff and Personnel Support
113	STANTA	Stanford Training Area
114	TACON	Tactical Control
115	TES	Theatre Entry Standards
116	ToA	Transfer of Authority
117	TOR	Terms of Reference
118	UHC	Unit Health Committee
119	UKTT(W)	United Kingdom Training Teams (West)
120	US	United States
121	USAF	United States Air Force
122	USAF SF	United States Air Force Security Forces
123	VWO	Visiting Warrant Officer
124	WO1	Warrant Officer First Class
125	WO2	Warrant Officer Second Class

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PART 1.2

Convening Order and Terms of Reference

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Defence Safety Authority

Service Inquiry Convening Order

26 Feb 18

SI President
SI Members

Hd Defence AIB
DSA Legad

Copy to:

PS/SofS
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PS/Min(DPV)
PS/Min(DP)
PS/Perm Sec
DPSO/CDS
MA/VCDS

Sec/1SLCNS
MA/CGS
PSO/CAS
PSO/Comd JFC
MA/DCGS
MA/CFA
MA/CJO

ADC/GOC 1(UK) Div
CO 3 SCOTS
Colonel AGC
DSA DLSR TL
DDC Director

DSA DG/SI/01/18 – CONVENING ORDER FOR THE SERVICE INQUIRY INTO THE FATALITY THAT OCCURRED IN AL ASAD AIR BASE, AL ANBAR PROVINCE, IRAQ ON 31 JANUARY 2018.

1. In accordance with Section 343 of Armed Forces Act 2006 and in accordance with JSP 832 – Guide to Service Inquiries (Issue 1.0 Oct 08), the Director General, Defence Safety Authority (DG DSA) has elected to convene a Service Inquiry (SI).

2. The purpose of this SI is to investigate the circumstances surrounding the incident and to make recommendations in order to prevent recurrence.

3. The SI Panel will formally convene at Ministry of Defence Main Building, Whitehall, London at 1500L on Monday 26 February 2018.

4. The SI Panel comprises:

President:	**Wing Commander** [redacted] **RAF**
Members:	**Lieutenant Commander** [redacted] **RN**
	Warrant Officer Class 2 [redacted] **(2 RIFLES)**

5. The legal advisor to the SI is **Wing Commander** [redacted] (DSA HQ LEGAD) and technical investigation/inquiry support is to be provided by the Defence Accident Investigation Branch (Defence AIB).

6. The SI is to investigate and report on the facts relating to the matters specified in its Terms of Reference (TOR) and otherwise to comply with those TOR (at Annex). It is to record all evidence and express opinions as directed in the TOR.

7. Attendance at the SI by advisors/observers is limited to the following:

Head Defence AIB – Unrestricted Attendance.

Defence AIB investigators in their capacity as advisors to the SI Panel – Unrestricted Attendance.

8. The SI Panel will work initially from the DAIB facilities at Farnborough. Permanent working accommodation, equipment and assistance suitable for the nature and duration of the SI will be requested by the SI President in due course.

9. Reasonable costs will be borne by DG DSA under UIN D0456A.

Original Signed

R F P Felton CBE
Lt Gen
DG DSA – Convening Authority

Annex:

A. Terms of Reference for the Service Inquiry into the fatality that occurred in Al Asad Air Base, Al Anbar Province, Iraq on 31 January 2018.

Annex A To
DSA DG/SI/01/18 Convening Order
Dated 26 Feb 18

TERMS OF REFERENCE FOR THE SERVICE INQUIRY INTO THE FATALITY THAT OCCURRED IN AL ASAD AIR BASE, AL ANBAR PROVINCE, IRAQ ON 31 JANUARY 2018.

1. As the nominated Inquiry Panel for the subject SI, you are to:

a. Investigate and, if possible, determine the cause of the occurrence, together with any contributory, aggravating and other factors and observations.

b. Examine the Command and Control on the base with particular emphasis on Duty of Care for civilians and military personnel from all participating Nations and identify which parties are responsible for ensuring that the Duty of Care is maintained on the base for civilians and military personnel. Assess any Health and Safety at Work and Environmental Protection implications in line with JSP 375.

c. Review the levels and extent of authority and supervision covering the incident. Examine the Duty Holder construct and how it was implemented in the base for UK Nationals by the relevant Duty Holders. Examine the governance and assurance for each activity to include examining if safety risks associated with the activity were properly identified and controlled in accordance with the Secretary of State's Statement on Health and Safety (H&S) for UK Forces and DSA 01.1 & DSA 01.2. The equivalent H&S procedures for other participating nations should be examined to assess coherence.

d. Examine the procedures, orders and instructions from all participating Nations that were applicable to the incident and whether they were complied with. Particular focus should be given to orders and instructions relating to Physical Training within the base and the operation and use of the type of vehicles involved in the incident.

e. Ascertain whether the personnel involved were acting in the course of their duties.

f. Establish the level of training, relevant competencies, qualifications and currency of the individuals involved in the activity.

g. Investigate and comment on any Human Factors that may have played a part in this incident.

h. Determine the status of any relevant equipment including serviceability status, defects or deficiencies.

i. Ascertain whether there were any ongoing medical issues which are of relevance to the incident.

j. Review whether the post incident actions, including immediate medical attention and ongoing care, were appropriate, adequate and carried out correctly.

k. Determine and comment on any broader organisational and/or resource factors.

l. Report and make appropriate recommendations to DG DSA.

2. You are to ensure that any material provided to the Inquiry by the United States, or any other foreign state, is properly identified as such, and is marked and handled in accordance with MOD security

guidance. This material continues to belong to those nations throughout the SI process. Before the SI report is released to any third party, authorisation should be sought from the relevant authorities in those nations to release, whether in full or redacted form, any of their material included in the SI report, or amongst the documents supporting it. You are not to make a judgement on the origin of any classified material. The relevant NATO European Policy or International Policy and Plans team should be informed early when dealing with any foreign state material. You should remain aware throughout the SI that other authorities will be conducting their own investigations, for example Service Police Investigations. Should any authority approach you seeking to use evidence obtained by the Service Inquiry you must consult with your DSA Legal Advisor for advice on the matter.

3. The Terms of Reference above have been designed to be wide ranging in order to ensure that you have the freedom to investigate wherever the evidence leads. During the course of your investigations, should you identify a potential conflict of interest between the CA and the Inquiry, you are to pause work and take advice from your DSA Legal Advisor and DG DSA.

4. If at any stage the Panel discover something they perceive to be a continuing hazard presenting a risk to the safety of personnel or equipment, the President should alert DG DSA without delay; in order to initiate remedial actions immediately. Consideration should also be given to raising an Urgent Safety Advice note.

5. Very particular care will be necessary regarding the classification and handling of the evidence and reporting for this SI.

PART 1.3

Narrative of Events

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PART 1.3 – NARRATIVE OF EVENTS

All times GMT + 3

Synopsis

1.3.1. On 31 Jan 18, at approximately 1528hr, a British Army Officer, Captain (Capt) Dean Sprouting, who was deployed on Operation (Op) SHADER in Iraq was run over by a US Forces' Fork Lift Truck (FLT) carrying a shipping container, which was under escort by a US up-armoured Medium Tactical Vehicle (MTV). He was transported to the Base Aid Station (BAS) and pronounced dead at 1558hr. No other personnel were injured in the accident. Exhibit 1

Background

1.3.2. **Op SHADER.** Op SHADER is the UK's contribution to the overarching Operation INHERENT RESOLVE, the Combined Joint Task Force operation to defeat Da'esh in Iraq and Syria and to set the conditions that will increase regional stability. UK personnel are deployed in several different roles in a variety of locations, one of these being Al Asad Airbase. Exhibits 2-3

1.3.3. **Al Asad Airbase (AAAB).** Based in the Anbar Province of Iraq (Figure 1.3.1), AAAB is an Iraqi Security Forces' airbase. It houses the 2nd Anbar Brigade and elements of the Iraqi Air Force. Coalition forces are stationed at Camp Havoc, within the base. The coalition camp is controlled by the Base Operating Systems - Integration (BOS-I) Headquarters, which has responsibility for camp operations and security and is commanded by a US Army OF5[1]. UK personnel have been operating from AAAB as part of Op SHADER since Aug 16. Exhibits 1, 4

Figure 1.3.1 – Location of AAAB.

[1] Colonel.

1.3.4. **248th Aviation Support Battalion (ASB) of the 449th Combat Aviation Brigade (CAB).** 248th ASB was a United States Army National Guard unit based in AAAB. The unit was responsible for the logistics of its parent unit, the 449th CAB.	Exhibit 1
1.3.5. **Kellogg, Brown & Root (KBR).** KBR is a civilian contractor which, in 2018, provided logistical support to AAAB. Support included facilities management and construction, food services, fuel and other services needed to support the day-to-day operations of the base.	Exhibit 5
1.3.6. **United Kingdom Training Team (West) (UKTT(W)).** As part of Op SHADER, UKTT(W) was the UK commitment within AAAB. Its responsibilities included building partner capacity, security and engineering support.	Exhibits 1, 4
1.3.7. **The Black Watch, 3rd Battalion, the Royal Regiment of Scotland (3 SCOTS).** 3 SCOTS is a light infantry battalion based in Fort George, near Inverness. It was tasked to provide the UKTT(W) in AAAB from 9 Jan to Jul 18.	Exhibit 1
Individuals involved	
1.3.8. **Captain Sprouting.** Capt Dean Sprouting joined the Army in 1989 and initially joined the Royal Green Jackets before transferring to the Adjutant General's Corps (AGC), Staff and Personnel Support (SPS) Branch in 1991. On commissioning, in late 2017, Capt Sprouting joined the Regimental Administration Office of 3 SCOTS from Headquarters 51st Infantry Brigade (51 Inf Bde), where he had previously served for over 2 years as the Visiting Warrant Officer (VWO)[2].	Exhibits 1, 6
1.3.9. **Soldier A.** Soldier A was a British Army captain assigned to 3 SCOTS. He had arrived at AAAB on 30 Dec 17. He is the last known British Serviceman to have seen Capt Sprouting alive and he also positively identified Capt Sprouting following the accident.	Witness 1
1.3.10. **Soldier B.** Soldier B was a warrant officer assigned to 3 SCOTS. He had arrived at AAAB on 30 Dec 17. Along with Soldier A, Soldier B positively identified Capt Sprouting following the accident.	Witness 2
1.3.11. **Commanding Officer (CO).** A lieutenant colonel in the British Army, the CO had been in this position at 3 SCOTS for 15 months at the time of the accident. He arrived at AAAB on 5 Jan 18, the same day as Capt Sprouting. He was the senior British representative at AAAB and was Deputy Commander Security.	Witness 3
1.3.12. **Officer Commanding Headquarters Company (OC HQ Coy).** A late entry major in the British Army, OC HQ Coy had held this position since Apr 17, and was responsible for the preparation of deploying personnel from 3 SCOTS HQ Coy. He did not deploy on Op SHADER.	Witness 4
1.3.13. **Operations Officer (Ops Offr).** A British Army captain, the Ops Offr had been assigned to 3 SCOTS since 2013. He was involved in planning and coordinating the training of 3 SCOTS personnel during the force generation period for Op SHADER. He arrived at AAAB on 5 Jan 18, the same day as Capt Sprouting.	Witness 5
1.3.14. **US Driver A.** A staff sergeant assigned to 248th ASB, US Driver A was driving the escort vehicle at the time of the accident.	Exhibit 1 Witness 6
1.3.15. **US Driver B.** A sergeant within 248th ASB, US Driver B was driving the FLT at the time of the accident.	Exhibit 1 Witness 7

[2] 51 Inf Bde VWO is considered a subject matter expert on all personnel administration issues and provides advice and assurance to all units under 51 Inf Bde, including 3 SCOTS.

1.3.16. **Dutch Medic A.** Dutch Medic A was a lieutenant in the Dutch Army and a Registered Intensive Care Unit and Emergency Room Nurse. He had been deployed in the AAAB BAS since 3 Jan 18. Dutch Medic A provided First Aid to Capt Sprouting following the accident. — Witness 8

1.3.17. **Dutch Medic B.** Dutch Medic B was a first lieutenant in the Dutch Army and a Nurse Anaesthetist within the Dutch Medical Services, deployed in the AAAB BAS since early Jan 18. He provided First Aid to Capt Sprouting following the accident. — Witness 9

1.3.18. **US Firefighter.** US Firefighter was a US civilian firefighter employed by KBR at AAAB, who provided First Aid to Capt Sprouting following the accident. — Witness 10

1.3.19. **Medical Officer A (MO A).** MO A was a British Army medical officer assigned to 3 SCOTS, who arrived at AAAB on 11 Jan 18. He provided medical care to Capt Sprouting during his time at AAAB and prior to his deployment. — Witness 11

1.3.20. **Medical Officer B (MO B).** MO B was a British Army medical officer who was employed within the BAS at AAAB. He declared the death of Capt Sprouting following the accident. — Witness 12

Pre-deployment movements and preparation

1.3.21. On 24 Jul 17, Capt Sprouting's Assignment Order (AO) to join 3 SCOTS as the AGC (SPS) Detachment Commander (Det Comd) was issued, a position that he had volunteered for. He was subsequently informed that he would be proceeding on the Operational Tour to Iraq with 3 SCOTS to AAAB in Jan 18. — Exhibits 1, 7-9 Witnesses 5, 13-14

1.3.22. On commissioning, Capt Sprouting was required to complete the AGC (SPS) Det Comds' course at the Defence School of Personnel Administration at Worthy Down, over the period 11 Sep - 24 Nov 17. To assume the rank of captain, he was taken on strength[3] of 3 SCOTS with effect from 11 Sep 17. — Exhibits 1, 10 Witnesses 14-15

1.3.23. Capt Sprouting was unable to complete the Op SHADER All Ranks Brief (ARB)[4] with 3 SCOTS due to a clash with his AGC (SPS) Det Comds' Course. Instead, he attended the brief with The Royal Highland Fusiliers, 2nd Battalion, The Royal Regiment of Scotland (2 SCOTS)[5] in Lydd, over the period 4 - 9 Sep 17. — Exhibit 1 Witness 15

1.3.24. Capt Sprouting was released for 3 days from his AGC (SPS) Det Comds' Course to attend part of the 3 SCOTS Mission Rehearsal Exercise (MRX) at Stanford Training Area (STANTA) so that he could complete elements of his Military Annual Training Tests (MATTs) and Live Fire requirements with the deploying element from 3 SCOTS. Most of his individual training was completed in a 72-hour window from 17 - 20 Nov 17. However, he did not complete MATT 2 (fitness tests), MATT 8 (Survive, Evade, Resist, Extract presentation) and MATT 9 (Counter Improvised Explosive Device practical training)[6]. — Exhibit 1 Witnesses 1, 3, 5 14, 16

1.3.25. On completion of the AGC (SPS) Det Comds' Course, Capt Sprouting reported to Fort George, Inverness on 29 Nov 17. He used his time at Fort George to start the 3 SCOTS induction process and to prepare for deployment to AAAB. He underwent a medical check on 1 Dec 17 with MO A, where his Medical Employment Standard (MES) was assessed as Medically Limited Deployable (Permanent) (MLD(P)) and was issued — Exhibits 1, 11 Witnesses 11, 15

[3] Assigned to the Det Comd position within 3 SCOTS.
[4] A mandatory requirement for all personnel deploying on Op SHADER.
[5] Who were force generating to assume responsibility for UKTT(Central).
[6] As per Op SHADER Mission Specific Training Directive Version 5 dated 20 Oct 17.

with a PULHHEEMS[7] Administrative Pamphlet (PAP) Appendix (App) 9[8] for a long-term [redacted].

1.3.26. Originally expecting to proceed on pre-deployment leave from 8 Dec 17 - 2 Jan 18, Capt Sprouting reported to the Fort George Medical Facility on 5 Dec 17, presenting with symptoms associated with [redacted]. He was medically stood down for 3 days, leading into the start of his Christmas leave period. He returned to his home address on 5 Dec 17, following his appointment at the Fort George Medical Facility. Exhibit 11 Witnesses 4, 15

1.3.27. On 16 Dec 17, Capt Sprouting reported to his local NHS Medical Facility with [redacted]. He was diagnosed with [redacted], commonly known as an [redacted], which had led to a [redacted]. He was prescribed medication to help manage the pain. Exhibits 13-15

1.3.28. All personnel deploying to AAAB were expected to return to Fort George for first parade on 2 Jan 18. After it was recognised that Capt Sprouting had not reported, a clerk from 3 SCOTS contacted him at home to ascertain why he had not reported for duty at Fort George to conduct his pre-deployment Readiness Administrative Check (RAC). Capt Sprouting declared his confusion, stating that he believed that he was not due to deploy until 9 Jan 18. On completion of the phone call Capt Sprouting travelled to Fort George to complete the RAC, then returned to his home address to pack the remainder of his kit. Witnesses 3, 5, 11, 15-17

1.3.29. On 3 Jan 18, Capt Sprouting was driven to Prestwick Airport by his wife where he met with the remainder of the personnel flying on the first main body flight. He arrived in Iraq on 5 Jan 18. Exhibit 16 Witnesses 3, 16

Pre-deployment timeline

1.3.30. The table below summarises the timeline of Capt Sprouting's pre-deployment movements and activities:

Date (a)	Event (b)
24 Jul 17	AO raised notifying Capt Sprouting of his assignment to 3 SCOTS.
4-9 Sep 17	Op SHADER ARB with 2 SCOTS in Lydd.
11 Sep 17	Formally assigned to 3 SCOTS and promoted to captain. Started Det Comds' Course at Worthy Down.
17-20 Nov 17	Attended MRX with 3 SCOTS at STANTA. Completed all elements of mandated training except MATTs 2, 8 and 9.
29 Nov 17	Reported to 3 SCOTS at Fort George, Inverness.
1 Dec 17	Attended appointment with MO A at Fort George Medical Facility. Assessed as MLD(P) and issued App 9.
5 Dec 17	Attended Fort George Medical Facility. Diagnosed with [redacted], and medically stood down until 8 Dec 17.
8 Dec 17	Started Christmas leave.
16 Dec 17	Attended local NHS medical facility and was diagnosed with [redacted] and [redacted].

[7] The PULHHEEMS system of medical classification is a Tri-Service system, described in JSP 950.
[8] Form for Notifying Medical / Functional Restrictions to Unit.

Date (a)	Event (b)
2 Jan 18	Recalled to Fort George.
3 Jan 18	Reported to Prestwick Airport and flew to Cyprus.
5 Jan 18	Arrived in AAAB.

Table 1.3.1

Capt Sprouting's responsibilities and movements prior to the accident

1.3.31. Capt Sprouting's operational role was the UKTT(W) J1 Det Comd. The J1 Cell was responsible for administration and personnel issues. It was manned by Capt Sprouting and one AGC (SPS) Lance Corporal (LCpl). The J1 Cell was not routinely required to leave AAAB. Exhibit 1 Witness 3

1.3.32. On 5 Jan 18, Capt Sprouting attended the AAAB Medical Facility to report that he had been diagnosed with a [redacted] whilst on leave and was experiencing hearing difficulties. He was declared 'fit for limited duties' by the medical officer of 2nd Battalion, The Rifles (2 RIFLES), which was the outgoing battalion being replaced by 3 SCOTS. Later that day he conducted Reception, Staging and Onwards Integration (RSOI) briefings at AAAB. It was during these briefings that he was informed about base administration and safety. Exhibits 11, 17 Witnesses 5, 11

1.3.33. On 14 Jan 18, Capt Sprouting again attended the AAAB Medical Facility to discuss his ongoing hearing difficulties. MO A noted [redacted]. He instructed Capt Sprouting that he would continue to be reviewed, and that he was fit for duties within his current MES of MLD(P). Exhibit 11 Witness 11

1.3.34. On 27 Jan 18, Capt Sprouting attended the AAAB Medical Facility for a further review of his ongoing hearing difficulties. Capt Sprouting stated that his hearing appeared to be improving but that he still felt [redacted]. MO A observed a [redacted] appeared to have settled. Capt Sprouting was declared fit for duties within his current MES. Exhibit 11 Witness 11

1.3.35. On the morning of 31 Jan 18, Capt Sprouting attended the AAAB Medical Facility [redacted] associated with his MES. Later that day Capt Sprouting went to lunch with his clerk and then returned to the J1 office. At approximately 1400hr, he stated to his clerk that he was going out for a run, which had been his routine since arriving in theatre. Exhibit 11 Witnesses 11, 16

1.3.36. At approximately 1425hr, Soldier A met Capt Sprouting at the TRIPOLI accommodation area. Capt Sprouting informed Soldier A that he was going for a run. Soldier A reminded Capt Sprouting to wear his identification (ID) discs[9] before they went their separate ways. Exhibit 1 Witness 1

US Drivers' movements prior to the accident

1.3.37. In the early afternoon of 31 Jan 18, in a compound known as the Supply Support Activity (SSA) area, US Driver A approached US Driver B to request that he assist in the movement of a small Shipping Container to Voodoo Ramp (Figure 1.3.2). The total distance of this move was approximately 3km. Exhibit 1 Witnesses 6, 18-20

[9] Personnel are briefed during RSOI briefs that they are to wear ID discs around their necks at all times.

