Defence
Safety
Authority

Service Inquiry

Death of a Soldier from a Gunshot Wound at Camp Taji, Iraq

2 January 2017

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/02/17/TAJI

Dated 19 Jun 19

DG DSA

SERVICE INQUIRY INVESTIGATION INTO THE FATALITY THAT OCCURRED IN CAMP TAJI, IRAQ ON 2 JANUARY 2017.

1. The Service Inquiry Panel formally convened at Ministry of Defence Main Building, Whitehall, London at 1500hr on Friday 20 January 2017 by order of the DG DSA for the purpose of investigating an accident involving Lance Corporal Scott Hetherington of the 2nd Battalion, The Duke of Lancaster's Regiment (King's, Lancashire and Border) on 2 Jan 17 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 REPORT	Part 2 RECORD OF PROCEEDINGS
Part 1.1 Covering Note and Glossary	Part 2.1 Diary of Events
Part 1.2 Convening Orders & TORs	Part 2.2 List of Witnesses
Part 1.3 Narrative of Events	Part 2.3 Witnesses Statements
Part 1.4 Findings	Part 2.4 List of Attendees
Part 1.5 Recommendations	Part 2.5 List of Exhibits
Part 1.6 Convening Authority Comments	Part 2.6 Exhibits
	Part 2.7 List of Annexes
	Part 2.8 Annexes
	Part 2.9 Schedule of Matters Not Germane to the Inquiry
	Part 2.10 Master Schedule

PRESIDENT

[Signature]

[redacted]
President
2 LANCS TAJI SI

MEMBERS

[Signature]

[redacted]
Royal Air Force Member
2 LANCS TAJI SI

[Signature]

[redacted]
Army Member
2 LANCS TAJI SI

GLOSSARY

Acronym/ Abbreviation	Explanation
1 (UK) Div	1st (United Kingdom) Division
1 RIFLES	1st Battalion, The Rifles
2 LANCS	2nd Battalion, The Duke of Lancaster's Regiment (King's, Lancashire and Border)
2IC	Second-in-Command
2 MERCIAN	2nd Battalion, The Mercian Regiment
3 (UK) Div	3rd (United Kingdom) Division
4 Inf Bde	4th Infantry Brigade
42 Inf Bde	42nd Infantry Brigade
AAR	After Action Review
ACMT	Annual Combat Marksmanship Test
ACOS	Assistant Chief Of Staff
ACSO	Army Command Standing Order
Adjt	Adjutant
AGAI	Army General Administrative Instructions
AKX	Army Knowledge Exchange
ANZAC	Australian and New Zealand Army Corps
AP	Air Publication
AQMS	Artificer Quartermaster Sergeant
ARB	All Ranks Brief
ATSB	Australian Transport Safety Bureau
Bde	Brigade
BG	Battle Group
Bn	Battalion
C-IED	Counter – Improvised Explosive Device
Capt	Captain
CASEVAC	Casualty Evacuation
CBRN	Chemical Biological Radiological and Nuclear
CESO	Chief Environment and Safety Officer
CIC	Combat Infantrymans' Course
CJFLCC-I	Combined Joint Forces Land Component Command - Iraq
CJO	Cheif Joint Operations
CJTF	Combined Joint Task Group
CLM	Command Leadership and Management
CMT	Combat Medical Technician A specialist military trade within the Royal Army Medical Corps capable of assisting with the management of surgical, medical and psychiatric casualties from the onset of the condition until the casualty is admitted to a hospital offering specialist care
CO	Commanding Officer
Comd	Commander
COMBRITFOR	Commander British Forces
Coy	Company An Army formation consisting of 3 platoons (Pl) and a Headquarters (HQ), a total of approximately 120 soldiers
Cpl	Corporal
CSM	Company Sergeant Major
CQB	Close Quarters Battle

	Tactical concept involving physical confrontation between several combatants
CQM	Close Quarters Marksmanship
CQMS	Company Quartermaster Sergeant A Colour Sergeant responsible for the logistics and equipment care of a Company
D Cap	Director of Capability
D Pers	Director of Personnel
DAIB	Defence Accident Investigation Branch
DCC	Dismounted Close Combat
DCCT	Dismounted Close Combat Trainer
DCGS	Deputy Chief of the General Staff
DE&S	Defence Equipment & Support A trading entity of the Ministry of Defence that manages projects to buy and support equipment and services
DH	Duty Holder
DDH	Delivery Duty Holder
DG	Director General
DJW	Director Joint Warfare
DLIMS	Defence Lessons Identified Management System
DOLS	Defence Organisational Learning Strategy
DOSR	Defence OME Safety Regulator
DSA	Defence Safety Authority
FAIR	Flowchart Analysis of Investigation Results
FGen	Force Generation
FHD	Foxhound (Armoured Vehicle)
FIRIC	Falkand Islands Roulement Infantry Company
FP	Force Protection
FRAGO	Fragmentary Order
GOC	General Officer Commanding
Gp	Group
GPMG	General Purpose Machine Gun
GSP	General Service Pistol
Hd	Head
HF	Human Factors
HFACS	Human Factors Analysis and Classification System
HoC GM	Head of Capability Ground Manoeuvre
Hrs	Hours
HSE	Health & Safety Executive
HQ	Headquarters
HQ NE	HQ North East
HQ NW	HQ North West
IDR	Initial Deployment Report
ILI	Inter-Limb Interaction
IM	Information Management
IPCC	Intergovernmental Panel on Climate Change
ISF	Iraqi Security Forces
ITC(C)	Infantry Training Centre (Catterick)
JNCO	Junior Non-Commissioned Officer
JPA	Joint Personnel Administration