Figure 1.3.2 – Planned route of convoy.

1.3.38. The US Drivers decided to conduct this move with a FLT[10] (Figure 1.3.3), driven by US Driver B, to carry the container. They set off at approximately 1445hr. During the move, the container was lifted approximately 3-5 feet from the ground. Neither vehicle carried any additional passengers.

Exhibit 1
Witnesses 6, 18, 21

Figure 1.3.3 – Side view of FLT with forks resting on ground.

1.3.39. The FLT was escorted by a MTV[11] truck (Figure 1.3.4), driven by US Driver A.

Witnesses 6, 21

[10] Skytrack Model 6K TPE862
[11] The MTV was a M1083A1P2 model which has a 14-foot cargo bay and can carry a 5 US Ton payload. While technically capable of carrying cargo, the model involved in the accident was fitted with seats similar to the UK Enhanced Seating System (ESS).

Figure 1.3.4 – MTV used as escort vehicle.

1.3.40. Based on information provided to the Danish Military Police (DANPOL)[12] and US CID after the accident, during the move the MTV drove approximately 50 feet ahead of the FLT at a speed of approximately 7mph. At various points during the move there was a requirement for US Driver A in the MTV to manoeuvre around people or obstructions on the road, which US Driver B would mimic in the FLT. Witnesses 6, 18, 21

Meteorology

1.3.41. The weather conditions on 31 Jan 18 were dry; visibility was good. The sun was shining from the South West and there was a light South Easterly wind. Exhibits 1, 18-19 Witnesses 9, 21

Accident events

1.3.42. At approximately 1528hr, whilst proceeding on Tower Road immediately south of the TRIPOLI accommodation area (Figure 1.3.5), US Driver B observed something pass under the container and he felt a bump under the FLT. He stopped, exited the vehicle and checked to see what it was. He found Capt Sprouting lying motionless on the road. He checked for a pulse but was unable to detect one. US Driver A, who was approximately 70m ahead of the FLT and about to turn left onto VOODOO Ramp, noticed that the FLT had stopped. He saw US Driver B exit and walk behind the FLT. US Driver A turned the MTV and approached to see what was going on and noticed US Driver B crouching beside Capt Sprouting. US Driver B shouted at US Driver A to get help, so he quickly drove to VOODOO Ramp to get help. Exhibit 1 Witnesses 8-9, 21-22

[12] Military Policing responsibilities within AAAB were undertaken by the Danish Army.

Figure 1.3.5 – Location of the accident.

Post-accident events

1.3.43. Shortly after the accident, a KBR contractor driving a service vehicle approached, observed the scene and positioned the vehicle across the road to stop traffic from getting past. Three personnel from 1st Space Brigade[13] passed by and observed US Driver B kneeling over Capt Sprouting. They informed their Commander via radio and requested medical assistance.

Exhibit 1
Witnesses 8-9, 21

1.3.44. At approximately 1535hr, Dutch Medics A and B, who had been out running, came upon the scene. Observing that Capt Sprouting was [redacted] During CPR, Dutch Medic A was informed by the members of 1st Space Brigade that an ambulance was en route to the scene of the accident.

Witnesses 8-9, 21

1.3.45. At 1537hr, the KBR Fire Department received a report of an accident on Tower Road near the Dining Facility. A US Firefighter, who had been at the Dining Facility, heard the call, proceeded to the scene on foot and assisted with First Aid.

Exhibit 20
Witness 22

1.3.46. At 1539hr, the KBR Fire Service arrived at the scene with [redacted]

Exhibit 20
Witnesses 8-10, 23

[13] The US Army Space and Missile Defense Command / Army Forces Strategic Command's 1st Space Brigade had personnel detached to AAAB.

[14] [redacted]

1.3.47. At approximately 1540hr, 4 members of the US Air Force (USAF) Security Forces (SF) were informed that an individual had been struck by a FLT on Tower Road. One member ran to KBR Fire Dispatch to ensure that they had been informed, whilst the other 3 made their way to the scene in a car. On arrival, they observed Dutch Medics A and B and US Firefighter administering CPR. They asked if they could assist but were told they were not required. They subsequently cordoned off the East side of Tower Road, directing traffic away from the scene.	Witnesses 23-25
1.3.48. At 1545hr, the BAS received a pre-alert of a patient who had been involved in an accident and prepared to receive the patient by assembling its Trauma Team, led by MO B.	Witness 12
1.3.49. At 1546hr, a member of the USAF SF contacted the Base Defence Operations Centre (BDOC) Watch Commander to ensure that he was aware of the accident.	Witnesses 23-24
1.3.50. At 1548hr, approximately 20 mins after the accident, the ambulance arrived at the scene of the accident. The personnel in the area moved Capt Sprouting onto a spinal board and lifted him into the ambulance. The ambulance left the scene at 1553hr. On the short journey to the BAS, CPR continued but with no detectable output. Dutch Medic A [redacted]	Exhibits 1, 20 Witnesses 8-9
1.3.51. Post-accident, it was observed that Capt Sprouting was not wearing any form of identification. This resulted in Op ACCOUNTABLITY[15] being called at 1555hr.	Exhibits 1, 20 Witness 1
1.3.52. At 1556hr, Capt Sprouting was transferred to the Trauma Team at the BAS. At 1558hr, MO B declared Capt Sprouting life extinct. Having observed a UK football team tattoo on Capt Sprouting, MO B dispatched a runner to UKTT(W) to find someone who might have been able to assist with identifying the deceased.	Exhibit 1 Witnesses 12, 22
1.3.53. At 1600hr, the DANPOL arrived at the scene of the accident, took over the cordon and started interviewing personnel.	Witnesses 21-24
1.3.54. Around this time Soldier B was approached by the runner who had been sent to UKTT(W) by MO B. He was informed of the casualty and agreed to help with the identification. Whilst en route, he passed Soldier A, explained the situation and asked if he could assist, to which Soldier A agreed. Soldier A accompanied Soldier B to the BAS, arriving at approximately 1625hr. On arrival, they were asked if they could identify the deceased; both identified him as Capt Sprouting. At approximately 1628hr Soldier B contacted the CO to inform him of Capt Sprouting's death. The CO then contacted the Base Commander to inform him that the individual involved in the accident was one of his officers.	Witnesses 1-3
1.3.55. At 1630hr, the UK element of Op ACCOUNTABILITY was reported as complete, with all UK personnel accounted for. At approximately 1640hr, the CO contacted the Base Commander to inform him that the individual involved in the accident was Capt Sprouting.	Exhibit 1
1.3.56. On 2 Feb 18, Soldiers A and B packed Capt Sprouting's belongings for his repatriation to the UK. During this time, they found Capt Sprouting's ID discs within his laundry bag.	Witness 1

[15] Op ACCOUNTABILITY is a method utilised to perform a quick but comprehensive count of all personnel at AAAB. Personnel are briefed during the RSOI briefs that when Op ACCOUNTABILITY is called they are to report to their Chain of Command immediately.

1.3.57. Capt Sprouting was repatriated to the UK on 8 Feb 18. His funeral was held with full military honours on 21 Feb 18. Exhibit 21

Cause of death

1.3.58. Capt Sprouting died because of injuries to his [redacted]. These injuries were in keeping with significant crush injuries as a result of being run over by a vehicle. Exhibits 22, 56 Witness 1

Accident timeline

1.3.59. The table below summarises the timeline of the accident:

Time (a)	Event (b)
c1400hr	Capt Sprouting declared to his clerk that he was going for a run.
c1425hr	Capt Sprouting passed Soldier A and informed him that he was going for a run.
c1445hr	US Drivers A and B departed SSA driving an MTV and FLT carrying a shipping container respectively.
c1528hr	Capt Sprouting run over by FLT.
c1530hr	KBR driver positioned his vehicle across the road to stop traffic from getting past.
	Three personnel from 1st Space Brigade observed US Driver B kneeling over Capt Sprouting. They informed their Commander via radio and requested medical assistance.
c1535hr	Dutch Medics A and B came upon the scene and commenced CPR. Dutch Medic A was informed by a member of 1st Space Brigade that an ambulance was en route.
1537hr	US Firefighter received a call informing him of the accident. He proceeded on foot to the scene and assisted with First Aid.
1539hr	KBR Fire Service arrived at the scene with AEDs. [redacted]
c1540hr	Four members of the United States Air Force (USAF) Security Forces (SF) were informed of the accident. One member ran to KBR Fire Dispatch to ensure they had been informed whilst the other 3 made their way to the scene. On arrival, they observed the ongoing CPR to Capt Sprouting. They cordoned off the East side of Tower Road, directing traffic away from the scene.
1545hr	BAS received a pre-alert of a patient who had been involved in an accident and prepared to receive the patient by assembling the Trauma Team, led by MO B.
1546hr	A member of the USAF SF informed BDOC Watch Commander of the accident.
1548hr	[redacted]

Time (a)	Event (b)
1553hr	[redacted]
1555hr	Op ACCOUNTABLITY was called.
1556hr	The ambulance arrived at the BAS. Capt Sprouting was transferred to the Trauma Team.
1558hr	MO B declared Capt Sprouting dead.
1600hr	MO B dispatched a runner to UKTT(W) to find someone who might have been able to assist with identifying the deceased, believing that he was a British Serviceman.
	DANPOL arrived at the scene of the accident, took over the cordon and started interviewing personnel.
c1625hr	Soldiers A and B arrived at the BAS. They both identified the deceased as Capt Sprouting.
c1628hr	Soldier B contacted CO 3 SCOTS to inform him of the death of Capt Sprouting.
1630hr	UKTT(W) element of Op ACCOUNTABILITY reported as complete with all UK personnel accounted for.
c1640hr	CO contacted the Base Commander to inform him that the individual involved in the accident was Capt Sprouting.

Table 1.3.2

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PART 1.4

Analysis

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Introduction

1.4.1. This Service Inquiry (SI) was convened on 26 Feb 18 to investigate the circumstances surrounding a Road Traffic Accident (RTA) at Al Asad Air Base (AAAB), Al Anbar Province, Iraq on 31 Jan 18, which resulted in the death of Captain (Capt) Dean Sprouting, who was struck by a forklift truck (FLT) carrying a shipping container. The FLT was driven by a United States (US) Military Service Person. At the time of the accident, Capt Sprouting was assigned to The Black Watch, 3rd Battalion The Royal Regiment of Scotland (3 SCOTS) as the Adjutant General's Corps (AGC) (Staff and Personnel Support (SPS)) Detachment Commander (Det Comd)[1]. To establish the facts, the SI Panel initially focused on events leading up to the accident, the accident itself, and post-accident actions, complying with the SI's Terms of Reference.

Exhibits 1, 7-9, 23-24, 56

1.4.2. Early in the SI, the Panel was given the Police Report which was produced by the Danish Military Police (DANPOL)[2]. This provided the Panel with short statements taken at the scene of the accident. The Panel was also informed that there was no CCTV or any form of surveillance at AAAB that captured the accident.

Witnesses 21-22

1.4.3. The Panel was delayed in interviewing those members of 3 SCOTS that were deployed until either they returned from AAAB on a period of Rest & Recuperation (circa Apr 18) or at the end of the 3 SCOTS deployment (circa Jul 18). The potential limitations of delayed interviews were: that distortion could have occurred because of stress (which can affect event processing and recall); hindsight bias (data being perceived differently with hindsight); or distortion and/or decay of memories. The witness interviews have, therefore, been analysed and discrepancies explored.

Exhibit 25

1.4.4. The Panel was delayed in conducting a visit to AAAB until Oct 18, 3 months after 3 SCOTS completed its deployment and returned to the UK. This was because of Iraqi delays in issuing entry visas. The ongoing criminal investigation conducted by the US Criminal Investigation Department (CID) prevented the Panel from conducting interviews with US personnel. The US CID, however, has given the Panel transcripts of interviews conducted with some personnel and gave regular updates on the progress of its investigation. The Panel was also granted access to vehicles similar to those involved; this enabled a safe reconstruction of elements of the accident and allowed hypotheses to be generated to understand better the events that took place.

1.4.5. The report is split into 2 sections: Section 1 investigates relevant events, activities and processes, including 3 SCOTS force generation, training, Capt Sprouting's existing medical issues and an explanation of the safety organisations that existed in AAAB. Section 2 details the events that took place on the day of the accident, including pre-accident movements, medical treatment received, cause of death and post-accident actions.

Methodology

1.4.6. **Accident Factors.** Once an accident factor had been determined it was then assigned to one of the following categories:

[1] The 3 SCOTS AGC (SPS) Det Comd is responsible for delivering Personnel Administration and Administrative Staff Support to 3 SCOTS.
[2] Military Policing responsibilities within AAAB were undertaken by the Danish Army.

a. **Causal Factor.** Causal factors are those factors that, in isolation or in combination with other factors and contextual details, led directly to the accident. Therefore, if a causal factor is removed from the accident sequence, the accident would not have occurred.

b. **Contributory Factor.** Contributory factors are those factors that made the accident more likely to happen. That is, they did not directly cause the accident. Therefore, if a contributory factor is removed from the accident sequence, the accident may still have occurred.

c. **Aggravating Factor.** Aggravating factors are those factors that made the outcome of an accident worse. However, aggravating factors do not cause or contribute to an accident. That is, in the absence of the aggravating factor, the accident would have still occurred.

d. **Other Factor.** Other factors are those factors that, whilst they played no part in the accident in question, are noteworthy in that they could contribute to or cause a future accident. Typically, other factors would provide the basis for additional recommendations or observations.

e. **Observations.** Observations are points or issues worthy of note to improve working practices that the SI Panel discovered during their investigation, but that do not relate directly to the accident being investigated.

1.4.7. **Human Factors (HF).** A psychologist from the Army Personnel Research Capability (APRC) provided HF specialist support to the SI. This included participation in witness interviews, and advice to the Panel throughout the investigation. A separate HF report was produced which has been considered in the production of this report.

1.4.8. **Services.** The Panel was assisted by the following personnel and agencies:

a. The Defence Accident Investigation Branch (DAIB).

b. The US CID.

c. Independent medical advisors nominated by the Head of the Defence Medical Services Regulator and Inspector General.

d. The Combined Joint Task Force - Operation Inherent Resolve (CJTF-OIR).

e. The Special Investigation Branch (SIB) of the Royal Military Police (RMP).

1.4.9. **Available evidence.** The Panel had access to the following evidence:

a. DAIB Triage Reports.

b. Evidence released to the SI Panel by the US CID.

c. Statements obtained by the SIB during the investigation.

d. The AAAB Police Report produced by the DANPOL.

e. The US Safety Report relating to the accident.

f. Capt Sprouting's Post-Mortem Report.

g. Interviews with 3 SCOTS personnel involved in the force generation of 3 SCOTS and its deployment to AAAB.

h. Key Ministry of Defence (MOD) documentation.

i. Relevant standing orders.

j. Full medical history of Capt Sprouting.

k. Full service history of Capt Sprouting.

l. Vehicles similar to those involved in the accident at AAAB.

m. HF Report provided by a psychologist from APRC.

n. Comments received from personnel following the application of the Regulation 18 process[3].

1.4.10. **Issues considered by the panel.** The Panel analysed the following key factors:

a. The actions of the personnel involved in the movement of the container and whether it was in accordance with recognised Standard Operating Procedures (SOPs).

b. Capt Sprouting's suitability to deploy.

c. 3 SCOTS pre-deployment preparations.

d. Safety and Duty of Care (DoC) within AAAB.

1.4.11. **Probability language.** This report uses a variety of terms to describe different levels of probability. The Panel considered that it was helpful to define these terms to assist readers and establish consistency. These definitions are found in DAIB's document 'Standard Operating Procedure 514' and are highlighted in Figure 1.4.1. The percentage likelihoods in the figure are for indicative purposes only and should not be taken to imply the Panel attempted to calculate probability with mathematical precision. Exhibit 26

[3] If a Service Inquiry President considers that it is likely that a person's character or reputation may be questioned based on the findings of the Service Inquiry they are considered a Potentially Affected Person in accordance with Regulation 18 of The Armed Forces (Service Inquiries) Regulations 2008 (Reg 18). The intention behind this is that the individual under Reg 18 is able to hear the evidence relating to the issue and to respond to that evidence. They are entitled to be present at the proceedings of a SI Panel, may question witnesses and may consider evidence provided to the Panel. They may do this themselves or be represented by another person. The SI President may impose such conditions and exclusions on the affected individual's attendance at SI proceedings as are reasonable.

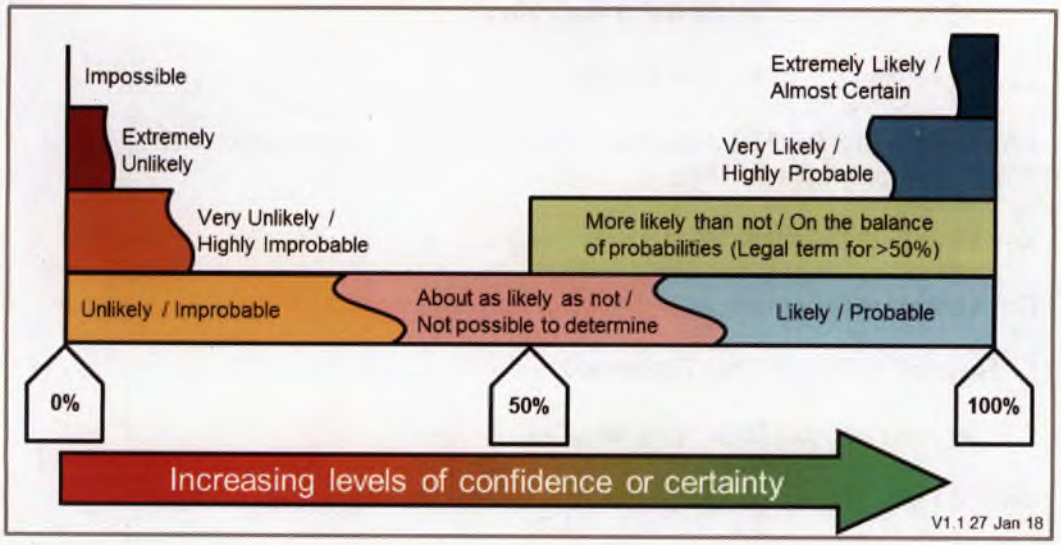

Figure 1.4.1 Probability expressions.

ANALYSIS OF FACTORS SECTION 1 – EVENTS LEADING UP TO THE DAY OF THE ACCIDENT

Pre-Deployment Preparations

3 SCOTS Force Generation

1.4.12. On 11 May 17, HQ 1 (United Kingdom) Division (1 (UK) Div) directed 51 Infantry Brigade (51 Inf Bde) to generate 3 SCOTS to provide the UK Training Team (West) (UKTT(W)) as part of Op SHADER in AAAB. They were to undertake transfer of authority (ToA) from 2nd Battalion, The Rifles (2 RIFLES) no later than 20 Jan 18. This direction was passed in the 1 (UK) Div force generation order (FGenO) on 11 May 17. This was to be a joint operation with direct liaison authority to Permanent Joint Headquarters (PJHQ). 51 Inf Bde subsequently wrote to 3 SCOTS, on 22 Jun 17, with additional timelines for assurance, training and preparation. Referencing these documents, on 24 Jul 17, 3 SCOTS distributed their own FGenO, authorised by the Commanding Officer (CO) 3 SCOTS.

Exhibits 4, 27-28
Witnesses 3, 5, 14

1.4.13. On 15 Sep 17, the CO wrote to 51 Inf Bde stating that, with 4 months until the deployment date, 3 SCOTS was on track to deploy on Op SHADER. Following this, between 1 - 3 Oct 17, the CO conducted a reconnaissance of AAAB. In his report, he listed RTAs as a very real threat to life, noting that robust management of vehicles, drivers' qualifications and hours for UK personnel would be maintained.

Exhibits 29-30

1.4.14. On 8 Dec 17, the CO wrote to 51 Inf Bde informing them that 3 SCOTS was ready to deploy with a Relief-in-Place (RiP) window of 3 - 16 Jan 18. However, a delay in receiving Iraq entry visas for a significant number of 3 SCOTS personnel resulted in reductions in the number of personnel able to deploy. Visa issues will be discussed further in this section. On 20 Dec 17, the CO once again wrote to 51 Inf Bde informing them that 3 SCOTS was ready to deploy but he highlighted mitigations against training shortfalls and stated that fewer personnel would deploy because of delays in Iraqi entry visas being received. 3 SCOTS pre-deployment training will be discussed further in this section.