JSP	Joint Service Publication
KLE	Key Leadership Engagement
KM	Knowledge Management
KSF	Kurdish Security Forces
L131A1	Designation for Glock 17 GSP
L85A2	Designation for SA80 rifle
LA	Learning Account
LCpl	Lance Corporal
LFMT	Live Fire Marksmanship Training
LFSO	Land Forces Standing Order
LFTT	Live Fire Tactical Training An exercise that provides realistic training for soldiers in all the skills and procedures required for Operations
Lt Col	Lieutenant Colonel
MAA	Minor Administrative Action
Maj	Major
MATT	Military Annual Training Tests
MID	Munitions Incident Database
MOD	Ministry of Defence
MRTS	Marker Round Training System
MRX	Mission Rehearsal Exercise
MST	Mission Specific Training
MTMC	Mission Training and Mobilisation Centre
MXS	Mission Exploitation Symposium
ND	Negligent Discharge
NLIMS	Navy Lessons Information Management System
NSI	Non-Statutory Inquiry
NSP	Normal Safety Precautions
OC	Officer Commanding
ODH	Operating Duty Holder
OF	Officer NATO designator of rank: OF 5 – Colonel or equivalent
OIR	Operation INHERENT RESOLVE
OME	Ordnance, Munitions and Explosives
OPCON	Operational Control
OpO	Operational Order
OR	Other Rank NATO designator of rank: OR 3 – Lance Corporal or equivalent
ORBAT	Order of Battle
OSP	Operational Shooting Policy The training manual that provides direction and guidance for the regime of weapon handling performance and usage to prepare soldiers for Operations
OSW	Operational Staff Work
PAM 21	Pamphlet Number 21, Dismounted Close Combat-Training The training regulations governing planning, conduct and supervision of training with AFV, IWS and pyrotechnics
PDT	Pre-Deployment Training
PJHQ	Permanent Joint Headquarters
Pl	Platoon

PNCO	Potential Non-Commissioned Officer
QM	Quartermaster
QMSI	Quartermaster Sergeant Instructor
R2E	Role 2 Enhanced Deployed medical facility capable of undertaking invasive surgery
RAF	Royal Air Force
RAMC	Royal Army Medical Corps
RAWO	Regimental Administration Warrant Officer
RCO	Range Conducting Officer
RE	Royal Engineers
REME	Royal Electrical and Mechanical Engineers
RMAS	Royal Military Academy Sandhurst
RMP	Royal Military Police
RSM	Regimental Sergeant Major
RSOI	Reception, Staging and Onward Integration
RtL	Risk to Life
Sgt	Sergeant
SAC	Senior Aircraftsman
SASC	Small Arms School Corps
SDH	Senior Duty Holder
SECR	Safety and Environmental Case Report
SEET	Safety Environment Enhancement Tool
SI	Service Inquiry
SIB	Special Investigations Branch
SME	Subject Matter Expert
SMO	Senior Medical Officer
SNCO	Senior Non-Commissioned Officer
SO	Standing Orders
SOP	Standard Operating Procedure
SQEP	Suitably Qualified and Experienced Person
Sqn Ldr	Squadron Leader
TACON	Tactical Control
TF	Task Force
TG	Task Group
TLB	Top Level Budgetholder
ToA	Transfer of Authority
Trg	Training
TTLFTT	Transition To Live Fire Tactical Training
TRiM	Trauma Risk Management
UD	Unintentional Discharge
UKTT	United Kingdom Training Team Teams established at locations in Iraq to deliver training to ISF: UKTT (Centre), UKTT(Kurdistan), UKTT(Taji) and UKTT(Besmaya)
USAD	Unintentional Small Arms Discharge
USEA	Unit Safety and Environmental Advisor
WHT	Weapon Handling Test
WO	Warrant Officer Two-level Army rank: WO First Class (WO1) or WO Second Class (WO2)
WUF	Weapon Unloading Facility

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PART 1.2

Convening Order

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Defence Safety Authority

Service Inquiry Convening Order

20 Jan 17

SI President	Hd Defence AIB
SI Members	DSA Legad

Copy to:

PS/SofS MA/	DPSO/CDS	MA/Comd JFC
Min(AF) PS/	MA/VCDS	MA/CFA
Min(DP) PS/	NA/CNS	MA/GOC 1 (UK) Div
Min(DVRP)	MA/CGS	Dir DDC
PS/PUS	PSO/CAS	CO 2 LANCS

DSA DG/SI/02/17 – CONVENING ORDER FOR THE SERVICE INQUIRY INTO THE FATALITY THAT OCCURRED IN THE ACCOMMODATION BLOCK AT CAMP TAJI, IRAQ ON 2 JAN 17

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 1000L on Friday 20 January 2017.

4. The SI Panel comprises:

President: [redacted]

Members: [redacted]

5. The legal advisor to the SI is [redacted] (DSA MAA 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 Defence AIB 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 [redacted].

Original Signed

Sir R F Garwood
Air Mshl
DG DSA – Convening Authority

Annex:

A. Terms of Reference for the SI into the Fatality that Occurred in the Accommodation Block at Camp Taji, Iraq on 2 Jan 17.

Annex A To
DSA DG/SI/02/17 Convening Order
Dated 20 Jan 17

TERMS OF REFERENCE FOR THE SI INTO THE FATALITY THAT OCCURRED IN THE ACCOMMODATION BLOCK AT CAMP TAJI, IRAQ ON 2 JAN 17.

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

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

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

   c. Examine what policies, orders and instructions were applicable and whether they were appropriate and complied with.

   d. Determine the state of serviceability and protective systems of relevant equipment.

   e. Establish the level of training, relevant competencies, qualifications and currency of the individuals involved in the accident.

   f. Investigate and comment on relevant fatigue implications of individuals' activities prior to the matter under investigation.

   g. Determine any relevant equipment deficiencies.

   h. Confirm that Post Incident Management procedures were carried out correctly and that they were adequate.

   i. Determine and comment on any broader organizational and/or resource factors.

   j. 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 a 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.

3. During the course of your investigations, should you identify a potential conflict of interest between the Convening Authority and the Service Inquiry, you are to pause work and take advice from your DSA Legal Advisor and DG DSA.

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PART 1.3

Narrative of Events

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PART 1.3 – NARRATIVE OF EVENTS

All timings are local (GMT +3)

Synopsis

1.3.1. On 2 Jan 17, the Force Protection Platoon (FP Pl) conducted small arms weapon cleaning within their accommodation in Camp Taji, Iraq. When complete, and following a session in the gymnasium, Lance Corporal (LCpl) Hetherington and Soldier A returned to their shared room at approximately 1545hrs to relax prior to a briefing. A single pistol shot was heard at approximately 1610hrs. Medics arrived immediately, entered the room, found LCpl Hetherington slumped on his bed and administered first aid. He was extracted to the Role 2 Enhanced (R2E) medical facility within minutes. Despite immediate surgery, for a single 9mm gunshot wound to the abdomen, LCpl Hetherington was pronounced dead at 1653hrs.

Context

1.3.2. The 2nd Battalion, The Duke of Lancaster's Regiment (King's, Lancashire and Border), (2 LANCS) was based in Weeton Barracks, Blackpool, Lancashire. 2 LANCS was a light-role infantry battalion (Bn) specialising in dismounted close combat operations on foot and from light vehicles. Infantry Bns such as 2 LANCS are capable of operating in a variety of terrain either as a Battle Group (BG) or as independent Company Groups (Coy Gp). Until 21 Nov 16, 2 LANCS was part of 42nd Infantry Brigade (42 Inf Bde) before resubordinating to 4th Infantry Brigade (4 Inf Bde).

Operation SHADER, Iraq

1.3.3. As part of the United Kingdom's (UK) role in the 68-member global coalition committed to defeating Daesh in Iraq within the US-led Operation INHERENT RESOLVE (OIR), 2 LANCS were nominated to lead the United Kingdom Training Team (Centre) Battle Group (UKTT(C) BG) for Operation SHADER 4 in the Army Commitments Programme 1/16. Exhibit 001

1.3.4. Headquarters 1st (United Kingdom) Division (HQ 1 (UK) Div) issued an Op SHADER Force Generation order on 12 Jul 16 to provide direction for the generation of the capability required for this on-going contribution to operations in Iraq. This directed 42 Inf Bde to generate 2 LANCS to assume the role of UKTT (C) BG from 1st Bn, The Rifles, (1 RIFLES) in order to build Iraqi Security Forces (ISF) and Kurdish Security Forces (KSF) capacity through the delivery of practical training. Exhibit 002

1.3.5. In this role, elements of 2 LANCS from Blenheim Coy Gp, Chindit Coy Gp and HQ Companies provided Force Protection (FP) to other British troops in Taji and Besmaya delivering training to ISF in basic infantry skills, weapons maintenance, battlefield medical treatment and military engineering. In the Kurdish Region, 2 LANCS delivered both infantry and medical training as well as enabling Counter-Improvised Explosive Device training.

1.3.6. The UKTT(C) Headquarters (HQ) and three subordinate UKTT were based in 3 major locations in support of ISF: Erbil, in the Kurdistan region, Taji and Besmaya, both near Baghdad, as illustrated in Figure 1.