Exhibits 31-32
Witness 3

1.4.15. The Panel considers that orders passed to 3 SCOTS relating to deployment preparations and force generation were clear; 3 SCOTS was content with its responsibilities in generating the Battalion for deployment. Communication and liaison between 3 SCOTS, 51 Inf Bde, 1 (UK) Div and PJHQ was appropriate during the period of force generation.

1.4.16. The Panel identified, however, that an order in the 1 (UK) Div FGenO relating to Medical Employment Standards (MES) was not consistent with PJHQ Op SHADER Force Health Protection Instructions (FHPI). This will be discussed further in this section under Op SHADER MES. Exhibits 4, 33-34

1.4.17. The Panel concludes that 3 SCOTS was appropriately supported during the period leading up to its deployment to AAAB. Therefore, 3 SCOTS force generation was **not a factor** in the accident.

Capt Sprouting's notification of deployment

1.4.18. **Previous employment.** Prior to joining 3 SCOTS, Capt Sprouting was employed as the Visiting Warrant Officer (VWO) at 51 Inf Bde, in Stirling, from 27 Apr 15. In this role, he was considered a subject matter expert (SME) on all personnel administration issues and provided advice and assurance, as well as supporting force generation to all units in 51 Inf Bde, including 3 SCOTS. Exhibits 35-36 Witness 26

1.4.19. **Commissioning.** A volunteer to become a commissioned officer, Capt Sprouting was selected into the AGC (SPS) at a selection board held 11 - 12 Oct 16. He was selected for an Intermediate Regular Commission (Late Entry) from 11 Sep 17. Exhibit 35

1.4.20. It was recognised at this Selection Board that Capt Sprouting had medical restrictions placed on him. The Board noted that his medical constraints were not insurmountable given that the nature of the roles that he would be expected to fulfil were unlikely to be physically demanding. Overall the Board believed that, with Capt Sprouting's 27 years' experience, he would be highly employable and competitive amongst his peers for further promotion. Capt Sprouting's medical history, relevant to the SI, will be discussed further in this section. Exhibit 35

1.4.21. Based on Capt Sprouting's Commissioning Board Report, the Panel considers that his ongoing medical limitations were appropriately considered. At this time nothing suggested any unsuitability to commission, and subsequent employment as the 3 SCOTS AGC (SPS) Det Comd. Exhibit 35

1.4.22. **Assignment to 3 SCOTS and pre-assignment course.** In Jul 17, 3 SCOTS initiated the process for backfilling the gapped AGC (SPS) Det Comd position in anticipation of its forthcoming Op SHADER deployment. The requirement was submitted to 51 Inf Bde, at which point Capt Sprouting became aware of it and, cognisant that it would be a posting that enabled his continued service in Scotland[4], he volunteered for the post, and was accepted by his Career Manager. His Assignment Order was raised on 24 Jul 17, assigning him to 3 SCOTS with effect from 11 Sep 17. With the agreement of 3 SCOTS, Capt Sprouting was taken-on-strength[5] to assume the rank of captain, then to proceed on the AGC (SPS) Det Comds' Course at Worthy Down from 11 Sep - 24 Nov 17, where he put in an impressive performance. Exhibits 1, 7-10, 35 Witness 13

[4] Which suited him domestically.
[5] Assigned to the AGC (SPS) Det Comd position within 3 SCOTS.

1.4.23. On completion of the AGC (SPS) Det Comds' Course, Capt Sprouting reported to 3 SCOTS at Fort George, Inverness, on 27 Nov 17 and began the mandated Joint Personnel Administration (JPA)[6] arrivals process. He was assigned to Headquarter Company (HQ Coy) and he was, therefore, responsible to Officer Commanding (OC) HQ Coy[7]. It was expected that Capt Sprouting would remain at Fort George until the 3 SCOTS Christmas block leave period, from 8 Dec 17. Capt Sprouting was then expected to return to Fort George on 2 Jan 18 and then to deploy to AAAB on 3 Jan 18. Exhibits 37-40 Witnesses 4, 14-15

1.4.24. The Panel considered the period between Capt Sprouting leaving 51 Inf Bde, and the date that he was due to proceed on pre-deployment leave, to identify if it was realistic to expect that he would complete all pre-deployment training. The Panel learned that the 3 SCOTS CoC recognised early that he would be spending a very short period physically located at Fort George and, therefore, engaged with Capt Sprouting, whilst he was still at 51 Inf Bde, to discuss his training timeline and to explain what he would be required to do prior to deploying. The Panel learned that Capt Sprouting was aware, and accepted without question, this expectation. With the exception of 2 training shortfalls, which will be discussed further in this section, Capt Sprouting was prepared when he deployed on 3 Jan 18.

1.4.25. The Panel determines that 3 SCOTS reasonably assumed that, given that Capt Sprouting had been the VWO of its parent brigade and his considerable Army experience, there was a realistic expectation that he would have enough time to prepare for deployment. The Panel, therefore, concludes that the notification and time to prepare Capt Sprouting for deployment was **not a factor** in the accident.

3 SCOTS Pre-Deployment Training

1.4.26. **Training instructions and responsibilities.** The Op SHADER Mission Specific Training Directive categorised 5 separate theatre entry training standards for personnel, depending on the deployment category associated with their role. This determined the level of training required, relative to the threat and environmental conditions associated with each role. Exhibits 1, 4, 41 Witness 3

1.4.27. The 3 SCOTS Operations Officer (Ops Offr) created a comprehensive training plan in accordance with the 3 SCOTS FGenO, which specified that the delivery of skills packages was a sub-unit responsibility, supported/enabled by Battalion Headquarters (BHQ). Exhibit 27 Witness 5

1.4.28. **All Ranks Brief (ARB).** All personnel deploying on Op SHADER were required to attend an Op SHADER specific ARB. Staff from the Mission Training and Mobilisation Centre delivered the ARB to 3 SCOTS in Fort George between 30 Oct – 2 Nov 17. It was identified at an early stage that, because of a clash with the Det Comds' Course, Capt Sprouting would not be able to attend this brief. An alternative brief was identified and, subsequently, he attended the ARB with deploying elements of the Royal Highland Fusiliers, 2nd Battalion, The Royal Regiment of Scotland (2 SCOTS)[8] in Lydd over the period 4 - 9 Sep 17. Exhibits 1, 27, 42-43 Witnesses 5, 14-15

[6] JPA is an intranet-based personnel administration system used by the British Armed Forces. Managers can interrogate JPA to gather essential information about personnel.
[7] OC HQ Coy was responsible for preparing all HQ Coy personnel for deployment; which incorporated checks on each individual's pre-deployment administration, Medical Employment Standard (MES) and training.
[8] Who were deploying to UKTT(C) in Iraq as part of another element of Op SHADER.

1.4.29. **Mission Rehearsal Exercise (MRX).** 3 SCOTS conducted its MRX at Stanford Training Area (STANTA) between 15 – 30 Nov 17. As Capt Sprouting was joining 3 SCOTS from a non-deployable Bde HQ, it was recognised that he would require a bespoke pre-deployment training package. It was subsequently, arranged for Capt Sprouting to be released from the AGC (SPS) Det Comds' Course to attend an element of the MRX between 17 - 20 Nov 17, along with the 3 SCOTS Regimental Administration Officer (RAO), who was to be Capt Sprouting's Line Manager and who had also very recently joined 3 SCOTS.

Exhibits 1, 4, 44-45
Witnesses 3, 5, 15

1.4.30. **Operational Deployment Record (ODR).** ODRs were utilised by the Ops Offr, Company (Coy) OCs, Coy Second in Commands (2ICs) and Coy Sergeant Majors (CSMs) to record the progress of individual pre-deployment training.

Exhibits 27, 47
Witnesses 4-5, 27

1.4.31. **Military Annual Training Tests (MATTs).** MATTs represent the endorsed minimum mandatory basic training requirement for all Army personnel. The requirement is determined by the readiness level of an organisation and the needs of certain appointments within it. All personnel deploying on Op SHADER were required to be in-date for MATTs 1 - 9. Capt Sprouting was expected to have completed most of his MATTs training by the end of MRX. However, because of technical and timing constraints, Capt Sprouting did not complete MATT 8 (Survive, Evade, Resist, Extract presentation) or MATT 9 (Counter Improvised Explosive Device practical training), which were planned to have been completed during this period. Capt Sprouting was instructed before he departed STANTA that he must complete both elements when he joined 3 SCOTS at Fort George from 27 Nov 17.

Exhibits 1, 41, 46
Witnesses 3, 5, 14-15, 27

1.4.32. **Capt Sprouting's training deficits.** After the 3 SCOTS MRX, Capt Sprouting's ODR stated that he was deficient in MATTs 2[9], 8 and 9. On 30 Nov 17, whilst Capt Sprouting was at Fort George, 3 SCOTS Rear Operations Group (ROG) Detail[10] was promulgated, listing the names of personnel, including Capt Sprouting, who were to report to the Physical Training (PT) Staff to conduct their fitness tests the following week. It stated that anyone who felt that they were exempt should inform the HQ Coy CSM. At that time, Capt Sprouting's MES was Medically Limited Deployable (Permanent) (MLD(P))[11] and he was, therefore, exempt from attempting MATT 2. He did not declare this to the HQ Coy CSM and did not attend the fitness test as directed.

Exhibits 44, 48-49
Witnesses 3-5, 27

1.4.33. By Dec 17, the 3 SCOTS Ops Offr expected all Coys to report by exception any MATTs training deficits for deploying personnel. At this time, the 3 SCOTS Command Team's focus was on addressing issues relating to the lack of visas that had been received, which will be discussed later in this section, and assumed that Coys would ensure that all pre-deployment training would be complete. The Panel opines that such an expectation to be placed on Coy CoCs was appropriate as it was within their areas of responsibilities and, therefore, this was a reasonable assumption for the 3 SCOTS command team to make.

Witnesses 3, 5, 14, 27

1.4.34. Capt Sprouting was reminded by HQ Coy CSM of his training deficits around 29 - 30 Nov 17 and he was instructed to rectify them prior to deploying. Information relating to these training deficits was available to OC HQ Coy and the Ops Offr by checking Capt Sprouting's ODR. However, the Panel has learned that neither were aware of these training deficits until after the accident.

Exhibits 1, 44
Witnesses 4-5, 27

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[9] MATT 2 is the completion of an Annual Fitness Test and Personal Fitness Assessment.
[10] An administrative order informing personnel working under HQ Coy of important events and notices.
[11] Owing to long-term [redacted], which will be discussed further in this section under Capt Sprouting's Pre-Deployment Medical Issues.

1.4.35. Capt Sprouting was stood down with [redacted] on 5 Dec 17 (which will be discussed further in this section under Capt Sprouting's pre-deployment medical issues) which led into his pre-deployment leave period. This meant that he spent 3 fewer days at Fort George than he was expecting to. He did not complete MATTs 2, 8 or 9 prior to deploying to AAAB. Exhibits 1, 44 Witnesses 4, 15, 28

1.4.36. The Panel is satisfied that Capt Sprouting was aware that he should have completed MATTs 8 and 9 prior to deploying. Given Capt Sprouting's rank and experience, there was a realistic expectation placed on him that he would ensure that this was completed. Ultimately, however, it was the responsibility of OC HQ Coy to ensure that training was complete for all personnel assigned to HQ Coy and to ensure that deficiencies were reported to the Chain of Command (CoC). Further, regular oversight of Capt Sprouting's ODR by the HQ Coy CoC would have noted that he had not completed MATT 2; further investigation would have recognised that he would have been exempt because of his MLD(P) MES.

1.4.37. During interviews with 3 SCOTS CoC, the Panel learned that, had it been recognised in the days leading up to deployment, that Capt Sprouting had not completed his outstanding MATTs then the risk associated with his deployment could have been re-assessed; it is likely that the decision would have been made to allow him to deploy 'at risk', and he would have conducted the outstanding MATTs in theatre. The Panel opines that this would have been entirely appropriate given the low-level risk associated with the role allocated to Capt Sprouting at AAAB. The nature of the training that Capt Sprouting did not undertake is not associated with the events that led to the accident. The Panel concludes, therefore, that Capt Sprouting's pre-deployment training deficits were **not a factor** in the accident. However, the Panel **observed** that improvements could be made to personnel's pre-deployment administration checks to include training, which will be discussed further in this section.

OP SHADER MES

1.4.38. Over the period that 3 SCOTS prepared to deploy there were 2 separate orders from PJHQ relating to MES that could have been applied to Op SHADER. Annex J to the PJHQ Broader Middle East Joint Mounting Instructions (BME JMI) dated 9 Jun 16 categorically stated that personnel who were MLD could be considered for deployment on a case-by-case basis, in consultation with PJHQ. It went on to state that **all** Army cases were to be referred to an Army Occupational Medicine (OM) Consultant for a decision on suitability to deploy. Commanders were not authorised to deploy MLD personnel without specific OM endorsement and, furthermore, that a medical officer (MO) familiar with the soldier's deployed role should undertake a documented Medical Risk Assessment (MRA). Exhibits 33-34, 50-51

1.4.39. The second order, the FHPI for Op SHADER dated 21 Sep 16, was specific to Op SHADER. It stated that personnel who were not Medically Fully Deployable (MFD)[12] **may** be granted permission to deploy following a documented MRA carried out by a MO in consultation with OM consultants. The Panel has learned that this is considered 'normal practice' for units with MOs attached to them. Exhibits 34 Witnesses 11, 29

1.4.40. The 1 (UK) Div FGenO issued on 11 May 17, when issuing instructions relating to MES, quoted from the BME JMI, not the Op SHADER specific FHPI. It stated that personnel deploying on Op SHADER were to be MFD without any restriction or caveat Exhibits 4, 27-28, 34, 50

[12] This would incorporate personnel that were MLD.

and that MOs and Commanders were not authorised to deploy individuals without OM agreement. This order was then mirrored in the FGenOs from 51 Inf Bde (dated 22 Jun 17) and 3 SCOTS (dated 24 Jul 17) with no amendments. PJHQ was not included in the distribution list of the 1 (UK) Div FGenO and, therefore, was not aware that 1 (UK) Div had issued more stringent medical instructions than had been directed by PJHQ.

1.4.41. Wishing to clarify the 1 (UK) Div instruction and mindful of the additional time that it would take to seek OM approval for all MLD personnel, MO A sought advice from his Regional Occupational Health Team (ROHT), based in Edinburgh. The ROHT SO1 advised that he believed that MO A was capable to assess the suitability for personnel to deploy and believed that this was appropriate, given the role of the MO in units. He went on to offer his specialist advice to MO A if required. Exhibit 4 Witnesses 11, 29

1.4.42. MO A believed that he was best placed to make recommendations to 3 SCOTS CoC as to MLD personnel's suitability to deploy, recognising that the ROHT was available to provide specialist advice if required. MO A did not clear this course of action (CoA) with 51 Inf Bde, 1 (UK) Div or PJHQ. Exhibits 52-53 Witness 11

1.4.43. The Panel determines that MO A was correct to question the order laid out in the 1 (UK) Div FGenO, as it was a deviation from normal routines, and made an appropriate decision about being best placed to make recommendations to his CoC about an individual's suitability to deploy. However, the Panel believes that it would have been appropriate for him to then ensure that higher authorities were aware and content with this CoA. The Panel is satisfied that had PJHQ or 1 (UK) Div been informed of MO A's intention then they would have authorised it, accepting that ROHT were on hand to provide support if required.

1.4.44. The Panel concludes that the MES instruction in the FHPI for Op SHADER dated 21 Sep 16 was appropriate and therefore was **not a factor** in the accident. It should be noted that, since the accident, PJHQ has revised its BME JMI and given unambiguous instructions relating to MES and the responsibilities placed on unit MOs.

Capt Sprouting's medical history

1.4.45. **Management of medical issues prior to arrival at 3 SCOTS.** Capt Sprouting was declared MLD (Temporary) (MLD(T)) on 13 Apr 10 during a Medical Screening. He had been having ongoing [redacted] Exhibit 11

1.4.46. On 6 Jan 11, Capt Sprouting reported to his local Defence Medical Facility to report [redacted] Exhibit 11

1.4.47. On 17 Jan 12, Capt Sprouting attended a medical review and remained MLD(P) because of ongoing [redacted] Exhibit 11

1.4.48. Capt Sprouting underwent Medical Reviews on 26 Feb 13, 6 Mar 14, 30 Jan 15 and 22 Feb 16. Each review confirmed his MLD(P) MES because of ongoing [redacted] It was judged that, because of the administrative roles he filled during these periods, there was no risk with keeping him in Service. Exhibit 11

1.4.49. On 18 Apr 16, Capt Sprouting was informed that [redacted] However, he completed his AFT on 16 Jun 16 and passed. Exhibit 11 Exhibit 54

1.4.50. Capt Sprouting attended a [redacted] Exhibit 11

1.4.51. On 24 Mar 17, Capt Sprouting underwent another medical review. [redacted] Exhibits 11, 44, 54

1.4.52. On 12 Sep 17, the second day of his attendance on the AGC (SPS) Det Comds' Course, Capt Sprouting attended the Worthy Down Medical Facility. He stated to the medical advisor that the previous day he had been involved in an RTA, explaining that his car had been hit from behind. He stated that he did not attend hospital at the time [redacted] Exhibit 11 Witness 15

1.4.53. The Panel determines that, although he had been affected by ongoing [redacted] issues between 2010 and 2018, Capt Sprouting's medical care had been appropriate, and he had been given ample opportunity to conduct [redacted] to address these conditions. He underwent annual reviews on his medical category and, in each instance, he was deemed employable and not a risk to himself or his colleagues.

1.4.54. The Panel determines that from a duty of care perspective, Capt Sprouting received appropriate medical care during his time in Service. In his own time, he enjoyed volleyball, cycling and running and, as recently as Oct 17, took part in activities such as cliff diving and surf-boarding. Although these activities may have led to residual stiffness, they were undertaken at Capt Sprouting's own choice, and he continued to be managed by Service medical facilities when required. The Panel concludes, therefore, that the management of Capt Sprouting's pre-3 SCOTS medical issues was appropriate and was, therefore, **not a factor** in the accident.

1.4.55. **Most recent MES review.** On 1 Dec 17 Capt Sprouting visited the Fort George Medical Facility to undergo an annual MES review. Capt Sprouting discussed with MO A his ongoing [redacted] issues but declared that he felt much improved since the RTA in Sep 17. Exhibit 11 Witness 11

1.4.56. MO A issued a PULHHEEMS[13] Administrative Pamphlet (PAP) Appendix (App) 9[14] to Capt Sprouting, stating that the overall risk assessment for deployment was 'Low'. He also placed the following restrictions on his activity: Exhibits 11, 55 Witness 11

- Physical Training – upper body
- Physical Training – impact[15]
- Physical Training – contact sports

1.4.57. MO A stated that Capt Sprouting did not require an OH Specialist review prior to deploying. This was consistent with the CoA described in this section under Op SHADER MES. Exhibit 55 Witness 11

1.4.58. Having sought advice from independent medical advisors the Panel is content that, with the information available to MO A during the MES review on 1 Dec 17, categorising Capt Sprouting as MLD(P), the declaration of 'Low Risk for deployment' and issuing a PAP App 9 was appropriate, therefore concludes that Capt Sprouting's most recent MES review was **not a factor** in the accident. Witnesses 11, 35

1.4.59. **Post-MES review administration.** After signing and issuing the PAP App 9 on 1 Dec 17, MO A advised Capt Sprouting that he must take it to his CoC to ensure that a PAP App 26 MRA[16] was conducted before he could be authorised to deploy. Capt Sprouting did not submit the PAP App 9 to his CoC before deploying on 3 Jan 17; therefore, no PAP App 26 MRA took place. Witnesses 4, 11, 14, 27, 30

1.4.60. Given Capt Sprouting's extensive experience in the AGC (SPS) Branch, as well as his personal experience of managing his own medical paperwork whilst being MLD(P) since 2011, it is highly likely that he would have been aware of the medical administrative process that he was to complete prior to deploying. The Panel was unable to determine the reason why he did not submit the PAP App 9 to his CoC to enable the PAP App 26 MRA to be raised. However, as the appointment took place on 1 Dec 17, at which point Capt Sprouting believed he had another full week at Fort George prior to going on Christmas Leave, he may have intended to carry this out the following week. Capt Sprouting would not have known the events that would lead to him being stood down on 5 Dec 17 (as will be further discussed in this section under Capt Sprouting's Pre-Deployment Medical Issues) which reduced the opportunity to submit his PAP App 9. Exhibits 6, 35, 57-65

[13] The PULHHEEMS system of medical classification is a Tri-Service system, described in JSP 950.