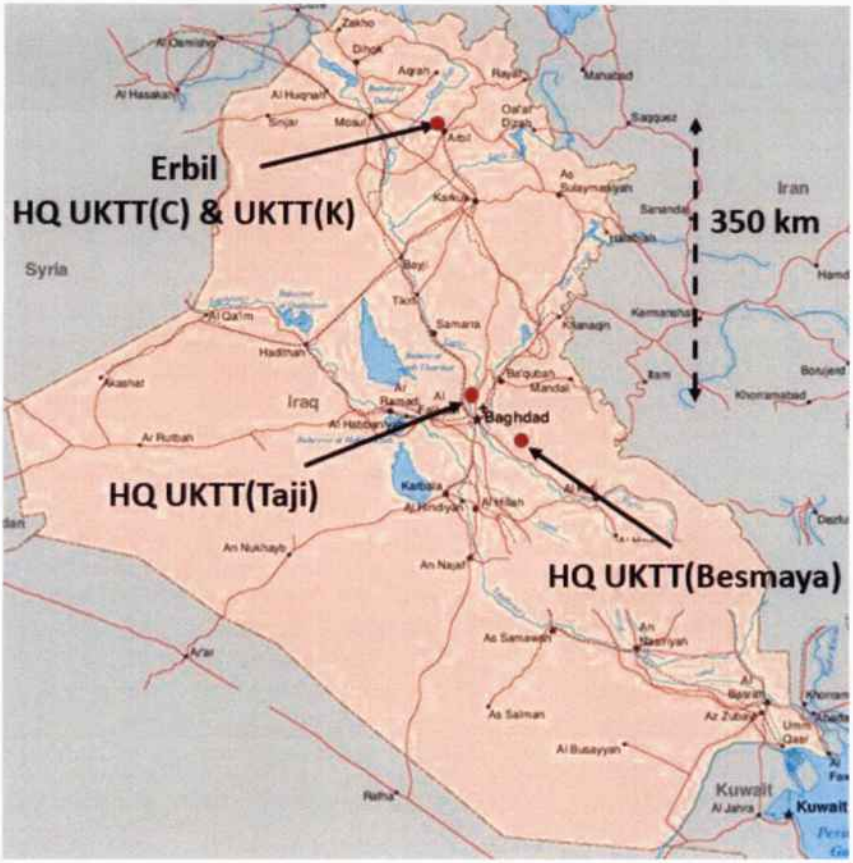

Figure 1: 2 LANCS HQ and training locations, Iraq, 2016

1.3.7. The UKTT(C) HQ staff in Erbil included the Commanding Officer (CO), Regimental Sergeant Major (RSM), Battle Group Logistics Officer, Senior Medical Officer, Adjutant (Adjt), Intelligence Officer (IO), Regimental Quartermaster Sergeant (RQMS) and Regimental Administration Warrant Officer.

Command and Control

1.3.8. UK forces in Iraq operated within complicated Command and Control (C2) arrangements. Subordinate to the 3* Commander Joint Operations (CJO) at Permanent Joint Headquarters (PJHQ), the OF5 Commander British Forces (COMBRITFOR) provided oversight and Operational Control (OPCON) to all UK land-focussed force elements in the theatre of operations (below the rank of OF5). Exhibit 003

1.3.9. UKTT(C) HQ maintained OPCON over the geographically separated UKTTs conducting Build Partner Capacity operations. In parallel, the UKTTs were under the Tactical Control (TACON) of the US-led 3* Combined Joint Task Force (CJTF), based in Kuwait and the 2* Combined Joint Forces Land Component Command Iraq (CJFLCC-I), based in Baghdad. [redacted].

1.3.10. The reality in Camp Taji was that a mix of joint and combined armed British personnel, operating under the command of an Infantry Company Commander (OF3), were working to both the [redacted] and UKTT(C), alongside a US Task Force, to train a variety of Iraqi forces. With no permission to venture out of the base, or accompany the ISF, UKTT(Taji) conducted their training from 'within the wire' of Camp Taji. Camp Taji also contained a significant number of multi-national contractors providing security and facilities management. A similarly complex command arrangement existed between the UKTT(Besmaya) and the [redacted]. These arrangements are simplified in Figure 2.

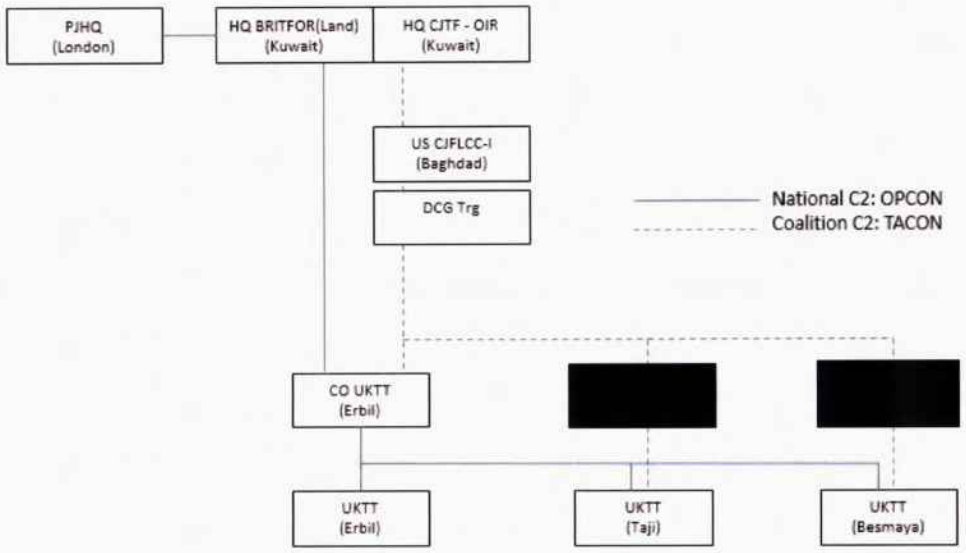

Figure 2: OIR C2 Construct, Op SHADER 4

1.3.11. Although a traditional structure, the Blenheim Coy command team was fragmented for Op SHADER and formed into UKTT(Taji) as an amalgam of 2 LANCS, Royal Engineers (RE), Royal Army Medical Corps (RAMC) and Royal Electrical and Mechanical Engineers (REME) personnel. In UKTT(Taji), C2 was the responsibility of the Officer Commanding (OC) Blenheim Coy, supported by his Company Sergeant Major (CSM) and Company Quartermaster Sergeant (CQMS) with the addition of a RE Captain as the Coy Gp Second–in-Command (2IC). Conversely, the UKTT(Besmaya) Coy Gp was commanded by a RE OC and a 2 LANCS 2IC. Infantry soldiers from 2 LANCS provided a Force Protection Platoon (FP Pl) for both Coy Gps. Witness 001 Witness 002

1.3.12. The UKTT (Taji) Coy Gp provided support to ISF through the provision of 3 Training Teams: Medical, Mobility Support (Breaching and Bridging[1]) and Counter-Improvised Explosive Device (C-IED). The joint, combined arms construct of UKTT(Taji) is shown overleaf in Figure 3. Exhibit 006 Exhibit 007

[1] STANAG 2287 defines BREACH as 'Break through or secure passage through an enemy defence, obstacle, or fortification'. Bridging refers to similar activities for passage over obstacles.