[14] Form for Notifying Medical / Functional Restrictions to Unit CoC. This informs the CoC what restrictions are placed on an individual during the course of their duties. It advises the individual what restrictions are placed on them, however cannot protect against what an individual chooses to do in their free time.

[15] The Panel understands that this includes running.

[16] A grade of MLD requires a deployed Medical Risk Assessment (MRA) to be carried out for deployment. The decision on that deployment will depend on the medical condition, individual function, the proposed employment, length of the deployment and the medical support available.

1.4.61. It was disclosed to the Panel during several interviews that, although Capt Sprouting performed admirably at coordinating and managing the administration of others, it sometimes came at the expense of his own personal administration. Therefore, it cannot be discounted that Capt Sprouting simply forgot to submit his PAP App 9 to his CoC. The issue surrounding fail-safe options to prevent similar events occurring will be discussed later in this section. Witnesses 3, 14-16, 33

1.4.62. The Panel is satisfied that, had the correct process been followed and the PAP App 26 MRA been completed, it is highly likely that the CO would have given his approval for Capt Sprouting to deploy, given the low-risk position that he was deploying into. The Panel, therefore, concludes that the post-MES review administration was **not a factor** in the accident. However, the Panel **observed** that improvements could have been made to monitor personnel's MES status. This will be discussed further in this section when describing the 3 SCOTS Unit Health Committee.

1.4.63. **Impact of Historical Medical Issues on the Accident.** As will be discussed in Section 2, the Panel determines that, at the time of the accident Capt Sprouting had been conducting personal physical training by going for a run. The Panel also identified that, during his time in Service, his [redacted] during periods where he had attempted to improve his personal fitness. It is possible, therefore, that [redacted] could have impacted on his ability to react at the time of the accident. The Panel opines that with the information contained in Capt Sprouting's PAP App 9 issued on 1 Dec 17, particularly relating to restrictions placed on physical training, he should not have been running at the time of the accident. MO A informed the Panel that he was not aware that Capt Sprouting had been running whilst at AAAB and, had he known, would have advised against it. It must be noted, however, that it was ultimately the decision of Capt Sprouting to run during his down time, knowing the medical restrictions placed on him. As the Panel is unable to identify any witnesses to the accident, and subsequently is unable to confirm whether or not Capt Sprouting's historical medical issues were a factor in the accident. Exhibit 11 Witness 11

Capt Sprouting's recent [redacted]

1.4.64. On 26 Sep 14, Capt Sprouting conducted a hearing test and was declared as [redacted]. He produced the same result when he sat it again on 22 Feb 16. Exhibit 11

1.4.65. On 13 Nov 17, whilst on the AGC (SPS) Det Comds' Course, Capt Sprouting sat another hearing test, this time scoring [redacted]. The change in results from his previous test was identified and he was advised that he needed to book a repeat audio test in 2 weeks; the repeat audio test was never conducted. Exhibits 11, 66

1.4.66. During interviews with independent medical advisors, the Panel learned that [redacted] not of such significance that they should have automatically precluded him from deploying. The Panel also learned through interviews with Capt Sprouting's colleagues that [redacted] Exhibit 11 Witnesses 3, 5, 14, 16, 31, 35

[17] [redacted]
[18] [redacted]

[redacted] will be discussed again when discussing Capt Sprouting's Pre-Deployment Medical Issues).

1.4.67. The Panel concludes that, given Capt Sprouting's role on Op SHADER, slight [redacted] at the time of his most recent medical checks should not have precluded him from deploying. Therefore, the consequences of Capt Sprouting's recent [redacted] were **not a factor** in the accident. Witness 31

3 SCOTS Unit Health Committee (UHC)

1.4.68. The UHC enables the CoC of a unit to monitor, manage and optimise the health, wellbeing and deployability of its personnel. At 3 SCOTS, it is chaired by the CO, attended by the MO, Coy OCs, Unit Welfare Officer, Padre and administered by the Adjutant (Adjt). Exhibits 67, 69 Witness 30

1.4.69. **Undertaking checks of MES.** According to Army General Administrative Instructions (AGAI) 57, one of the main objectives of the UHC is to confirm and update the MES status of all individuals within the unit, ensuring that the MES on JPA matches that on the individual's PAP App 9[19]. In 3 SCOTS, Coy OCs were assigned permissions on JPA to carry out this check. However, it was not conducted by HQ Coy in advance of UHC meetings leading up to deploying on Op SHADER. Instead, HQ Coy relied on personnel to hand in their PAP App 9 before inputting this information onto PAPMIS[20]. They then monitored MES using only this system and did not refer to JPA. As discussed later in this section, Capt Sprouting did not present the PAP App 9 that he was issued on 1 Dec 17, and, therefore, he was not discussed at the UHC that convened on 4 Dec 17. Exhibits 67-69 Witnesses 4, 27, 30

1.4.70. As Capt Sprouting was assigned to 3 SCOTS on 11 Sep 17, albeit not physically located at Fort George because of attendance on the AGC (SPS) Det Comds' Course at Worthy Down, he still would have shown on any 3 SCOTS JPA report from that date. JPA is linked to the medical electronic database and therefore automatically updates MES status. There was the opportunity, therefore, from 11 Sep 17, for HQ Coy to have identified Capt Sprouting's MES on JPA as MLD(P). 3 SCOTS HQ Coy CoC relied only on PAPMIS and depended, therefore, solely on personnel submitting their PAP App 9s in a timely manner. There was, therefore, the risk that personnel could be employed in positions for which they were not medically fit, because the CoC were not aware of medical restrictions that should be in place. Exhibits 7, 10 Witnesses 4, 30

1.4.71. The Panel considers that, by relying wholly on PAPMIS MES data and not cross-checking against MES data held on JPA, there was a risk of deploying personnel outside of their MES. Not completing this important cross-check also led to Capt Sprouting, who was MLD(P), not being discussed at the 3 SCOTS UHC meetings held prior to deploying. The Panel determines that improvements could be made to JPA that would allow the CoC better oversight of personnel's MES changes. The Panel further determines that responsibilities over cross-checking MES between JPA and PAPMIS should be more clearly defined in AGAI 57. The Panel concludes, therefore, that undertaking checks of personnel MES was an **other factor**.

[19] Although AGAI 57 states that the UHC should confirm and update the MES of all individuals within the unit and ensure that the MES on JPA matches that on the individual's PAP App 9, it does not specify whose responsibility this is.
[20] PULHHEEMS Administrative Pamphlet Management Information System (PAPMIS) is a single electronic application where appropriate personnel can access information for individuals with medical issues. It is limited to personnel directly involved in the medical welfare management of soldiers. It is strictly an administrative process with no medical-in-confidence information recorded (PULHHEEMS Admin Pamphlet).

1.4.72. **Recommendation.** Director Armed Forces Personnel Policy should work with the Joint Medical Group to develop a direct and immediate electronic link between the medical categorisation of personnel and the required actions of their Chain of Command, in order for the chain of command to understand better the medical deployability of its personnel, in the context of readiness.

1.4.73. **Recommendation.** Senior Health Advisor (Army) should revise AGAI 57 in order to clearly define where the responsibility lies for cross-checking personnel's MES on JPA and PAPMIS prior to deployment.

1.4.74. **3 SCOTS Pre-UHC administration.** At 3 SCOTS, UHC meetings were held monthly. Prior to these meetings the Adjt would email a calling notice requesting that Coy CoCs provide names of those to be discussed at the meeting. HQ Coy CoC would interrogate PAPMIS to identify those to be discussed, particularly personnel that were not MFD who were nominated to deploy. As previously discussed, HQ Coy CoC did not complete a MES cross-check on JPA. Witnesses 3-4, 14, 30

1.4.75. MO A prepared for UHCs by taking a list of all personnel who were not MFD from the unit, and any notes that he had on those personnel. This was so that he was prepared to answer any question relating to personnel under medical recovery and to offer advice on their suitability to deploy. Witness 11

1.4.76. MO A had made a request at previous UHCs for Coy OCs to declare personnel who were MLD and who were also nominated to deploy on Op SHADER, and to ensure that the PAP App 26 MRA would take place. Witness 11

1.4.77. The Panel determines that Capt Sprouting, as someone that was MLD(P) and due to deploy, should have been discussed at the UHC that was held on 4 Dec 17, but was not. The Panel determines that it is likely that he would have been discussed if at least one of the following 4 actions had occurred:

a. HQ Coy CoC should have cross-referenced PAPMIS with JPA and identified Capt Sprouting as being MLD(P).

b. HQ Coy CoC should have interrogated Capt Sprouting's ODR and identified that he was deficient in MATT 2, as previously discussed in this section under Capt Sprouting's Training Deficits. The Panel believes that it is likely that this would have generated a discussion with Capt Sprouting surrounding his MES and, therefore, appropriate action would have taken place, such as requesting for him to present his PAP App 9 and highlighting him as exempt from completing MATT 2 on his ODR.

c. Capt Sprouting should have submitted his PAP App 9 that he had been issued on 1 Dec 17 to HQ Coy CoC, and, subsequently, a PAP App 26 MRA for deployment had been raised.

d. Capt Sprouting should have informed HQ Coy CoC of his MES and reasons for not attending his fitness test, previously discussed in this section under MATTs.

1.4.78. The Panel determines that, even if the correct processes had been followed, then 3 SCOTS would still have allowed Capt Sprouting to deploy to AAAB with a PAP App 26 MRA. This would have been appropriate given the administrative nature of the role that he was allocated. However, improvements could be made to the coordination Witnesses 3, 11, 14

of the 3 SCOTS UHC administrative procedures in order to reduce the risk of deploying personnel that are not MFD without the appropriate PAP App 26 MRA. The Panel concludes, therefore, that 3 SCOTS Pre-UHC Administration was an **other factor**.

Fort George Medical Centre

1.4.79. The Care Quality Commission (CQC) carried out an announced inspection of Fort George Medical Centre on 17 Jan 18. This provides an indication of the standard of care at the Medical Centre that supported 3 SCOTS during the short period that Capt Sprouting was based at Fort George. Exhibit 12

1.4.80. The CQC made the following assessments: Exhibit 12

- Overall rating – Inadequate
- Are services safe? – Inadequate
- Are services effective? – Inadequate
- Are services caring? – Good
- Are services responsive to people's needs? – Requires Improvement
- Are services well led? – Inadequate

1.4.81. The CQC found that the inadequate leadership structure was a result of MO A being frequently deployed, leaving a gap in leadership for extended periods. Of the 107 weeks that MO A had been based at Fort George, he had only worked from the Medical Centre for 24 of those weeks. It also found that many of the staff were not appropriately trained, and some staff did not have the appropriate skills and knowledge to deliver effective care and treatment to their patients. Exhibit 12 Witness 11 Witness 28

1.4.82. Of note the CQC made the following recommendations: Exhibit 12

a. A review of the establishment of GPs at the Practice, to include deputising arrangements and cascade of GP responsibilities within the practice during any absence to assure safe and effective patient care.

b. Review of premises to ensure they are suitable for the purpose for which they are being used.

1.4.83. Some of the issues identified in the CQC inspection were already known to 3 SCOTS and had been reported to 1 (UK) Div, most recently in Jun 17. The Panel considered whether the findings of this report had any bearing on the medical care provided to Capt Sprouting during his short time at Fort George. The Panel, however, determines that the care provided to Capt Sprouting during his short period at Fort George was appropriate and, therefore, **observed** that although there are significant improvements that should be made to the facility, which will continue to be monitored by the CQC and 1 (UK) Div, the care provided by the Fort George Medical Centre to Capt Sprouting was **not a factor** in the accident. Exhibits 12, 70-71 Witnesses 11, 28

Pre-deployment visa issues

1.4.84. PJHQ BME JMI 6 Sep 17 stated that all personnel deploying to Iraq were required to be in possession of an official passport and a 12-month multi-entry visa. It was the responsibility of the unit administrative chain, not PJHQ, to obtain the correct visas in time to deploy; visa applications had a projected turnaround time of 4 weeks. Exhibit 51

1.4.85. 3 SCOTS FGenO, dated 24 Jul 17, identified that visa applications posed the greatest risk to deployment timelines and ordered that visa applications for all deploying personnel were to be submitted no later than 8 Sep 17. This gave a period of just under 4 months before the planned deployment date. Exhibit 27

1.4.86. On 28 Jul 17, 3 SCOTS received a Post-Operational Report from The Highlanders, 4th Battalion, The Royal Regiment of Scotland (4 SCOTS) which was deployed at AAAB between Feb and Jul 17. The report highlighted visa issues that they experienced and recommended that units should work off a more realistic assumption that visas would take a minimum of 6 weeks to be returned from the date of submission. Exhibits 29, 72

1.4.87. On 15 Sep 17, the CO wrote to 51 Inf Bde stating that, with 4 months until their deployment date, 3 SCOTS had submitted all the necessary paperwork for official passports and visas and that everything had been done to ensure visas would be received on time. Exhibit 29

1.4.88. In late Nov 17, it became apparent that the predicted visa output from the Iraqi Embassy was unlikely to be met over the pre-tour leave period (8 Dec 17 - 2 Jan 18); this was declared to 51 Inf Bde and 1 (UK) Div. On 8 Dec 17, projections indicated that, at the time of ToA, only 183 of the anticipated 233 personnel would be able to deploy. This was based on 126 persons with visas on that date, plus an anticipated 57 that were to be received prior to deployment. Exhibits 1, 31-32 Witnesses 3, 14

1.4.89. An estimate was then conducted as to whether 3 SCOTS could deploy given the visa shortage. The CO's preferred CoA was to delay the deployment by 2 weeks to allow more visas to arrive. He was informed by 51 Inf Bde that, because of future plans for 2 RIFLES, the ToA date would not be delayed and to mitigate the risk during ToA, 2 RIFLES would leave behind a small number of personnel to fill gaps until 3 SCOTS personnel could deploy[21]. Exhibits 1, 32 Witness 3

1.4.90. Although the visa issue was ongoing, all personnel expecting to deploy to Iraq, including Capt Sprouting, were ordered to return to Fort George post-Christmas Leave on 2 Jan 18. By this time the number of visas issued had still remained significantly below forecasted numbers, resulting in 3 SCOTS only being able to deploy a total of 161 personnel out of the anticipated 233. Capt Sprouting's Iraq visa had been received by 3 SCOTS, enabling his deployment on 3 Jan 18. Exhibits 1-2 Witness 5

1.4.91. The Panel identified that efforts to establish who held, or was forecast to hold, visas in time to deploy, as planned, with Main Body (MB) 1 on 3 Jan 18 and MB 2 on 9 Jan 18, consumed the majority of 3 SCOTS BHQ staff and sub-unit effort between the end of the MRX and commencement of pre-tour leave. Recognising that much of the focus of the CoC was placed on attempting to rectify this issue, they placed additional trust in their Coy CoCs to ensure that personnel were fully prepared for deployment. Witnesses 3, 5, 14, 30, 32

[21] Subsequently, this CoA allowed the RiP and ToA to occur without incident.

1.4.92. The Panel determines that the 3 SCOTS CoC understood very early in the force generation process that visa delays could be an issue and did all that they could to ensure that visas would be received well in advance of their deployment date. The delay was beyond the control of 3 SCOTS and, indeed, beyond the control of the MOD. As Capt Sprouting's visa arrived on time, the Panel concludes that the pre-deployment visa issues experienced by 3 SCOTS were **not a factor** in the accident, however **observed** that it created additional friction and workload to the 3 SCOTS CoC during their force generation period.

Capt Sprouting's pre-deployment medical issues

1.4.93. **Fort George medical appointment.** Capt Sprouting attended the Fort George Medical Facility on 5 Dec 17, presenting with symptoms associated with [redacted]. The medical nurse stood Capt Sprouting down for 3 days' sick leave, leading into Christmas leave, and advised that, should he feel worse, he should seek medical assistance from his nearest medical facility. Capt Sprouting informed the Ops Offr and the RAO that he had been stood down on sick leave, before he left for home on 5 Dec 17. The RAO subsequently informed OC HQ Coy on 6 Dec 17. Exhibit 11 Witness 4-5, 15, 28

1.4.94. Although the medical nurse was aware that Capt Sprouting was deploying in Jan 18, no follow-on appointment was made. This is not a deviation from any rule or order, however the Panel has learned from independent medical advisors that 'best practice' would have been to organise a further check-up to ensure that he was fit to deploy. However, as Capt Sprouting was informed that he was to seek medical advice should his condition worsen, responsibility was placed on Capt Sprouting to report if his condition worsened and / or he felt unable to deploy. Witnesses 28, 35

1.4.95. [redacted] On 16 Dec 17, Capt Sprouting reported to his local NHS Medical Facility with [redacted]. He was diagnosed with [redacted] which was likely to have caused a [redacted]. He was prescribed medication to help manage the pain. He informed the doctor that he was due to deploy on 3 Jan 18, and that he would discuss this matter with an Army GP. On 20 Dec 17, he attended his local minor injuries unit complaining that [redacted] and that he was in pain. He was advised that the pain was likely [redacted] and to continue taking the medication that had been previously prescribed. Exhibits 13-15, 123

1.4.96. Capt Sprouting deployed to AAAB on 3 Jan 18, and did not declare that he had [redacted] to a Service medic until 5 Jan 18. Although there was no method of formally testing Capt Sprouting's hearing in AAAB, the Panel learned that conversationally he could maintain one-on-one conversations, albeit he would complain that hearing was limited in his right ear. He did, however, find it a challenge conversing in noisy environments. Advice from an Ear, Nose and Throat Specialist suggests that due to the [redacted] it would be unlikely that Capt Sprouting's hearing would have returned to normal by the time that the accident occurred. Exhibit 11 Witnesses 3, 5, 11, 14, 16, 31

1.4.97. As will be discussed in Section 2, the Panel determines that Capt Sprouting was likely struck from behind, and subsequently considered the possibility that he did not hear the vehicles approach him. The Panel assessed that it is more likely than not that Capt Sprouting did not hear the vehicles approaching and, therefore, concludes that Capt Sprouting suffering from a [redacted] was a **contributory factor** in the accident.

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[22] [redacted].

1.4.98. **Notification of** [redacted]. During an interview with the RAO, the Panel learned that Capt Sprouting had informed him of his [redacted] during Christmas leave. The RAO suggested that Capt Sprouting consult the MO when he returned to Fort George. Witness 15

1.4.99. Capt Sprouting declared his [redacted] to the 2 RIFLES MO on 5 Jan 18, the day of his arrival at AAAB. He was subsequently reviewed by MO A on 14 and 27 Jan 18. On each visit, it appeared that the [redacted] was gradually healing. MO A believed that the issue could be monitored in theatre. He believed that, given the administrative role that Capt Sprouting was performing there was no additional risk to him being at AAAB compared with similar duties at Fort George. Although MO A had discussed sending Capt Sprouting home, Capt Sprouting declared that he was keen to remain in AAAB. Additionally, MO A considered that whilst there is no risk to a person flying with a [redacted], as the [redacted] would prevent any build-up of pressure behind the [redacted], there is a greater risk when the [redacted]. This is because a build-up of pressure on a [redacted] and further pain to the patient. Exhibit 11 Witnesses 11, 31

1.4.100. Queen's Regulations for the Army state that officers and soldiers are to notify their unit MO and CO, without delay, of all medical treatment obtained from civilian sources. Although Capt Sprouting informed the RAO of his [redacted], he did not inform MO A, as advised by the RAO. The Panel has been unable to identify the exact reason why he did not do this, however there are 2 possible scenarios: Exhibit 75 Witnesses 3, 13-15, 17

a. As will be discussed later in this section, there was confusion surrounding Capt Sprouting's deployment date and, potentially, he may have intended on reporting this when he returned from Christmas leave.

b. Capt Sprouting did not want to risk being prevented from deploying[23].

1.4.101. MO A stated that, had Capt Sprouting declared his [redacted] to him prior to deploying, it is likely that he would have recommended delaying his deployment date until the [redacted] had recovered. Advice from independent medical advisors suggests that this would have been appropriate, as it would have been inadvisable for 3 SCOTS to allow Capt Sprouting to deploy with this medical issue, had the issue been raised. Witnesses 11, 35

1.4.102. Had Capt Sprouting declared his [redacted] then it is likely that his deployment date would have been delayed until it had healed and therefore he would not have been at AAAB at the time of the accident. The Panel concludes that Capt Sprouting's not declaring his [redacted] to a Service medical advisor until after arriving at AAAB was a **contributory factor** to the accident.

Capt Sprouting's pre-deployment administrative check

1.4.103. The purpose of the Readiness Administrative Checks (RAC) were to check that deploying personnel were administratively organised for deploying. In 3 SCOTS, the Op SHADER Pre-RAC took place throughout Nov 17 to keep a track on personnel's preparations. The formal RAC took place at BHQ on 2 Jan 18, the first day back from Christmas Leave and the day before MB 1 deployed. It was then that staff identified that Capt Sprouting had not returned from leave, as will be discussed later in this Exhibits 76-77, 122 Witnesses 4, 15-16, 30, 32, 33

[23] The Panel established from interviews that Capt Sprouting was determined to deploy, as he had not served in Iraq before.

section. The Adjt instructed a clerk to contact Capt Sprouting, who then drove to Fort George. On arrival, he completed the full RAC process and was issued all relevant documentation and ID discs.

1.4.104. The Panel noted that MES is not an element of the RAC process. Had it been, then it may have offered 3 SCOTS an opportunity to identify that Capt Sprouting's MES precluded him from deployment without conducting a PAP App 26 MRA, as previously discussed.

1.4.105. The Panel also noted that an ODR check is not an element of the RAC process. Had it been, then it may have offered 3 SCOTS an opportunity to ensure that Capt Sprouting had a plan in place to ensure completion of all MATTs training, as previously discussed.

1.4.106. Administratively, Capt Sprouting was not ready to deploy because he did not have a PAP App 26 and he had not completed all necessary MATTs training. Future RAC procedures could be the final opportunity to ensure that all personnel are safe and ready to deploy, therefore the Panel concludes that the pre-deployment administrative process was an **other factor.**

1.4.107. **Recommendation.** Hd Army Personnel Support Group should amend the Unit Administration Manual to ensure that the RAC incorporate 100% check of medical employment status in order to confirm individual medical and dental deployability before issuing Med Pack-up (FMed 965 and FMed 965D (dental). The checks should also confirm completion of all necessary MATTs training.

Confusion surrounding Capt Sprouting's deployment date

1.4.108. Capt Sprouting submitted a leave request on JPA to cover the period 9 Dec 17 – 1 Jan 18; this indicates that he expected to return from Christmas Leave on 2 Jan 18. On proceeding on sick leave on 5 Dec 17, Capt Sprouting was aware that the first 2 flights for deploying personnel would be departing on 3 Jan 18 (MB1) and 9 Jan 18 (MB2). All 3 SCOTS personnel were expected to return from leave on 2 Jan, unless they had sought permission from their CoC to return at a later date. As previously discussed, on 16 Dec 17 Capt Sprouting disclosed to a doctor at his local NHS facility that he was due to deploy on 3 Jan 18.

Exhibits 13, 77
Witnesses 4, 15, 17, 30, 32

1.4.109. It was identified during the final RAC checks, on the morning of 2 Jan 18, that Capt Sprouting had not reported to Fort George. When contacted by a clerk to find out where he was, Capt Sprouting expressed surprise at the phone call and declared that he believed that he was to fly with MB2 on 9 Jan 18. He stated that he believed this to be the case after he had declared to someone that he had [redacted] with MB1 on 3 Jan 18. On completion of the phone call, Capt Sprouting travelled to Fort George to complete the RAC, then returned to his home address to pack the remainder of his kit. Witness interviews suggest that Capt Sprouting appeared to be in a rush during his short period at Fort George.

Witnesses 15-17, 30

1.4.110. Given that Capt Sprouting's input of leave on JPA was 9 Dec 17 – 1 Jan 18, and the disclosure of his deployment date to the NHS Doctor on 16 Dec 17, the Panel determines that, when he was stood down on 5 Dec 17, he was aware that he was to return to Fort George on 2 Jan 18, at the end of 3 SCOTS main leave period. The Panel learned that Capt Sprouting had informed the RAO prior to 2 Jan 18 that he had [redacted] whereupon the RAO informed him that he should report the medical condition to the MO. Given that the CO, 2IC, Ops Offr, HQ Coy OC, Adjt, MO

Exhibits 13, 77
Witnesses 3-5, 14-15, 30

A and RAO all stated that they did not authorise Capt Sprouting to return to Fort George later than 2 Jan 18, it is not known why he believed that authorisation to return at a later date had been given. The Panel was also unable to identify the date that he subsequently believed that he was due to return to Fort George. The Panel was unable to obtain any evidence to suggest that he formally sought permission to deploy with MB2.

1.4.111. Capt Sprouting did not declare his [redacted] to a Service medical advisor until after he arrived at AAAB. It is possible that he did not do this prior to deploying because he wrongly believed that he was deploying on a later date. When he was contacted on 2 Jan 18 and informed that he was due to deploy the following day, he scrambled to collect and pack his kit and opted to deploy even though he was still suffering the effects from his recent medical issues. It is therefore possible that the confusion surrounding Capt Sprouting's deployment date led to him spending a shorter period of time at Fort George and not declaring his [redacted] to a Service medical advisor. However, the Panel is unable to determine the degree to which confusion surrounding Capt Sprouting's deployment date had on the accident.

AAAB

CoC for UK personnel

1.4.112. Op SHADER is the UK contribution to the overarching Operation INHERENT RESOLVE (OIR), the Combined Joint Task Force (CJTF) operation to defeat Da'esh in Iraq and Syria, and to set the conditions to increase regional stability. Exhibit 2

1.4.113. AAAB is a coalition camp that was operated by the Base Operating Systems - Integration (BOS-I) Headquarters. It had responsibility for camp operations and security and was commanded by a US Army OF5[24]. Exhibits 1-2 Witness 14

1.4.114. UKTT(W) was the UK commitment within AAAB. Responsibilities included: building partner capacity (BPC), security, and engineering support. 3 SCOTS took over as the UKTT(W) on 9 Jan 18. Exhibits 1-2

1.4.115. UKTT(W) consisted of: BHQ and Combat Service Support Group, the Security Force (SECFOR), the BPC Coy and the Military Construction Force (MCF) Sqn. Exhibits 1, 4

1.4.116. Commander British Forces (Land) COMBRITFOR(L), an OF5, was established to act as PJHQ Chief Joint Operations' (CJO) agent for UK political and military strategy and the execution of the coalition campaign plan. COMBRITFOR(L) assured the delivery of land forces operational and tactical objectives within the coalition construct and was the overall commander of the Op SHADER National Support Element. Exhibit 4

1.4.117. The 3 SCOTS CO, as CO UKTT(W) and the UK Senior National Representative at AAAB, was OPCON[25] to COMBRITFOR(L). Regarding base business at AAAB, the CO was Deputy Commander Security under TACON[26] to BOS-I, and reported directly to the US OF5 for all associated matters (Figure 1.4.2). Exhibits 2, 27 Witnesses 3, 14

[24] Colonel.

[25] Joint Doctrine Policy (JDP) 3-00: OPCON – Operational Control. Authority delegated to a commander to direct forces assigned so that he may accomplish specific missions or tasks, usually limited by function, time or location; to deploy units concerned, and to retain or assign TACON of those units. It does not include authority to assign separate employment of components of the units concerned nor does it include administrative or logistic control.

[26] JDP 3-00: TACON – Tactical Control. The detailed direction and control of movements or manoeuvres necessary to accomplish missions or tasks.

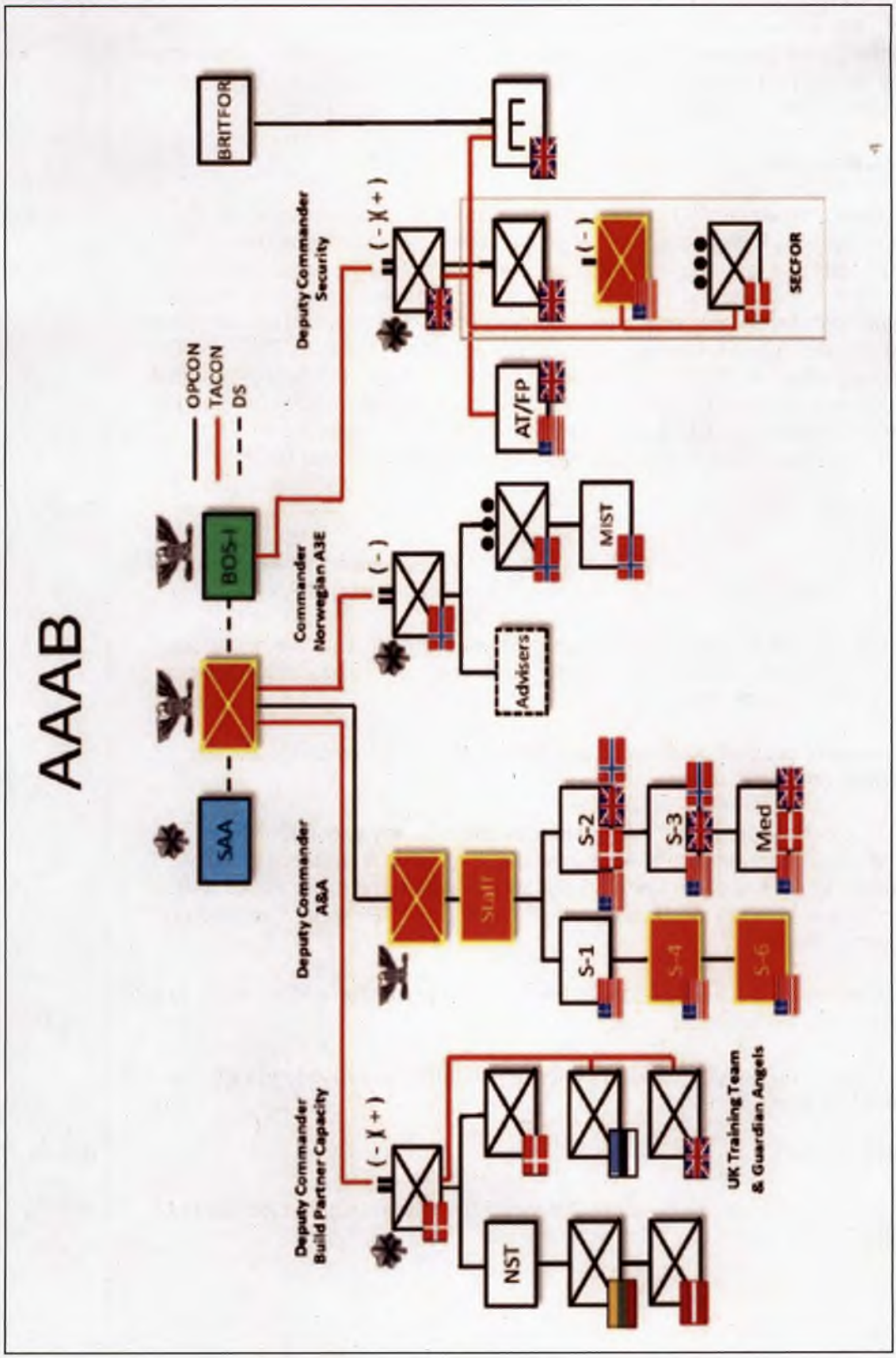

Figure 1.4.2 AAAB Task Organisation.

1.4.118. During the course of the SI, the Panel interviewed the 3 SCOTS CoC and consulted with key personnel from PJHQ and COMBRITFOR(L). All 3 organisations explained to the Panel that they were fully aware of their responsibilities in theatre, and to whom they reported. The Panel, therefore, concludes that the CoC for UK personnel at AAAB was **not a factor** in the accident. Witness 3

Duty Holder Construct

1.4.119. Direction on how the MOD deals with activities that pose a credible and reasonably foreseeable Risk to Life (RtL) is encapsulated in the process known as Duty Holding (DH)[27]. DH is a requirement which sits over and above the legal DoC policy. DH is only to be implemented for military activities which present a justified, credible and reasonably foreseeable RtL and where the DoC and other statutory arrangements are shown to be inadequate for owning, assuring or escalating the risk. DoC and DH are not mutually exclusive: DH is a mechanism used within MOD to capture the most serious risks (where there is RtL) and is therefore a tool to assist MOD in fulfilling the DoC. The responsibilities for DH management are split into 3 levels: Senior Duty Holder (SDH), Operating Duty Holder (ODH) and Delivery Duty Holder (DDH). Exhibits 78-82

1.4.120. The SDH is to: Exhibit 78

a. Promote a positive safety culture which encourages effective operations with RtL reduced to As Low as is Reasonably Practicable (ALARP).

b. Ensure that effective safety management arrangements are resourced, implemented and appropriately managed for the high risk military / Defence RtL activities under his control.

c. Appoint suitably qualified and experienced ODHs to manage the RtL activities under his control.

d. Subject to operational circumstances, discuss any excursions from defined safe operating conditions involving the high risk military / defence RtL activities under his control with his suitably qualified and experienced SMEs and document those discussions with the rationale for any risk mitigation decisions made.

e. Escalate any risks that cannot be mitigated to ALARP and tolerable to the Secretary of State for Defence.

f. Provide an annual report of performance and assurance to the Permanent Under Secretary.

1.4.121. ODHs are to: Exhibit 78

a. Identify all high risk military / Defence RtL activities within their areas of control.

[27] As set out in the Defence Safety Authority publication DSA01.2 *Implementation of Defence Policy for Health, Safety and Environmental Protection* Chapter 3 *Duty Holding*.

b. Identify suitably qualified and experienced SMEs to advise them on the operating and technical aspects of the RtL activities within their areas of control.

c. Ensure that effective safety management arrangements are resourced, implemented and appropriately managed for the RtL activities under their control.

d. Where necessary, appoint suitably qualified and experienced DDH to manage the high risk military / Defence RtL activities under their control.

e. Ensure that relevant inspections / audits take place and that any recommendations / actions are acted upon within the required timescale.

f. Subject to operational circumstances, discuss any excursions from defined safe operating conditions involving the high risk military / Defence RtL activities under their control with their suitably qualified and experienced SMEs and document those discussions with the rationale for any risk mitigation decisions made.

g. Escalate any risks that cannot be mitigated to ALARP to the appropriate SDH.

h. Provide an annual performance and assurance report to the SDH.

1.4.122. DDHs are to: Exhibit 78

a. Identify all high risk military / Defence RtL activities within their areas of control.

b. Identify suitably qualified and experienced SMEs to advise them on the operating and technical aspects of the high risk military / Defence RtL activities within their areas of control.

c. Identify relevant assurance providers / licensing authorities who can permit activities to continue / provide assessments of compliance with statutory duties and / or MOD policy for all the high risk military / Defence RtL activities within their areas of control.

d. Confirm that suitable and sufficient risk assessments, have been completed and safety cases, safe systems of work / safe operating procedures are in place.

e. Ensure that operators are suitably qualified and experienced to be able to carry out the high risk military / Defence RtL activities under their control in accordance with the safety cases, safe systems of work / safe operating procedures.

f. Assure themselves that the workplace is suitable to enable the high risk military / Defence RtL activities under their control to be carried out in accordance with the safety cases, safe systems of work / safe operating procedures.

g. Ensure that any incidents / accidents occurring during the high risk military / Defence RtL activities under their control are investigated and reported in the appropriate way and that any lessons learnt are implemented within their areas of control within the required timescale.

h. Ensure that relevant inspections / audits take place and that any recommendations / actions are acted upon within the required timescale.

i. Subject to operational circumstances, discuss any excursions from defined safe operating conditions involving the high risk military / Defence RtL activities under their control with their suitably qualified and experienced SMEs and document those discussions with the rationale for any risk mitigation decisions made.

j. Escalate any risks that cannot be mitigated to ALARP to the appropriate ODH.

k. Provide an annual performance and assurance report to the ODH.

1.4.123. Until Nov 17, Joint Force Command (JFC) DH Construct was articulated in Standard Operating Procedure (SOP) 0013, with specific instructions relating to UKTT(W) laid down in Fragmentary Orders (FRAGOs). These referred to COMBRITFOR(L) as the DDH, with CJO as the ODH. Exhibits 78, 83-84 Witness 3

1.4.124. SOP 0013 was rescinded on 1 Nov 17 in a letter to Deployed Operational Commanders from CJO which declared that CJO would **not** be ODH for joint operations and that this responsibility would remain with the single-Service organisations. For UKTT(W) at AAAB, this meant that General Officer Commanding 1 (UK) Div would be ODH, with the DDH responsibilities falling to CO UKTT(W), a responsibility familiar to CO 3 SCOTS. The SDH was the Chief of the General Staff (a 4 star Army Officer). Exhibits 78, 82, 85

1.4.125. Confusion existed, however, as the FRAGOs were not updated to reflect the change to the DH construct. This led to conversations between CO and COMBRITFOR(L) to clarify these areas of responsibility. They both agreed that the responsibilities of DDH at AAAB rested most appropriately with CO 3 SCOTS. Therefore, the working arrangement in theatre aligned with policy, despite unnecessary confusion. Exhibits 78, 82-84

1.4.126. The Panel determines that the DH construct that existed at AAAB was fit for purpose at the time of the accident: however, **observed** that, prior to 3 SCOTS deployment, responsibilities were not made clear to the appropriate personnel, leading to unnecessary confusion relating to personal responsibilities. The Panel is satisfied that PJHQ has since ensured that the appropriate orders have been promulgated to deploying Commanders.

1.4.127. Routine activities, such as personal PT on camp, are DoC matters and not those associated with DH. The Panel, therefore, concludes that the implementation of the DH process was **not a factor** in the accident.

UK Health and Safety Assurance at AAAB

1.4.128. CJO's Operational Safety Intent letter listed responsibilities relating to safety and DoC of personnel deployed on Joint Operations. PJHQ's Chief Environmental and Exhibit 85-86

Safety Officer (CESO) was the qualified SME for operational safety and was the focal point for all such matters. He reported to the Chief of Staff (Operations), who had delegated authority for operational safety from CJO.

1.4.129. PJHQ reiterated that, on operations, all Commanders and Line Managers had DoC for the health, safety and welfare of their people and were to manage risks so far as reasonably practicable. The 3 SCOTS CO was aware of this responsibility and fully embraced it. Exhibit 86 Witness 3

1.4.130. In accordance with JSP 375 'Management of Health and Safety in Defence', PJHQ SOP 0012 covered Operational Management Systems, describing the Health and Safety Management System for CJO's areas of control. Figure 1.4.3 shows the PJHQ Op Safety Organisation. Exhibit 86

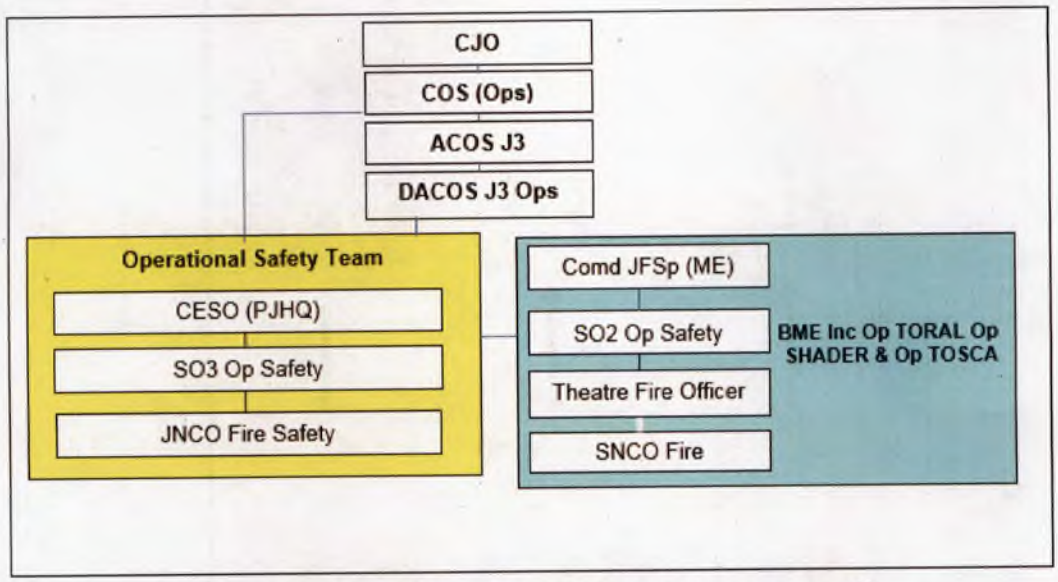

Figure 1.4.3 PJHQ Operational Safety Organisation[28].

1.4.131. Safety compliance at AAAB was evaluated through a 3-tier analysis system as listed in PJHQ SOP 0014 (Figure 1.4.4). These consisted of the following: Exhibit 125

a. **Level 1 (L1) – Subjective Self-Assessment.** L1 assurance measures were self-assessment checks conducted by UKTT(W) quarterly, using a PJHQ self-assessment template and submitted to COMBRITFOR (L) as the in-Theatre representative of the PJHQ Operational Safety Team (OST). Exhibit 125

b. **Level 2 (L2) – Objective Assessment.** L2 assurance measures were conducted utilising a more detailed question set and were conducted by nominated members of the COMBRITFOR(L) organisation, on behalf of PJHQ OST. The checks complemented the L1 outputs by facilitating an objective assessment of UKTT(W)'s living and working environment compared against previous L1 submissions. Exhibit 125

c. **L3 – PJHQ Operational Safety Visits.** L3 audits provided a review of the implementation, integration and functionality of the Operational Safety Exhibit 125

[28] Above unit level.