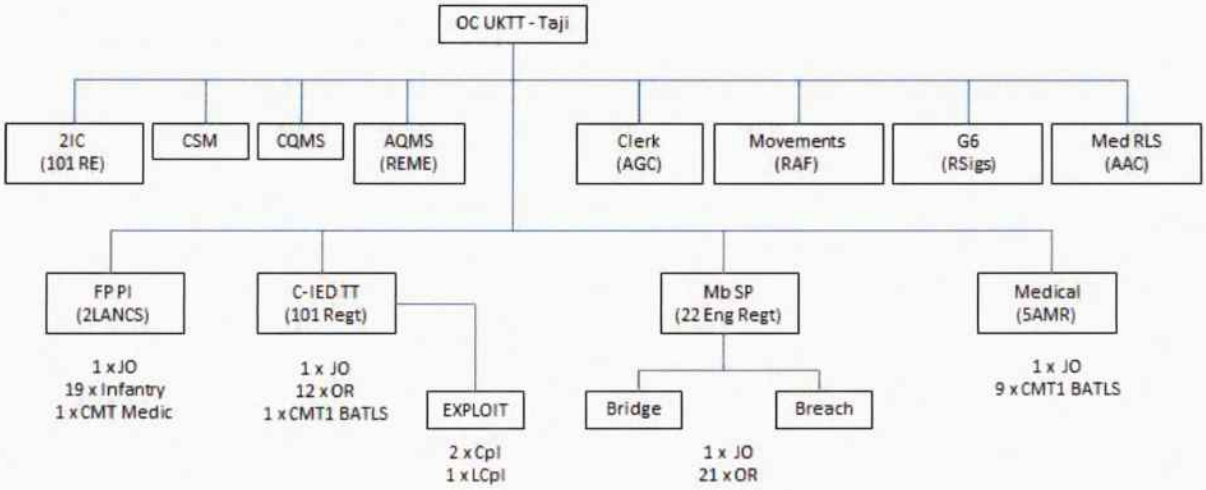

Figure 3: UKTT(Taji) Construct, Op SHADER 4

Pre-Accident Events

1.3.13. From early 2016, 2 LANCS was required to force generate a Coy Gp for Op TOSCA in support of 4 LANCS. From mid 2016, 2 LANCS began force generating several elements for Op SHADER, including a tactical HQ and 2 Coy Gps for the UKTT(C) BG, individual augmentees for deployment across the theatre and a small Training Team for a bespoke task in Turkey. In late 2016, 2 LANCS was also tasked to deploy a Coy Gp from Dettingen (Support Coy) to the Falkland Islands from 9 Mar to 9 May 17. Due to the complex and differing character of these operational deployments, the Bn needed to reorganise and provide training to its personnel. 2 LANCS soldiers were asked for their preferred deployment location and arrangements to prepare an appropriate Order of Battle (ORBAT) began. Exhibit 008 Exhibit 009 Witness 004 Witness 001 Exhibit 011

1.3.14. During May and Jun 16, separate activities were undertaken that offered opportunities to inform the preparation and learning of the 2 LANCS Pre-Deployment Training (PDT). The Army Training Branch undertook a reconnaissance visit to Iraq in the period 15 to 26 May 16, but did not visit Camp Taji. On 15 Jun 16, 1 RIFLES published an Initial Deployment Report (IDR) from their experience in command of UKTT(C) BG to inform and shape 2 LANCS' preparation and training. Exhibit 012 Witness 003

1.3.15. A new CO arrived in Weeton Barracks to assume command of the Bn on 29 Jul 16, immediately on completion of his Advanced Command and Staff Course. The Bn were then released on summer leave between 29 Jul and 30 Aug 16, resuming Mission Specific Training (MST) on return. Exhibit 003 Exhibit 014

1.3.16. 2 LANCS PDT, including live firing of the General Service Pistol (GSP), was undertaken following formal notification of the task from HQ 1 (UK) Div. This included individual and collective training covering the moral, conceptual and physical components of warfare, at various locations as well as in-barracks at Weeton. The key events in this period were:

a. Live Fire Tactical Training (LFTT) at Altcar, 25 - 28 Jul 16. This included firing the General Purpose Machine Gun (GPMG), SA80 rifle and GSP. Exhibit 014

b. An All-Ranks Brief (ARB) at the Mission Training and Mobilisation Centre (MTMC) in Lydd, 19 - 23 Sep 16. This included introduction to foreign weapons. — Exhibit 016

c. A BG HQ reconnaissance to Erbil, Iraq, 20 - 27 Sep 16. This was coincident with a visit by the UK Secretary of State and COMBRITFOR. The reconnaissance party visited UKTT(C) HQ and UKTT(Kurdistan), not the sub-unit locations at Taji or Besmaya. — Exhibit 017, Exhibit 018

d. LFTT, Warcop, 25 Sep - 2 Oct 16. This included firing of the GPMG and SA80 rifle. Soldier A passed a Weapons Handling Test (WHT) on the SA80 rifle on 27 Sep, prior to firing the Annual Combat Marksmanship Test (ACMT). — Exhibit 019

e. Soldier A undertook a WHT on the GSP on 1 Sep 16 and passed his ACMT on 6 Oct 16. — Exhibit 019