Management System in each area and were completed by the PJHQ OST. This provided SME level of assurance.

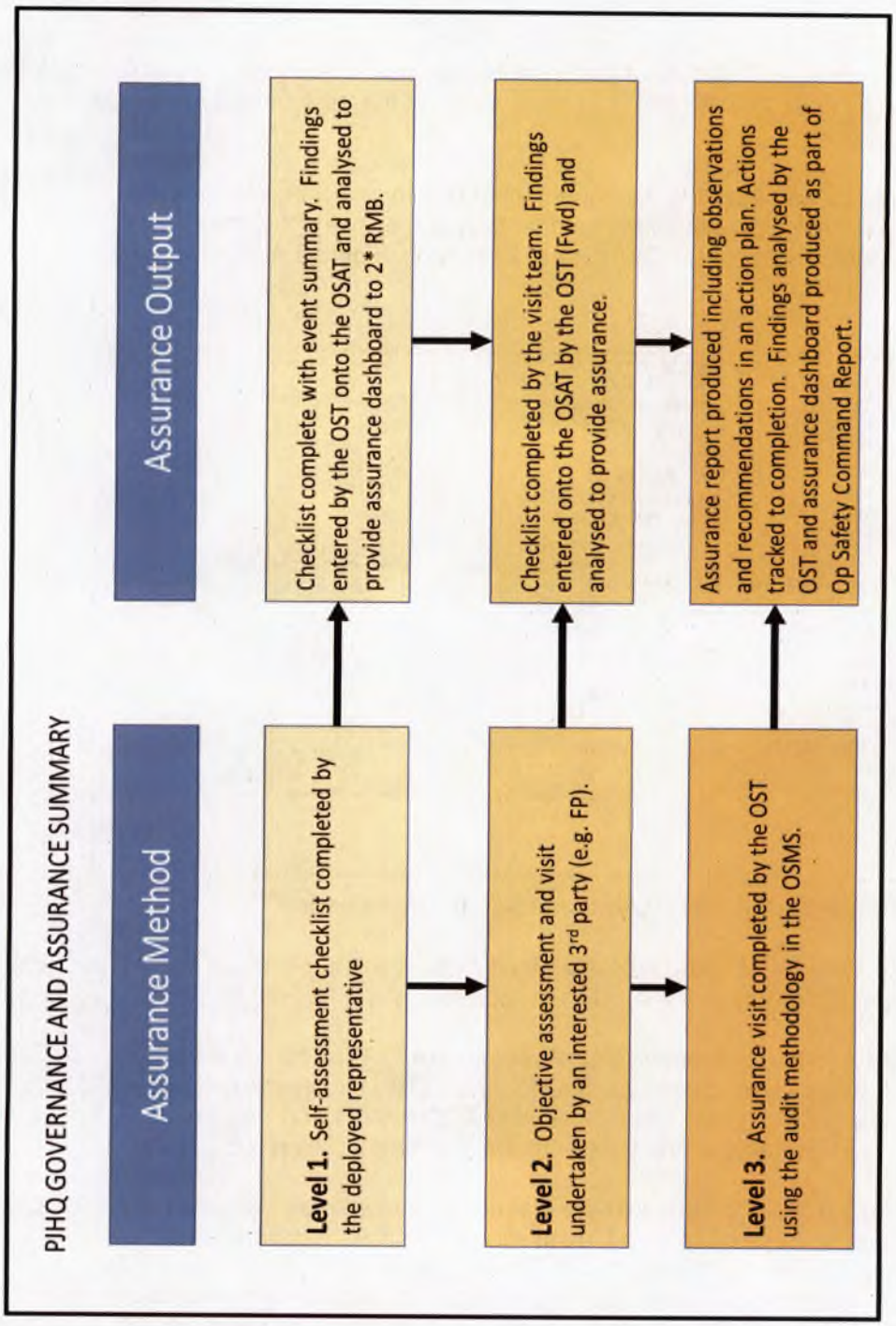

Figure 1.4.4 PJHQ Governance and Assurance Summary.

1.4.132. JSP 375 'Management of Health and Safety in Defence 'Part 2 Vol 2 describes the rating categories used to determine the assurance levels during safety assessments (Figure 1.4.5).

A (Full Assurance) 90% - 100%	There is a sound system of control in place to meet overall system objectives. This is to be maintained and reviewed as necessary to reflect changes in legislation.
B (Substantial Assurance) 75% - 89%	Control systems found to be largely compliant. A small number of important lapses found or some "fine tuning" across the board required. Concentrated action on specific problems required.
C (Limited Assurance) 60% - 74%	The Safety, Health and Environment (SHE) system is considered to be placed at risk due to significant inadequacies of control in a number of critical areas, or over a wide range of control procedures. Senior Management is required to prepare a prioritised SHE Plan.
D (No Assurance) Below 60%	Major deficiencies found over a broad range of areas indicating significant lack of control and leaving the system open to system failure. Senior Management need to direct that these deficiencies are rectified as soon as practically possible.

Figure 1.4.5 Health, Safety and Environmental Protection assurance categories.

1.4.133. All necessary L1 assessments at AAAB were in date at the time of the accident. An L2 assessment took place over the period 18 - 20 Jun 17, followed by an Operational Safety Advisory Visit[29] between 17 - 20 Aug 17. The next L2 assessment was planned to take place in Feb 18, which would have been the first L2 assessment with 3 SCOTS holding responsibility for UKTT(W). Exhibits 87-90

1.4.134. During the Aug 17 L2 assessment, safety at UKTT(W) was assessed as the following: Exhibit 89

- Operational Safety – Substantial Assurance
- Management of Risk – Full Assurance
- Fire – Substantial Assurance
- Environment – Full Assurance
- Electrical – Full Assurance
- Road Safety – Full Assurance
- Weapons – Full Assurance
- Food and Water – Full Assurance

1.4.135. No L3 PJHQ Operational Safety Visit took place at AAAB. Attempting to manage the resources available to him, PJHQ CESO drew information from the L1 and L2 assessments and considered that the risk profile associated with UKTT(W) did not Exhibits 91-92

[29] The operational safety advisory visits utilise the L2 question set from PJHQ SOP0014 but with more emphasis placed on the provision of advice, guidance and, if required, training. Advisory visits were planned to coincide with RiPs to ensure continuity and therefore maintain levels of compliance.

meet a level necessary to determine that an L3 audit of UKTT(W) should take priority over other areas across the Joint Operational Area (JOA).

1.4.136. The Panel opines that, in accordance with JSP 375, the appropriate L1 and L2 assessments took place at UKTT(W) during the period leading up to the accident and that PJHQ exercised appropriate judgement, risk management and understanding of resources available in judging that a L3 Operational Safety Visit was not a priority. This judgement was sound and consistent with the feedback they had received from the L1 and L2 assessments. There is no evidence to suggest that, had a L3 assessment been conducted, then the accident would have been avoided. The Panel therefore concludes that assurances of health and safety against UKTT(W) were **not factors** in the accident.

AAAB Safety Committee

1.4.137. The Safety Committee at AAAB was coordinated by BOS-I and met monthly. The purpose of the committee was to establish the AAAB Safety Programme, to develop and implement guidance to reduce accidents and injuries and to promote a safe working and living environment. It was chaired by the BOS-I Safety Officer, a US Army Chief Warrant Officer; at these meetings and attended by representatives from a number of nations based at AAAB. UKTT(W) was represented by an OF2[30]. Minutes from the committee meetings were taken and distributed. Exhibits 93-95

1.4.138. The most recent Safety Committee meeting prior to the accident took place on 16 Jan 18, which was attended by a representative from UKTT(W). The meeting highlighted the need to ensure that personnel were aware of BDOC emergency contact details. It also discussed the need for speed bumps on Tower Road[31], which implies that it was a road with a recognised increased risk of RTAs, potentially because of the proximity to Tripoli accommodation area, the Dining Facility (DFAC) and because it was a recognised running route. Exhibit 93-94, 96

1.4.139. The Panel determines that the safety organisational structure at AAAB was appropriate and UK personnel were represented at the Safety Committee. The Panel concludes, therefore, that the AAAB Safety Committee was **not a factor** in the accident.

AAAB induction briefs

1.4.140. As the outgoing Unit, 2 RIFLES coordinated the base induction period for 3 SCOTS personnel, including Capt Sprouting, arriving at AAAB during the RiP period. The Reception, Staging, Onward Movement and Integration (RSOI) brief was given to all UK personnel that arrived at AAAB to enable them to attain Full Operating Capability once in theatre. It is distinct from other routine handover elements, which do not begin until completion of the RSOI Brief. Exhibits 1, 16, 97

1.4.141. Capt Sprouting arrived at AAAB on 5 Jan 18, then attended the RSOI Brief delivered by 2 RIFLES later that day. Topics covered during the RSOI brief included: administration, intelligence picture, operations, operational safety, wellness, medical and vehicle safety. Exhibits 1, 16-17, 96

[30] Captain.
[31] Tower Road is where the accident occurred.

1.4.142. UK personnel that arrived at AAAB were also issued with a UKTT(W) information leaflet. Much of the leaflet reinforced the information provided at the RSOI brief, with the following areas covered: actions to take in the event of an attack, camp protection conditions, dress policy, weapon states, medical, dining facilities, administration, welfare services, gym / PT and fire prevention. Exhibits 98-99

1.4.143. **Physical Training.** PT was covered during the Wellness element of the RSOI brief (Figure 1.4.6). The accompanying brief stated that running with headphones was prohibited and that personnel should, ideally, run in pairs. Further, the information leaflet stated that designated running routes existed, personnel were not to conduct running in the dark hours, running with headphones was prohibited and that runners were to be in possession of their ID discs and MOD 90 identification card. Exhibit 96, 98-100

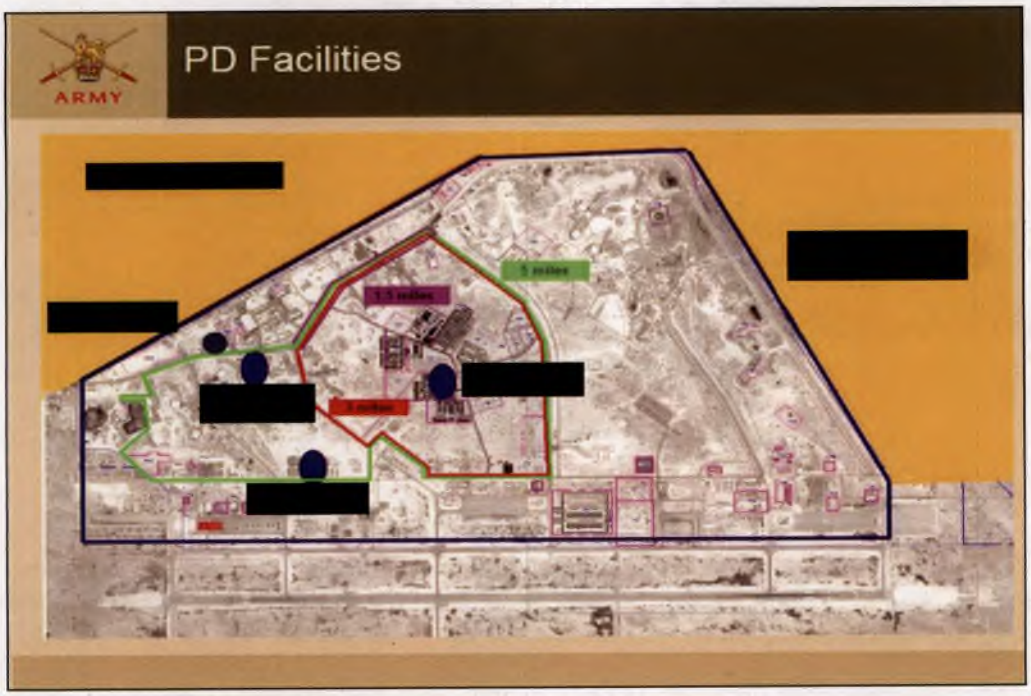

Figure 1.4.6 – UK RSOI Physical Development (PD) briefing slide of designated running routes.

1.4.144. Although it was not included on any PowerPoint slide, through interviews conducted with personnel that attended the RSOI brief with Capt Sprouting, the Panel believes that it is more likely than not that Capt Sprouting was verbally briefed that personnel should run facing oncoming traffic. It should be noted that, post-accident, 3 SCOTS amended the PowerPoint slide briefing notes to ensure that they clearly stated that runners should run facing oncoming traffic. Exhibits 96, 100-102 Witness 2

1.4.145. In the days prior to the accident, Capt Sprouting was observed running on the appropriate side of the road. The Panel concludes, therefore, that it is likely that he was aware that this was the safest method of running. Witness 2

1.4.146. **Base emergency procedures.** Both the RSOI brief and information leaflet listed those actions to be taken in the event of attack and those to be taken in the event of a fire. It stated that, in the event of a fire, personnel were to locate the nearest Kellogg, Brown and Root (KBR) firefighter. There was no mention of a contact telephone number or any way of reporting any other emergency. Exhibits 96, 98-99

1.4.147. As previously discussed, the Safety Committee meeting held 2 weeks prior to the accident highlighted the need to ensure that personnel were aware of BDOC emergency contact details. The RSOI brief and information leaflet did not go into detail about actions to be taken in the event of a medical emergency. Exhibits 93-94, 96, 98-99

1.4.148. The Panel believes that the RSOI brief was comprehensive and placed a considerable emphasis on personnel safety and the need to remain vigilant. It could, however, have included useful information, such as emergency contact details and actions to take in the event of a medical emergency.

1.4.149. As will be discussed in Section 2, the Panel believes that there was confusion about reporting the accident, which could have been a result of personnel not being briefed on actions to take in the event of a medical emergency. Although this, ultimately, did not contribute towards Capt Sprouting's death, the Panel identified that improvements could be made to briefings to include emergency contact procedures and concluded that the lack of contact details in the base emergency procedures was an **other factor**.

1.4.150. **Recommendation.** Chief Joint Operations should direct that induction briefs include 'actions on' and contact details in the event of on-base emergencies in order to ensure that all deployed UK personnel are aware of the correct procedure to follow.

ANALYSIS OF FACTORS SECTION 2 – EVENTS THAT OCCURRED ON 31 JAN 18

Pre-accident

Capt Sprouting's movements

1.4.151. Capt Sprouting attended the medical facility on the morning of 31 Jan 18 to obtain medication to assist with [redacted] associated with his MES. He went for lunch with his clerk at the dining facility and returned to work afterwards. Exhibit 11 Witnesses 11, 16

1.4.152. It had become routine for Capt Sprouting to exercise most afternoons since arriving at AAAB, having stated his intention to lose weight whilst deployed. After running, he would normally shower and change at the TRIPOLI accommodation area before returning to his office. At approximately 1400hr he informed the clerk that he was going for a run and then departed; he appeared in good spirits. Exhibit 1 Witnesses 1, 16

1.4.153. At approximately 1425hr Soldier A met Capt Sprouting at the TRIPOLI accommodation area. Capt Sprouting informed him that he was going for a run. Soldier A reminded Capt Sprouting to apply sun cream and to wear his ID discs, before they both went their separate ways. Soldier A was the last known member of UKTT(W) to see Capt Sprouting alive. Exhibit 1 Witness 1

Capt Sprouting's running route

1.4.154. In his first few days at AAAB, Capt Sprouting was shown by Soldier A the known running routes. After a couple of runs, Capt Sprouting was comfortable with the routes and stated that he preferred to run on his own. He had identified routes that he enjoyed, which varied between 2 and 4 miles. During interviews, the Panel learned that Capt Sprouting routinely ran on the road, facing oncoming traffic. Witnesses 1-2, 16

1.4.155. The Panel was unable to identify witnesses who could confirm which route Capt Sprouting had taken on the day of the accident. His location on the road at the time of the accident will be discussed in more detail later in this section.

Movement of the container

1.4.156. In the early afternoon of 31 Jan 18, at the Supply Support Activity (SSA), several US service personnel attached to the 248th Aviation Support Battalion (ASB) of the 449th Combat Aviation Brigade[32] were directed to prepare a container to be moved to the VOODOO Ramp. By 1300hr a container had been identified and prepared for the move. The total distance of this move was approximately 3km (Figure 1.4.7). Exhibit 1 Witnesses 7, 18-20

Figure 1.4.7 – Planned route of the convoy.

1.4.157. US Driver A requested that US Driver B, a qualified and experienced forklift driver, help move the container using a forklift truck (FLT)[33] (Figure 1.4.8). Witnesses 7, 19-20

[32] A United States Army National Guard unit based in AAAB.
[33] Skytrack Model 6K TPE862.

Figure 1.4.8 – Side view of the FLT.

1.4.158. US Driver B informed US Driver A that he would like an escort vehicle to assist while performing the task as his view would be severely obstructed when carrying the container. US Driver A informed US Driver B that he would be his escort in a Medium Tactical Vehicle (MTV)[34] (Figure 1.4.9). Witnesses 7, 19-20

Figure 1.4.9 – MTV used as the escort vehicle.

[34] The MTV was a M1083A1P2 model which had a 14-foot cargo bay and could carry a 5 US Ton payload. While technically capable of carrying cargo, the model involved in the accident was fitted with seats like the UK Enhanced Seating System (ESS).

1.4.159. The vehicles left the compound at approximately 1440hr with US Driver A leading in the MTV and US Driver B following in the FLT carrying the container. Witnesses 7, 18, 20

1.4.160. **Weather conditions.** The route of the convoy was predominantly proceeding from East to West, with the sun shining from the South West. Weather conditions were dry, there was a light South Easterly wind and visibility was good. Exhibits 1, 18-19 Witness 9

1.4.161. **Requirement for Vehicle Commander in MTV.** In 2004 a US Safety of Use Message was released which highlighted potential safety hazards found during the testing of MTV with the Armoured Protection Kit fitted, particularly related to reduced visibility. It mandated the use of an assistant driver in the cab. Additionally, Appendix D to the 248th ASB maintenance SOP stated that 'All vehicles, tactical and non-tactical, will have one qualified operator and a vehicle commander physically in the vehicle for the duration of the dispatch'. It further stated that all US personnel were to maintain situational awareness and self-discipline when they performed their duties and must: Exhibits 103-105

a. Understand and apply risk management.

b. Execute controls directed by their leaders and perform to standards.

c. Carry risk management over into training and activities, both on and off duty.

d. Look out for others. Anyone has authority to halt something that is unsafe. Every individual should consider themselves a safety officer in performing their duties.

1.4.162. US Driver A, who was suitably qualified to operate the MTV, was alone during the convoy and at the time of the accident; there was no second person acting as a vehicle commander / assistant driver in accordance with extant requirements. As the Panel has been unable to interview the drivers, it could not identify the reason why US Driver A elected to operate the MTV in this manner. From statements taken following the accident, there appeared to be several personnel at the SSA during the organisation of the convoy. The Panel believes it is unlikely that no one was available to act as a vehicle commander / assistant driver. It appears that many of the US personnel were aware that visibility from within the MTV was limited and that an assistant driver was required when operating the vehicle. Given the seniority of US Driver A (a Staff Sergeant), it is likely that he was also aware of the policy regarding the requirement for a vehicle commander. Had US Driver A opted to operate the MTV with a vehicle commander / assistant driver, then the Panel opines that this would have been a safer operation as it is more likely that the occupants of the MTV would have been aware of other road users, including Capt Sprouting. The Panel concludes that the lack of a vehicle commander / assistant driver was a **contributory** factor in the accident. Exhibit 25 Witnesses 7, 18-20, 24

1.4.163. **Serviceability of the MTV.** From the Equipment Inspection and Maintenance Worksheet (EIMW) associated with the MTV on 31 Jan 18, it appears that there were several minor defects. These included damaged windshield wipers and delamination of the windscreens. Despite these defects, the vehicle was considered serviceable according to the EIMW. Had a vehicle commander / assistant driver been present during the convoy, then there would have been an additional person able to watch out for obstructions and pedestrians, thereby mitigating the decision to use a vehicle with restricted visibility. However, US Driver A was alone in the MTV at the time of the accident, so it is possible that these defects had the potential to obscure his vision Exhibit 106 Witness 7

whilst operating the vehicle. The Panel concludes that serviceability (excluding visibility) of the MTV was **not a factor** in the accident. Visibility from the MTV will be discussed later in this section.

1.4.164. **Serviceability of the FLT.** From the EIMW associated with the FLT on 31 Jan 18, it appears that there were 9 faults noted against it, all of which were minor, indicating that the vehicle was serviceable. When the FLT was inspected again by the Bde Maintenance Supervisor on 3 Feb 18, 3 days after the accident, 14 faults were identified. Of note, it identified that the fire extinguisher was not charged, rendering the FLT as unserviceable. Had this been the case on 31 Jan 18, then the vehicle should have been classed as inoperable until after the defect had been corrected. Exhibit 106 Witness 7

1.4.165. The Panel is unable to determine the charged state of the fire extinguisher on the day of the accident. Therefore, it is, unable to identify whether or not the FLT should have been classed as 'serviceable'. Ultimately, however, this would not have had any bearing on how the FLT was operating. The Panel concluded that serviceability of the FLT was **not a factor** in the accident. Exhibit 106

1.4.166. **Visibility from the MTV.** Photographs obtained by the DANPOL in the aftermath of the accident showed that the MTV windscreen was dirty with delaminating film. The photographs also showed that the defective window wiper, as previously discussed, wiped less than its designed parameters. Exhibits 106-109

1.4.167. Elements of the MTV driver's view were obscured by dirty windows, sun visors, window wipers settled in the middle of each window, and the windscreen was delaminating (Figures 1.4.10, 1.4.11 and 1.4.12). Visibility was further reduced by a large central windscreen column which held vehicle equipment. Exhibits 107-109

Figure 1.4.10 - Front view of the MTV.

Figure 1.4.11 - View from driver's position in the MTV looking ahead.

Figure 1.4.12 - View from driver's position of the MTV looking half right.

1.4.168. The view from the driver's position in the MTV was obscured, particularly at the right-hand side. The Panel opines that visibility may have been further reduced by dirt on the windscreen and bright sunshine from the front-left arc. As the Panel has been unable to interview US Driver A, it is unable to determine whether or not poor visibility from the MTV made spotting other road users more difficult. It is, therefore, unable to determine whether it was a factor in the accident.

Exhibits 108-113
Witness 24

1.4.169. **Visibility from the FLT.** According to US Driver B, the container was lifted 3-5 feet above the ground while driving. He had side-shifted the container a little to the right on the FLT forks for a better view out of the windshield (Figure 1.4.13). However, the right arc was significantly obscured by the container (Figure 1.4.14).

Exhibits 114-115
Witnesses 7, 21

Figure 1.4.13 - Front view of the FLT.

Figure 1.4.14 - View from driver's position in the FLT[35].

[35] The container would have been lifted 3-5 feet higher during the convoy.

1.4.170. The overall view from the FLT was significantly obscured, limited to just a small arc at the left of the windscreen, thus escalating the risk to pedestrians and other road users. After the accident, US Driver B disclosed that he did not see road users that were positioned on the right-hand side of the road during the convoy until he passed them. The Panel determines, therefore, that the poor visibility from the FLT made spotting other road users more difficult and an accident more likely. The Panel concludes that obscured visibility from the FLT was a **contributory** factor.

1.4.171. **Avoidance measures.** Statements given to investigators following the accident confirm that the drivers had developed avoidance measures to take in the event of approaching pedestrians or obstructions on the road. In such an event US Driver A in the MTV, when approaching pedestrians or obstructions, would swerve in an unambiguous manner which would then be imitated by US Driver B in the FLT, who would swerve at the same point in the road. This plan required that US Driver B had to have clear visibility of the MTV and that the obstructions would remain static. This happened at least 2 times during the convoy, prior to the accident. It should be noted that there was no radio contact between the US Drivers during the convoy because it was deemed unsafe for FLT users to operate a handheld radio during its operation. Witnesses 7, 18

1.4.172. The Panel believes that by generating this mitigating plan, the US drivers had clearly identified that there was an additional risk to other road users due to the conduct of this move. However, the mitigation plan based on swerving to avoid obstructions and other road users was not failsafe as it relied solely on the operator of the MTV as the escort vehicle. US Driver A, whose visibility may have been obscured, operated the vehicle without a vehicle commander / assistant driver. The lack of a vehicle commander / assistant driver significantly compromised this method of avoiding action. The Panel, therefore, concludes that inadequate avoidance measures were a **contributory** factor in the accident.

1.4.173. **US Driver A's focus of attention at the time of the accident.** At the time of the accident, the drivers had been conducting the convoy for approximately 45 mins and were approaching their final turn to the left to enter their destination at VOODOO Ramp. Several factors may have resulted in focussing US Driver A's attention on the left arc of the direction that he was travelling. At the time of the accident, the upcoming turn was approximately 70m ahead to the left, and he had visibility of their destination on his left-hand side. He was also likely using his left-wing mirror to check the FLT driving behind him. The sun was shining from the SW meaning that he would have had to concentrate more on this area to maintain visibility through the dirty and delaminating windows, as previously discussed. Exhibits 25, 110, 116 Witnesses 7, 18, 21

1.4.174. It is possible that a combination of these factors resulted in US Driver A paying less attention to the right side of the MTV, from which he already had restricted visibility. The Panel, however, has been unable to interview US Driver A and therefore cannot determine whether his focus of attention at the time of the accident was a factor in the accident. Exhibits 108-112

1.4.175. **Requirement to conduct the move.** The Panel has been unable to find evidence to suggest that the movement of the container at this time and in this configuration was mission critical. The Panel determines that this move could have been postponed until a more suitable method of moving the container, such as on the back of a flat-bed truck, and / or the presence of a vehicle commander in the MTV were available. Witnesses 7, 19-20

1.4.176. **Overall Analysis of the conduct of the move.** As discussed throughout this section, the Panel identified that the method of the movement of the container performed by US Drivers A and B, who were both suitably qualified and experienced to operate their respective vehicles, led to several factors that increased the risk of an accident:

a. The lack of a vehicle commander / assistant driver in the MTV resulted in there being less likelihood of the driver being aware of other road users.

b. Visibility from the MTV **may** have been restricted further by environmental factors and a dirty windscreen.

c. Visibility from the FLT was significantly obscured, escalating the risk to pedestrians and other road users.

d. The avoidance measures that the drivers were to take in the event of approaching other road users was not failsafe.

There is no evidence that a dynamic risk assessment was conducted prior to the move and, from statements obtained by US CID from US Driver B after the accident, it appears that this method of moving containers around AAAB had been utilised previously. It is, therefore, possible that this was a routine violation of US SOPs and had become accepted behaviour. Ultimately, these deviations from SOPs resulted in 2 vehicles with limited visibility proceeding on a moderately to highly used road (as discussed later in this section), and part of a designated running route, with inadequate planned avoidance measures. Overall, with these elements combined, the conduct of the movement of the container was a **causal** factor in the accident.

Environmental

1.4.177. **Location.** The accident took place on Tower Road, South of the TRIPOLI accommodation area (Figure 1.4.15).

Exhibits 1, 20
Witnesses
21-22, 34

Figure 1.4.15 – Location of the accident

1.4.178. Tower Road is a wide, metalled road that allows for the flow of traffic in both directions. It is a primary means of transportation and used by moderate to high levels of traffic. It also runs parallel to the flight line and taxiway. It is the main route connecting the SSA and VOODOO Ramp. The TRIPOLI accommodation area is adjacent to the North of Tower Road, surrounded by concrete blast walls. In addition, Tower Road is a main access route to the DFAC and the Green Bean coffee facility, a high foot-fall establishment. Tower Road is also highlighted as part of one of the main running routes in AAAB. Along both sides of Tower Road, at the scene of the accident, the ground is compacted sand. It is solid enough to walk and run on and there is no evidence of any obstructions which would force pedestrians to walk or run on the road (Figure 1.4.16). Witness 21

1.4.179. At an early stage of the Service Inquiry the Panel requested access to all video evidence of the scene that was recorded by video systems that support the safety of the base. A number of witnesses reported that there was no video evidence of the accident scene. Witnesses 23-24, 36

Figure 1.4.16 - The View of Tower Road by the scene of the accident, facing West.

1.4.180. **Noise from runway.** Tower Road runs parallel to the taxiway and main runway at AAAB (Figure 1.4.17). Measured from satellite imagery, the taxiway is approximately 460m South of Tower Road, and the main runway is approximately 760m South of Tower Road. The Panel considers that the distance between Tower Road and any aircraft movements would have reduced most aircraft noise. The Panel, therefore, believes that it is unlikely that aircraft noise would have reduced Capt Sprouting's ability to hear road traffic on Tower Road. The Panel concludes that aircraft noise from the runway and taxiway was **not a factor** in the accident. Exhibit 117

Figure 1.4.17 – Tower Road in relation to runway

The Accident

1.4.181. At approximately 1528hr, whilst proceeding from East to West on Tower Road, immediately South of the TRIPOLI accommodation area and at a speed of approximately 6-8 mph[36], US Driver B observed something pass from under the container and felt a bump under the FLT. He stopped the vehicle, lowered the container, switched off the engine and exited to check what it was. He found Capt Sprouting [redacted]

Exhibit 1
Witnesses 7, 21, 34

1.4.182. US Driver A, who was approximately 70m ahead of the FLT and about to turn left onto VOODOO Ramp, noticed that the FLT had stopped. He saw US Driver B exit and walk behind the FLT. US Driver A turned the MTV and approached to see what was going on. When he saw US Driver B crouching beside Capt Sprouting shouting for help, US Driver A quickly drove to VOODOO Ramp to seek help, which will be discussed further under the section 'Reporting the Accident'.

Exhibit 118
Witnesses 7, 21

Capt Sprouting's location on Tower Road

1.4.183. The accident took place on the North side of Tower Road, close to Capt Sprouting's accommodation[37], approximately one hour after he stated, to Soldier A, his intention to go for a run. Capt Sprouting was wearing sports clothing and not wearing headphones. These factors led the Panel to believe that it is likely that he was at the final stage of a run and was heading towards his accommodation. With no known witnesses, the Panel attempted to piece together Capt Sprouting's final movements and road positioning before the accident and considered a number of possible scenarios.

Exhibit 20
Witnesses 21-22

[36] US Driver B stated to the DANPOL that he believed he was driving at this speed, although the Panel have learned that there was no speedometer in the FLT.
[37] Which was approximately 250m away.

1.4.184. **Crossing Tower Road from North to South.** The area South of where the accident took place is an area for US operations, a site which British service personnel would have no reason to visit. Further, his destination was his accommodation, situated on the North side of Tower Road. The Panel, therefore, opines that it is unlikely that Capt Sprouting was attempting to cross Tower Road from the North side to the South side at the time of the accident. Exhibit 119 Witnesses 1, 14

1.4.185. **Crossing Tower Road from South to North.** Had Capt Sprouting been crossing Tower Road from South to North, then the Panel believes that it is likely that he would have been visible to both drivers, as their view was less restricted on their left side. It is therefore more likely that avoiding action would have been taken by either of the drivers and / or Capt Sprouting in this scenario. The Panel does not believe, therefore, that he was attempting to cross Tower Road at the time of the accident. Exhibits 110, 112-115, 119 Witness 7

1.4.186. **Heading East along Tower Road.** The Panel believes that it was highly unlikely that Capt Sprouting was heading East facing oncoming traffic. Had the vehicles involved in the accident been approaching from his front, their size and slow speed would have made them highly noticeable to Capt Sprouting, providing him time and opportunity to move out of their way. Exhibit 107 Witness 1

1.4.187. **Heading West along Tower Road.** As previously discussed, the accident occurred, approximately one hour after Capt Sprouting stated, to Soldier A, his intention to go for a run. This, along with his proximity to his accommodation, suggests that it is likely that he was at the final stage of a run, heading towards his accommodation. Previous behaviour suggests that Capt Sprouting would usually run facing oncoming traffic. It is, therefore, possible that he had finished running and had started a 'cool-down' period by walking in a Westerly direction along the North side of Tower Road towards his accommodation. The Panel was unable to find evidence to corroborate, or disprove, this hypothesis, however determines that this was the most likely hypothesis. Exhibit 56 Witnesses 1, 9, 12, 21-22

1.4.188. **Health episode.** As will be discussed later in this section, Capt Sprouting's Post Mortem suggested that there were no pre-existing health issues that would have suggested that Capt Sprouting had had a health episode immediately prior to the accident. It is unlikely, therefore, that he was lying prone on Tower Road prior to the convoy approaching him. Exhibit 56

1.4.189. **Decision to be on the road.** As previously discussed, Capt Sprouting could have opted to walk or run on the packed sand area adjacent to Tower Road, as it was wide enough, there were no obstructions and the ground was solid. The Panel is unable to determine the reason why Capt Sprouting may have positioned himself on the road, with his back to oncoming traffic. Furthermore, the Panel is unable to confirm why he did not seem to notice the vehicles approaching him from behind. As discussed in Section 1, Capt Sprouting had suffered a slight degradation of hearing in the years preceding this deployment, which would have been exacerbated by his [redacted] These elements may have contributed to him not being able to hear the convoy approach from behind. It is also possible that Capt Sprouting did hear the vehicles but had confidence that they would move around him on the wide road. Ultimately, the Panel concludes that Capt Sprouting's apparent personal decision to walk or run along Tower Road not facing oncoming traffic was a **contributory** factor in the accident. Exhibits 11, 13-14, 25 Witness 21

DNA samples

1.4.190. Following the accident, US CID carried out blood identification measures and DNA extraction procedures on the FLT and MTV. Although it was clear that the FLT had struck Capt Sprouting, DNA was also found to be present on the front of the MTV. However further testing could not identify the source due to mixture complexity and / or insufficient amount of DNA detected. A partial DNA profile was obtained from a swab of the interior wheel hub of the MTV, however this too proved inconclusive due to an insufficient amount of DNA detected. Exhibit 120

1.4.191. The MTV left the scene of the accident immediately afterwards as US Driver A drove it when he went to get help. It is unclear whether it continued to be utilised as normal after the accident, and the swabs were not taken until 2 days after the accident occurred. The Panel cannot discount, therefore, that the MTV may have struck Capt Sprouting prior to him being run over by the FLT, although there is not clear evidence of this. Exhibit 120 Witness 7

Likely accident scenarios

1.4.192. Based on the method of the movement of the convoy, the movements of Capt Sprouting, the DNA samples and environmental factors, for this accident to occur the Panel hypothesise that there are 2 most likely accident scenarios that explain how Capt Sprouting came to be run over:

Scenario 1 – Capt Sprouting was struck by the MTV prior to being run over by the FLT

1.4.193. Both drivers had restricted visibility from their vehicles, and the Panel understands that neither driver saw Capt Sprouting immediately before the accident occurred.

1.4.194. In this hypothesis, the MTV, driven by US Driver A, struck Capt Sprouting from behind as he was making his way along the Northern edge of Tower Road. The impact from contacting a person at a low speed in a vehicle the size and mass of an MTV may not have generated a noticeable 'bump' to indicate impact. It is unlikely, therefore, that US Driver A would have been aware that his vehicle had made contact with Capt Sprouting. Having inspected a similar MTV during a technical visit to AAAB, the Panel also noted that there is room below an MTV for it to pass over a person of Capt Sprouting's size without making further contact. It is possible, therefore, that Capt Sprouting was hit by the MTV and either passed along the side of the vehicle, or was knocked below and passed under it, ultimately resulting in him being left prone on the road.

1.4.195. During this time, US Driver B would have been focussing his attention on the route being taken by the MTV, watching out for manoeuvres that would indicate avoidance of pedestrians or obstructions. As the MTV did not swerve, US Driver B would have continued his course along the right-hand side of the road and would have driven over Capt Sprouting who was lying on the road having been struck by the MTV. Photographs of the FLT taken after the accident, which was positioned at the point where US Driver B stopped, shows that he had been driving the FLT at the right-hand edge of the road (Figure 1.4.13), the position where a pedestrian opting to use the road would most likely transit.

Scenario 2 – Capt Sprouting was struck by the FLT only

1.4.196. In this hypothesis, US Driver A positioned the MTV slightly more centrally on Tower Road when there was no immediate oncoming traffic. The Panel had witnessed this 'centering' by vehicles occurring when it conducted its technical visit to AAAB and studied vehicles transiting Tower Road. The effect of 'centering' the MTV in such a manner (whether deliberate or not) could have broadened the margin along the edge of the road which would have provided a safe zone for pedestrians to move along. In this scenario, US Driver A would have passed Capt Sprouting making his way along the edge of Tower Road, but without seeing or striking him.

1.4.197. US Driver B drove the FLT at the immediate right-hand edge of Tower Road. His concentration would have been on the MTV and he would have had no visibility of the right arc of the direction that he was travelling. As the MTV did not demonstrate avoiding behaviour, the FLT maintained its route and made contact with Capt Sprouting.

1.4.198. **Accident scenario conclusion.** With the Panel unable to identify any witnesses to the accident, and having been unable to interview the US drivers, the Panel concludes that both scenarios are equally as likely.

Post-accident

Medical assistance received

1.4.199. At approximately 1535hr Dutch Medics A and B, who had been out running, came upon the scene. [redacted] — Exhibit 20 Witnesses 7-9, 21

1.4.200. At 1537hr the KBR Fire Department received a report of an accident on Tower Road near the DFAC. A US Firefighter, who was in the DFAC, heard the call and proceeded to the scene with a medical kit and assisted with First Aid. The medical kit included a Resuscitative Endovascular Balloon[38] and cylinder of oxygen. — Exhibit 20 Witness 9, 22

1.4.201. At 1539hr the KBR Fire Service arrived at the scene with [redacted] — Exhibit 20 Witnesses 8-9, 22-25

1.4.202. At 1545hr the Base Aid Station (BAS) received a pre-alert of a patient who had been involved in an RTA and prepared to receive the patient by assembling its trauma team, led by MO B. — Witness 12

1.4.203. At 1548hr the ambulance arrived at the scene of the accident. [redacted] — Exhibits 1, 20 Witnesses 8-9

[38] Resuscitative endovascular balloon occlusion of the aorta is used in trauma victim resuscitation, to elevate blood pressure and limit fluid infusion, while other procedures aimed to stop the bleeding are performed.

1.4.204. At 1556hr Capt Sprouting was transferred to the Trauma Team at the BAS. It was reported to MO B that the patient had been found in cardiac arrest having been run over. [redacted] At 1558hr, resuscitation was stopped and MO B declared life extinct. — Exhibits 1, 22 Witnesses 12, 22

1.4.205. Having sought advice from independent medical advisors, the Panel believes that the First Aid response was entirely appropriate and that the personnel undertaking it were suitably qualified and experienced to do so. However, the injuries that Capt Sprouting sustained in the accident were not survivable. The Panel therefore concludes that the immediate First Aid received was **not a factor** in the death of Capt Sprouting. — Witnesses 8-9, 12, 35

Reporting the accident

1.4.206. The accident occurred at approximately 1528hr. Immediately after the accident, US Driver A left the scene in the MTV and proceeded to the VOODOO Ramp flight line to seek help. Although the Panel was unable to identify who he reported the accident to, as will be discussed further, it did not initiate emergency response procedures from the BAS. He returned to the scene of the accident a short while later. — Witnesses 8-9, 21-22

1.4.207. At approximately 1530hr, 3 personnel from 1st Space Brigade[39] passed the scene and observed US Driver B kneeling over Capt Sprouting. They informed their Commander via radio and requested medical assistance. They were informed that their Commander would contact the BAS to get medical assistance and an ambulance. When the Dutch Medics, who came upon the scene having been out running, arrived they were assured by a member of 1st Space Brigade that the incident had been reported and that medical assistance was on its way. — Witnesses 7-8, 21-22

1.4.208. **Accident + 9 mins.** At 1537hr, the KBR Fire Department received a report of an RTA on Tower Road, near the DFAC. The US Firefighter, who had been in the DFAC, heard the call, proceeded to the scene on foot and assisted with First Aid. Additional members from KBR Fire Service arrived at the scene in a fire engine at 1539hr, approximately 11 mins after the accident. — Exhibit 20 Witnesses 7-9, 22

1.4.209. **Accident + 12 mins.** At approximately 1540hr, information about the accident was passed to 4 members of the United States Air Force Security Forces (USAF SF) by a contractor. One member ran to KBR Fire Dispatch to ensure that they had been informed whilst the other 3 made their way to the scene in a car. When they arrived, at approximately 1541hr, they cordoned off the East side of Tower Road, directing traffic away from the scene. — Witnesses 23-25

1.4.210. **Accident + 17 mins.** At approximately 1545hr, 17 minutes after the accident and 8 minutes after KBR Fire Department were informed, BAS received a pre-alert of a patient who had been involved in an RTA. They assembled their trauma team and dispatched an ambulance. Concurrent to this activity, at 1546hr, one member of the USAF SF contacted the BDOC, which up to this point had not been made aware of the accident. — Exhibit 20 Witnesses 12, 21-25

[39] The US Army Space and Missile Defense Command / Army Forces Strategic Command's 1st Space Brigade have personnel detached to AAAB.