f. A G1 Wargame, Weeton Barracks, 29 Sep 16. This considered a variety of incident scenarios, including deaths on operations, for 2 LANCS command team and external stakeholders. — Exhibit 003

g. Exercise UNITED LION at Swynnerton, 17 - 21 Oct 16. This combined arms sub-unit exercise included deployment of the Foxhound (FHD) armoured fighting vehicle and achievement of live firing to Close Quarter Marksmanship (CQM) standard. — Exhibit 003, Exhibit 019

h. Further live firing training took place on 27 Oct 16, Soldier A again passed his GSP ACMT. — Exhibit 019

i. The Blenheim Coy Mission Rehearsal Exercise (MRX), Thetford, 7 - 14 Nov 16. The GSP and holsters were issued to participating personnel, but without ammunition and magazines. — Exhibit 020

1.3.17. On 21 Nov 16, MTMC issued an Assurance Note that assessed 2 LANCS as ready for deployment. This identified some shortfalls and areas of risk but stated that the Bn as a whole did well throughout the MRX. — Exhibit 020

1.3.18. Post-MRX and prior to deployment, all GSP and holsters were inspected by a suitably qualified and experienced armourer and confirmed serviceable. — Exhibit 021

1.3.19. The lead elements of 2 LANCS deployed to Camp Taji in the period 3 - 5 Dec 16, carried out a Reception, Staging and Onward Integration (RSOI) package and received a handover from 1 RIFLES. — Exhibit 003

1.3.20. Weapon Handling Tests were undertaken on arrival in-theatre. LCpl Hetherington passed his WHT on 12 Dec 16 and Soldier A passed his WHT on 15 Dec 16, both being assessed as suitably trained, qualified and current on both the GSP and SA80 rifle. — Exhibit 023

1.3.21. 2 LANCS assumed authority for UKTT(C) BG on 18 Dec 16. — Exhibit 003

1.3.22. The BG policy for weapon states and dress was reviewed by CO UKTT(C) on assumption of command. [redacted] Exhibit 023

1.3.23. At the time of the occurrence, the full complement of UKTT(C) BG had yet to deploy. The final elements of 2 LANCS arrived in Camp Taji on 12 Jan 17. Exhibit 003

Key Personalities

1.3.24. **LCpl Hetherington**. LCpl Scott Hetherington joined the Army on 19 Feb 12. He went to Infantry Training Centre (Catterick) (ITC(C)) to receive basic training. He deployed on Op HERRICK 18 and Ex ASKARI STORM in Kenya as a Kingsman (OR-2). He completed his Section 2IC Course on 23 Oct 15 before promotion to LCpl (OR-3) on 15 Dec 15. LCpl Hetherington moved to Blenheim Coy in Jul 16 in order to deploy on Op SHADER. He was a qualified FHD commander and arrived in theatre on 11 Dec 16. He was 22 years old in Jan 17. Exhibit 025

1.3.25. **Soldier A**. Soldier A joined the Army in Mar 13 and went to ITC(C) to receive basic training. He deployed on Ex ASKARI STORM in Kenya and Ex MAYAN WARRIOR in Belize as a Kingsman[3] (OR-2) before promotion to LCpl (OR-3) in Dec 15. For MST prior to deploying on Op SHADER, he completed a FHD Commanders' (Comd) Course in the period 26 Sep - 03 Oct 16. He received his first formal training on the GSP at Weeton Barracks on 6 Oct 16, achieving CQM standard on 17 Oct 16, as part of the Blenheim Coy training exercise at Swynnerton. Soldier A and LCpl Hetherington were known to be best friends. He was [redacted] years old in Jan 17. Witness 025

1.3.26. **Commanding Officer**. The CO commissioned in 2000 into the 1st Bn King's Own Royal Border Regiment and had served for 17 years. He had completed operational tours in Iraq, on Op TELIC 7, with 7th Armoured Brigade, and Afghanistan, on Op HERRICK 16, as a Company Commander with 3rd Bn, Yorkshire Regiment. He had served as the 2IC of 2 LANCS and after staff training, assumed command as CO 2 LANCS on 29 Jul 16. Within this role, he assumed command of UKTT(C) BG in Erbil, Iraq, for the duration of Op SHADER 4 (Dec 16 - Jun 17). Witness 003

1.3.27. **Officer Commanding**. The OC commissioned in 2005 into the Queen's Lancashire Regiment and had served for 12 years. After a tour as Pl Comd he completed an operational tour in Iraq, on Op TELIC 11, as Coy 2IC. He was subsequently appointed Aide-de-Camp to General Officer Commanding (GOC) Theatre Troops, then worked as Adjt 1 LANCS and as SO3 Training Plans at Operational Training Advisory Group (OPTAG). After a staff role as SO2 Organisation Plans at Joint Helicopter Command he was appointed OC Blenheim Coy, 2 LANCS, in Mar 15. Witness 001

1.3.28. **FP Pl Comd**. The FP Pl Comd commissioned in 2015 into The Duke of Lancaster's Regiment and had been with 2 LANCS since May 16. He had Witness 007

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[2] *"The weapon is 'Ready to fire' when there is a round in the chamber and the firing pin assembly is cocked".* DCC Trg, Vol II, SAA.
[3] A private soldier in the Duke of Lancaster's Regiment.

deployed to Belize on Exercise with the Coy but had no previous operational experience.

1.3.29. **Company Sergeant Major**. The CSM joined the Army in 2000 and had served for 16 years. He had completed operational tours in Northern Ireland, Iraq and Afghanistan as well as postings as a Section Commander at ITC(C), PI Sergeant (Sgt) at the Infantry Training Battalion (Catterick) and as a Colour Sergeant Instructor at the Infantry Battle School (Brecon). Promoted to WO2 in Apr 15 and assumed the role of CSM of Blenheim Coy in Jul 16. Witness 004

1.3.30. **FP PI Sergeant**. The FP PI Sgt joined the Army in 2007. He completed a tour in Afghanistan on Op HERRICK and has deployed on Ex ASKARI STORM in Kenya and Ex MAYAN WARRIOR in Belize. He was promoted to Sgt in Oct 15. He was [redacted] years old in Jan 17. The FP PI Sgt, Soldier A and LCpl Hetherington were known to be close friends. Exhibit 028 Exhibit 029 Witness 006

The General Service Pistol

1.3.31. The Austrian-made Glock Model 17 Generation 4 pistol was brought into service in 2013 as the new standard sidearm to replace the Browning, Sig Sauer and Walther pistols. A common sidearm also carried by some UK police firearms units, in British military service it is designated as the L131A1 General Service Pistol (GSP), as illustrated in Figure 4. Where deemed appropriate, it is carried as a primary weapon by those working in operational staff appointments and some vehicle commanders and as a secondary or backup weapon by frontline troops.

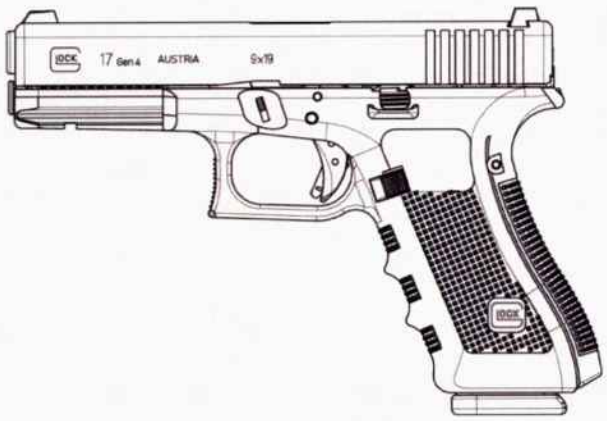


Figure 4: L131A1 General Service Pistol

1.3.32. The Glock is a short-recoil locked breech semi-automatic pistol that fires via a striker-fired mechanism. It has 3 internal safety features and the issued holster forms part of the safety system, described in detail in Part 1.4. Its frame, magazine body and other components are made from high-strength nylon-based polymer. The version purchased for the British Armed Forces features a dual recoil spring assembly which reduces felt recoil and utilises a double-stack magazine which holds 17 rounds of 9mm Parabellum ammunition.

Sequence of Events – 2 Jan 16

1.3.33. The UKTT(Taji) accommodation is located in the coalition garrison, separate from the prinicipal training areas and Coy Gp HQ. Blenheim Coy were accommodated in two-person rooms situated within a citadel of concrete blast walls. In [redacted] accommodation block was a communal rest area known colloquially as 'the Den', as illustrated in Figure 5.

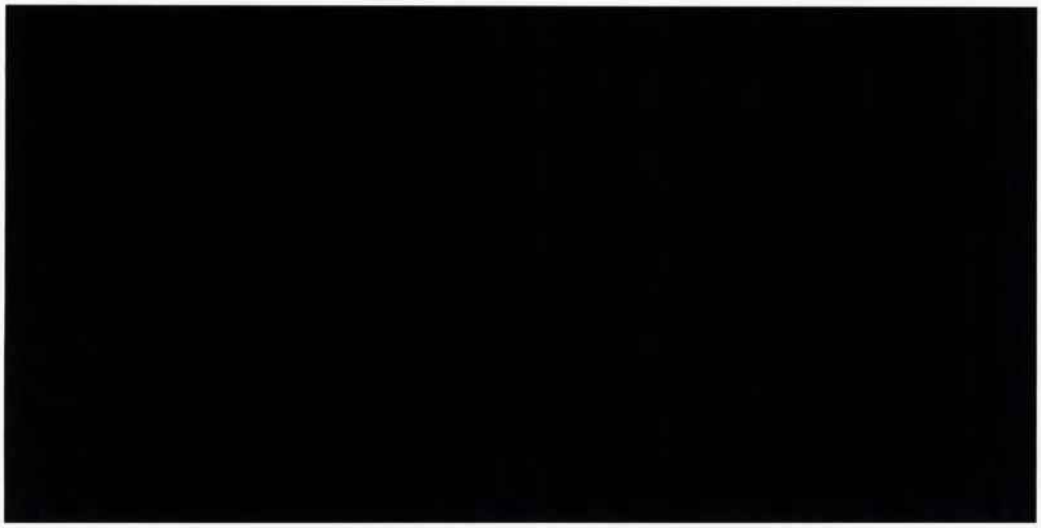


Figure 5: UKTT(Taji) Accommodation Plan

1.3.34. On the morning of 2 Jan 17, LCpl Hetherington was utilised as the FHD Comd on a Key Leader Engagement (KLE) task with elements of the FP Pl and support team. On completion of the KLE, LCpl Hetherington and his team returned to the accommodation at 1230hrs, unloaded their SA80 rifles and went to lunch.