1.4.211. **Accident + 20 mins.** At 1548hr, 20 minutes after the accident, the ambulance arrived at the scene, departing with Capt Sprouting at 1553hr. At 1552hr the BDOC Watch Commander was contacted again and asked if the DANPOL had been informed; prior to this point they had not been. Witnesses 23-25

1.4.212. **Accident + 32 mins.** At approximately 1600hr a DANPOL patrol driving East on Tower Road noticed blue lights from the fire engines and proceeded toward the scene. They contacted the DANPOL station commander by radio to inform him about the incident. On arrival at the scene they took control and began interviewing witnesses. Witnesses 21-25

1.4.213. A visual timeline of how the accident was reported is at Figure 1.4.18.

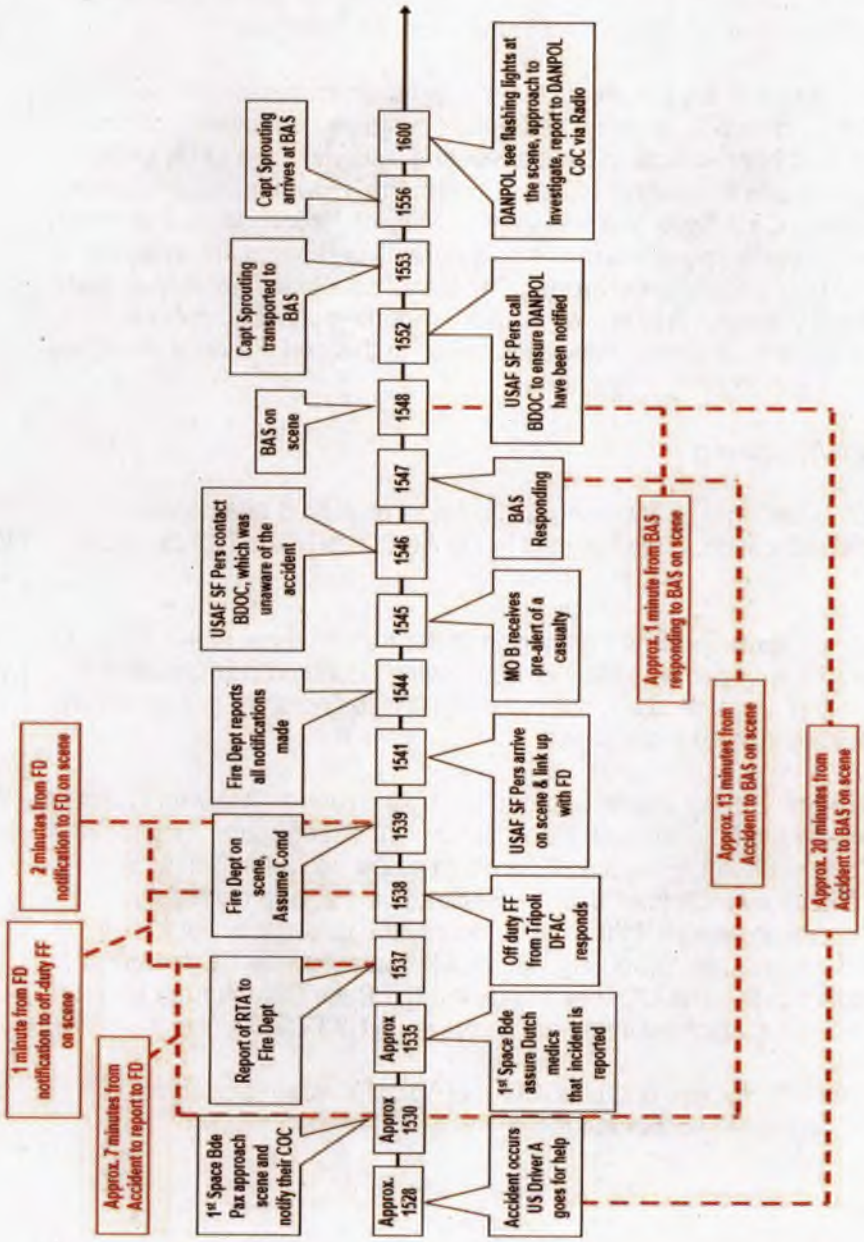

Figure 1.4.18 – Accident reporting timeline

1.4.214. The Panel was unable to interview the personnel involved in the immediate aftermath of the accident, and therefore relied on information in the DANPOL report, US CID statements and KBR fire log to put together this timeline. From this information, the Panel opines that there was confusion immediately following the accident about how to get assistance as quickly as possible. The personnel from the 1st Space Brigade stated that they reported the accident to their Command. It took 9 minutes from the accident occurring until the KBR fire department was informed and on their way to the scene. It was a further 7 minutes until the BAS was aware and an ambulance was dispatched. In total, it took 20 mins from the accident occurring until the ambulance arrived at the scene.

Exhibit 20
Witnesses 8-9, 21-25

1.4.215. As identified in Section 1, it had already been discussed at the most recent Safety Committee meeting that an area that required improvement was to ensure that all personnel on the base knew who to contact in the event of an accident.

Exhibits 93-94

1.4.216. The Panel opines that the length of time it took for an ambulance to be dispatched to the scene was too long. Had the injuries sustained not been fatal and urgent access to BAS had been critical to Capt Sprouting's survival, the delay could have prevented timely access to specialist trauma treatment. However, as discussed in this section, the injuries Capt Sprouting's sustained were non-survivable. The Panel determines that improvements should be made to ensure all personnel are aware of emergency contact details in operational areas. The Panel concludes, therefore, that reporting of the accident was an **other factor**, as poor reporting could contribute negatively in future accidents. A recommendation linked to this conclusion is proposed in Section 1 under Base Emergency Procedures.

Identification of Capt Sprouting

1.4.217. Whilst Capt Sprouting was receiving CPR, it was observed that he was not wearing any form of identification. This resulted in Op ACCOUNTABLITY[40] being called at 1555hr.

Exhibit 20
Witnesses 23-25

1.4.218. At 1556hr, Capt Sprouting was transferred to the trauma team at the BAS. At 1558hr, MO B declared Capt Sprouting life extinct. Having observed a UK football team tattoo on him, MO B dispatched a runner to UKTT(W) to find someone who may be able to assist with identifying the deceased.

Exhibit 22
Witnesses 8-9, 12

1.4.219. At around 1605hr, Soldier B was approached by the runner. He was informed of the casualty and agreed to help with the identification. Whilst en route, he passed Soldier A, explained the situation and asked if he could assist, to which Soldier A agreed. Soldier A accompanied Soldier B to the BAS, arriving at approximately 1625hr. On arrival, they were asked if they could identify the deceased; both immediately identified him as Capt Sprouting. Soldier B contacted the CO to inform him of Capt Sprouting's death. The CO then contacted the Base Commander to inform him that the individual involved in the accident was a UKTT(W) officer.

Witnesses 1-3

1.4.220. At 1630hr, the UK element of Op ACCOUNTABILITY was reported as complete, with all UK personnel accounted for.

Exhibit 1

[40] Op ACCOUNTABILITY is a method utilised to perform a quick but comprehensive count of all personnel at AAAB. Personnel are briefed during the RSOI briefs that when Op ACCOUNTABILITY is called they are to report to their CoC immediately.

1.4.221. On 2 Feb 18, Soldiers A and B packed Capt Sprouting's belongings for his repatriation to the UK. During this time, they found his ID discs within his laundry bag. Exhibit 124 Witnesses 1-2

1.4.222. Op ACCOUNTABILITY was called as soon as it was discovered that a casualty had been found without any form of identification. Within 35 minutes all UK personnel were accounted for. The Panel, therefore, concludes that this was good practice. Had Soldiers A and B not been available to identify Capt Sprouting as the deceased within such a short period, Op ACCOUNTABILITY would have highlighted that Capt Sprouting was absent and subsequently highlighted his name to AAAB authorities relatively quickly. The Panel concludes, therefore, that this demonstrated positive execution of accounting for UK personnel in a timely manner. Exhibits 1, 121 Witnesses 2, 36

Cause of death

1.4.223. The Post Mortem stated that Capt Sprouting died because of injuries to his [redacted]; these injuries were non-survivable and in keeping with significant crush injuries through being run over. Exhibits 22, 56 Witness 12

1.4.224. There was no significant pre-existing natural disease identified that could have contributed to his death. Capt Sprouting was not under the influence of alcohol at the time of his death. Pain relief medication was detected in his blood sample in keeping with the history of pain relief medication that he had been prescribed. No other drugs were detected. The Panel concludes, therefore, that Capt Sprouting died as a result of being struck by one, or both, of the vehicles. Exhibit 56

Summary of findings

1.4.225. The Panel highlighted a number of accident factors from the SI. They are as follows:

1.4.226. **Causal Factor**.

a. Deviations from US SOPs resulted in 2 vehicles with limited visibility proceeding on a moderately to highly used road, and part of a designated running route, with inadequate planned avoidance measures. Overall, the conduct of the movement of the container was a **causal** factor in the accident.

1.4.227. **Contributory Factors**.

a. The Panel assessed that it is more likely than not that Capt Sprouting did not hear the vehicles approaching and, therefore, concludes that Capt Sprouting suffering from a perforated eardrum was a **contributory factor** in the accident.

b. Had Capt Sprouting declared his perforated eardrum then it is likely that his deployment date would have been delayed until it had healed and therefore he would not have been at AAAB at the time of the accident. The Panel concludes that Capt Sprouting's not declaring his perforated eardrum to a Service medical advisor until after arriving at AAAB was a **contributory factor** to the accident.

c. Had US Driver A opted to operate the MTV with a vehicle commander / assistant driver, then the Panel opines that this would have been a safer

operation as it is more likely that the occupants of the MTV would have been aware of other road users, including Capt Sprouting. The Panel concludes that the lack of a vehicle commander / assistant driver in the MTV was a **contributory** factor in the accident.

d. The overall view from the FLT was significantly obscured, limited to just a small arc at the left of the windscreen, thus escalating the risk to pedestrians and other road users. After the accident, US Driver B disclosed that he did not see road users that were positioned on the right-hand side of the road during the convoy until he passed them. The Panel determines, therefore, that the poor visibility from the FLT made spotting other road users more difficult and an accident more likely. The Panel concludes that obscured visibility from the FLT was a **contributory** factor.

e. The Panel determines that the mitigation plan based on swerving to avoid obstructions and other road users was not failsafe as it relied solely on the operator of the MTV as the escort vehicle. US Driver A, whose visibility may have been obscured, operated the vehicle without a vehicle commander / assistant driver. The lack of a vehicle commander / assistant driver significantly compromised this method of avoiding action. The Panel, therefore, concludes that inadequate avoidance measures were a **contributory** factor in the accident.

f. The Panel concludes that Capt Sprouting's apparent personal decision to walk or run along Tower Road not facing oncoming traffic was a **contributory** factor in the accident.

1.4.228. **Other Factors.**

a. The Panel determines that improvements could be made to JPA that would allow the CoC better oversight of personnel's MES changes. The Panel further determines that responsibilities over cross-checking MES between JPA and PAPMIS should be more clearly defined in AGAI 57. The Panel concludes, therefore, that undertaking checks of personnel MES prior to deploying was an **other factor**.

b. Administratively, Capt Sprouting was not ready to deploy because he did not have a PAP App 26 and he had not completed all necessary MATTs training. Future RAC procedures could be the final opportunity to ensure that all personnel are safe and ready to deploy, therefore the Panel concludes that the pre-deployment administrative process was an **other factor.**

c. The Panel opines that the length of time it took for an ambulance to be dispatched to the scene was too long. Had the injuries sustained not been fatal and urgent access to BAS had been critical to Capt Sprouting's survival, the delay could have prevented timely access to specialist trauma treatment. However, as discussed in this section, the injuries Capt Sprouting sustained were non-survivable. The Panel determines that improvements should be made to ensure all personnel are aware of emergency contact details in operational areas. The Panel concludes, therefore, that reporting of the accident was an **other factor**, as poor reporting could contribute negatively in future accidents.

1.4.229. **Observations.**

a. The Panel **observed** that there are significant improvements that should be made to the Fort George Medical Facility, as identified in the CQC report in Jan 18, which will continue to be monitored by the CQC and 1 (UK) Div.

b. The Panel **observed** that the pre-deployment visa issues experienced by 3 SCOTS created additional friction and workload to the 3 SCOTS CoC during their force generation period.

c. The Panel determines that the DH construct that existed at AAAB was fit for purpose at the time of the accident: however, **observed** that, prior to 3 SCOTS deployment, responsibilities were not made clear to the appropriate personnel, leading to unnecessary confusion relating to personal responsibilities.

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PART 1.5

Recommendations

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Part 1.5 – RECOMMENDATIONS

	Analysis Reference
1.5.1 **Introduction.** The panel recommends the following:	
a. **Director Armed Forces Personnel Policy** should work with the Joint Medical Group to develop a direct and immediate electronic link between the medical categorisation of personnel and the required actions of their Chain of Command, in order for the chain of command to understand better the medical deployability of its personnel, in the context of readiness.	1.4.72
b. **Senior Health Advisor (Army)** should revise Army General Administrative Instructions 57 in order to clearly define where the responsibility lies for cross-checking personnel's Medical Employment Standard on JPA and PAPMIS prior to deployment.	1.4.73
c. **Hd Army Personnel Support Group** should amend the Unit Administration Manual to ensure that Readiness Administration Checks incorporate 100% check of medical employment status in order to confirm individual medical and dental deployability before issuing Med Pack-up (FMed 965 and FMed 965D (dental). The checks should also confirm completion of all necessary MATTs training.	1.4.107
d. **Chief Joint Operations** should direct that induction briefs include 'actions on' and contact details in the event of on-base emergencies in order to ensure that all deployed UK personnel are aware of the correct procedure to follow.	1.4.150

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PART 1.6

Convening Authority Comments

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PART 1.6 – CONVENING AUTHORITY COMMENTS

1.6.1. Capt Sprouting was an experienced soldier within the Adjutant General's Corps (AGC) (Staff and Personnel Support (SPS)) branch. His journey through the ranks of the Army to Warrant Officer and further selection for LE Commission was a testament to his abilities, and he was clearly an individual that the Army had intended to invest in further.

1.6.2. Whilst on an operational tour at Al Asad Airbase (AAAB), Iraq, Capt Sprouting was involved in a road traffic accident whilst he was conducting personal physical exercise. The injuries that he sustained in the accident were not survivable.

1.6.3. As the Convening Authority for this Service Inquiry (SI), I am grateful to the President and his Panel for the thoroughness of their Report in meeting their Terms of Reference. SIs that involve personnel from our coalition partners add a layer of complexity with regard to respecting their national legal processes. In addition to this complexity, there were no witnesses to the accident and, therefore, the Panel had to rely on a balance of probabilities based on the information that was available in order to present 2 credible hypotheses as to exactly what happened. I agree with the findings of the Report and with the recommendations it makes.

1.6.4. The accident was caused by personnel not following recognised Standard Operating Procedures, which resulted in 2 vehicles with limited visibility proceeding along a road, which was part of a designated running route, with inadequate planned avoidance measures. The personnel operating these vehicles were attached to the US Army and resulting action and safety recommendations are, therefore, a matter for the US Army to coordinate. At the time of publishing this report, the US Criminal Investigation Department is continuing their investigation and should they determine that there is evidence of a crime punishable under the Uniform Code of Military Justice, the case will be brought to a Trial Counsel to determine if a court-martial is appropriate. The US individuals were given the opportunity to comment on the findings of the Service Inquiry, however they declined to comment. Despite the fact that these are US-led investigations, it is important that we, the British Armed Forces , learn from this episode. Specifically, never to lose focus on safety, particularly on operations, and remind ourselves that safety procedures exist for a reason: for our safety and the safety of those around us.

1.6.5. The Panel found that Capt Sprouting had not suffered a medical episode prior to the accident and determined that it was most likely that he was walking along the road, with his back to oncoming traffic. Although it is not possible to determine the reason behind this apparent decision, it should act as a further reminder to personnel that they should never take their own safety for granted, and to ensure that they remain vigilant at all times.

1.6.6. Trained medics from the Dutch Army came upon the scene by chance shortly after the accident and attempted resuscitation for approximately 20 minutes until his arrival at the Base Aid Station. I commend both their efforts in attempting to resuscitate Capt Sprouting during this period.

1.6.7. The Panel noted that there was a delay in the length of time it took for an ambulance to be dispatched to the scene of the accident. Had the injuries sustained not been fatal and urgent access to BAS had been critical to Capt Sprouting's survival, the delay could have prevented timely access to specialist trauma treatment. Operational Commanders should ensure that all personnel are fully aware of actions to take in the event of any realistic emergency; it may one day be the difference between someone's survival or not.

1.6.8. At the time of the accident, Capt Sprouting was not in possession of his ID discs, thus making it more difficult to identify him after the accident. Although Op ACCOUNTABILITY positively accounted for UK personnel in a timely manner, the need to carry out Op ACCOUNTABILITY could have been avoided. Service Personnel must be reminded of the importance of wearing their ID discs on operations.

1.6.9. The Panel gave extensive focus to the period leading up to 3 SCOTS deploying to AAAB. It is pleasing that the force generation process was, for the most part, very comprehensive and successful. However, circumstances beyond their control - namely the delay in receiving Iraqi entry visas - contributed additional stress to the Command Team during an already demanding period. It is extremely important that Command Teams do not lose focus of the basic elements of pre-deployment planning. Although not related to the accident itself, Capt Sprouting deployed to AAAB having not completed his mandated pre-deployment training. This training exists to ensure that personnel are ready in all respects for the demands placed on them, particularly on operations. Whilst it is recognised that Capt Sprouting only spent a small number of days physically attached to 3 SCOTS at Fort George, it was recognised at an early stage that he would be deploying and his training shortfalls should, therefore, have been recognised and rectified.

1.6.10. Capt Sprouting, who was Medically Limited Deployable (Permanent), deployed to AAAB without a mandated Medical Risk Assessment being completed by his Command Team. Whilst unrelated to the accident itself, it is further evidence that final pre-deployment checks and controls were not being conducted thoroughly. Although it was not ideal for Capt Sprouting to be joining 3 SCOTS so close to their pre-deployment leave period and subsequent deployment, the reality of the manning structure of the Armed Forces means that circumstances such as these are entirely realistic. Command Teams, therefore, need to ensure that robust checks exist to assure themselves that all of their personnel, regardless of how long they have been at the unit, are ready to deploy.

1.6.11. The Service Person has an important part to play in this process also. Although the force generation period is a very busy one, it is imperative that everyone is aware of what is required of them, and to highlight any potential shortfalls early. Capt Sprouting was aware of his training shortfalls, and his requirement to declare his medical status to his Chain of Command, but he chose not to do so.

1.6.12. In the weeks leading up to deploying, Capt Sprouting contracted an illness and was stood-down by the Fort George Medical Facility. He then suffered an infection and additional medical complications during his pre-deployment leave period. He sought medical care from a civilian medical facility close to his family home. However, he did not subsequently report these issues to a Service Medical Adviser until after he arrived at AAAB. Had he reported these issues then it is likely that his deployment date would have been delayed until he was medically cleared to. Although individuals may feel that they know best what they are and are not able to do, it is the responsibility of the Command, not the individual, to make the decision as to their suitability to deploy. The Command Teams have a far more comprehensive understanding of the operational climate in which they are deploying to and, therefore, are best placed to make a comprehensive risk-based assessment as to the individual's suitability to deploy and what impacts that it may have on the individual and the unit as a whole. On the day of the accident Capt Sprouting should not have been at AAAB, and would not have been had he declared his perforated ear drum. Although the impact of this relating to the accident itself is not clear, it was an additional unnecessary risk.

1.6.13. This has proved a useful SI. Its findings are widely applicable and should be understood across commanders at all levels. This spans those responsible for personnel in operational theatres or environments that rely on multinational, Joint or contracted cooperation where total responsibility and Duty Holding boundaries are not as clear cut as we are traditionally accustomed to.

1.6.14. Overall, the conduct of the movement of the container was the single **causal** factor in the accident. A total of 6 **contributory** factors made the tragic accident more likely to happen and situated Capt Sprouting in harm's way. It is upon these factors that the lessons should be learned by Defence through the implementation of the recommendations. As with any accident involving a fatality, the outcome is a tragic loss for the affected families and o the Army of a valued Officer.

1.6.15. On behalf of the Defence Safety Authority I offer my condolences to Capt Sprouting's family, friends and loved ones.

DG DSA