1.3.35. At approximately 1330hrs, the FP Pl met in the Den to undertake mandated weekly weapon cleaning. With no formal end to this cleaning period, by approximately 1430hrs the majority of members of the FP Pl had completed their weapon cleaning and dispersed to carry out personal administration. It then became apparent that two unnamed GSP holsters had been left behind in the Den. The FP Pl Sgt directed that they be secured by Soldier CC and returned to their owners at the daily Pl Briefing scheduled at 1700hrs. The FP Pl Sgt then went to the gymnasium with LCpl Hetherington, Soldier A and Soldier D for approximately one hour.

Witness 006
Witness 008
Witness 006

1.3.36. Shortly before 1600hrs, Soldier CC met LCpl Hetherington in the Den and informed him of the whereabouts of the two holsters. Despite this, LCpl Hetherington did not retrieve them, but returned to the room he shared with Soldier A [redacted]. Sitting in the adjacent room, Soldier Z then heard Soldier A and LCpl Hetherington messing about.

Witness 008
Witness 009

1.3.37. At approximately 1610hrs, Soldier Z heard LCpl Hetherington urge restraint. A single gunshot was then heard throughout the accommodation. During an interview with the RMP, Soldier A recalled LCpl Hetherington saying to him "You've shot me" immediately after the weapon discharged. Soldier A then dropped his GSP. Almost immediately, Soldier A began shouting for help at the door to Room [redacted] and was seen to be in a highly distressed state.

Witness 009
Exhibit 034
Witness 009

1.3.38. First responders arrived quickly on scene. On entering the room, they found LCpl Hetherington [redacted]. A Combat Medical Technician, Class 1 (CMT1) immediately administered first aid, [redacted]. It was at this point that [redacted]. Under the CMT's direction, [redacted] and transport to the R2E medical facility was arranged. — Witness 009, Witness 010

1.3.39. Up to 7 individuals assisted with the first aid and extraction of LCpl Hetherington from [redacted]. The GSP found on Soldier A's bed was placed on the refrigerator by Soldier B to eliminate risk during this process. This GSP was loaded and Made Ready but not secured to a lanyard or in a holster. A second GSP was found under the head of Soldier A's bed; it was unloaded and unholstered although the lanyard was fitted. During the first aid and casualty evacuation the state of both weapons remained unaltered; only later was Soldier A's weapon unloaded. — Exhibit 036

1.3.40. At this time OC UKTT(Taji) was conducting his daily planning and coordination meeting in Coy HQ. Attendees included the 2IC, and FP Pl Comd. A runner was dispatched immediately to inform them of the occurrence.

1.3.41. LCpl Hetherington was extracted to the hospital facility in a FHD approximately 6 minutes after the gunshot wound had been sustained. — Exhibit 037

1.3.42. The ANZAC General Surgeon on duty in the R2E facility assessed LCpl Hetherington on arrival. Despite conducting immediate surgery LCpl Hetherington was pronounced dead at 1653hrs. — Exhibit 037, Exhibit 036

Follow-Up Action / Post-Accident Events

1.3.43. Room [redacted] was secured by personnel from Blenheim Coy and then guarded as a crime scene with Coaltion support from ANZAC personnel. — Witness 002

1.3.44. In the aftermath of the occurrence, an investigation was commenced by the Special Investigation Branch (SIB) Regiment, Royal Military Police (RMP) from the UK. There being no RMP SIB in theatre, US Crime Scene Investigators searched Room [redacted] forensically to collect and preserve all evidence.

1.3.45. The Defence Accident Investigation Branch (DAIB) was informed of the occurrence on 3 Jan 17. The Branch deployed both an operations and an engineer investigator to conduct an initial assessment and complete a Triage Report for the Director General Defence Safety Authority (DG DSA).

1.3.46. Soldier A was allocated separate accommodation from the remainder of Blenheim Coy immediately after it was known that LCpl Hetherington had died. After the accident, Soldier A was given full access to an ANZAC Padre and a US Psychologist for welfare support, and supervised at all times, predominantly by the FP Pl Sgt, for duty of care. — Witness 008, Witness 008, Witness 002, Exhibit 037

1.3.47. The UK Medical Officer was in Erbil and there was no UK Community Psychiatric Nurse (CPN) support in Theatre. The UK Op SHADER Padre was rear-based in Cyprus. Although en route to Iraq on 2 Jan 17 for a routine visit, he did not arrive until late on 4 Jan 17. [redacted] — Exhibit 037

[redacted]

1.3.48. Soldier A and the FP Pl Sgt flew back to the UK together on 5 Jan 17. On arrival at Weeton Barracks, a package of welfare support for Soldier A was co-ordinated by the 2 LANCS 2IC. [redacted]. Without respite, the FP Pl Sgt returned immediately to theatre. Exhibit 038

1.3.49. An in-theatre memorial service was conducted in Camp Taji prior to LCpl Hetherington's repatriation. He arrived back in the UK on 12 Jan 17. In the aftermath of the accident, welfare support was provided for remaining UKTT(Taji) personnel through application of the TRiM process by training coordinators and practitioners within Blenheim Coy, the arrival of the Op SHADER padre and support from Coalition specialists. Exhibit 037 Witness 002

1.3.50. On 20 Jan 17, DG DSA convened a Service Inquiry (SI) under Section 343 of the Armed Forces Act 2006. The principal aim was to determine the cause and contributory factors with a view to preventing reoccurrence. Within the Terms of Reference, the Panel was given a wider responsibility to determine and comment on broader organisational and/or resource factors.

1.3.51. LCpl Hetherington's funeral took place on 26 Jan 17, with full military honours.

Cause of Death

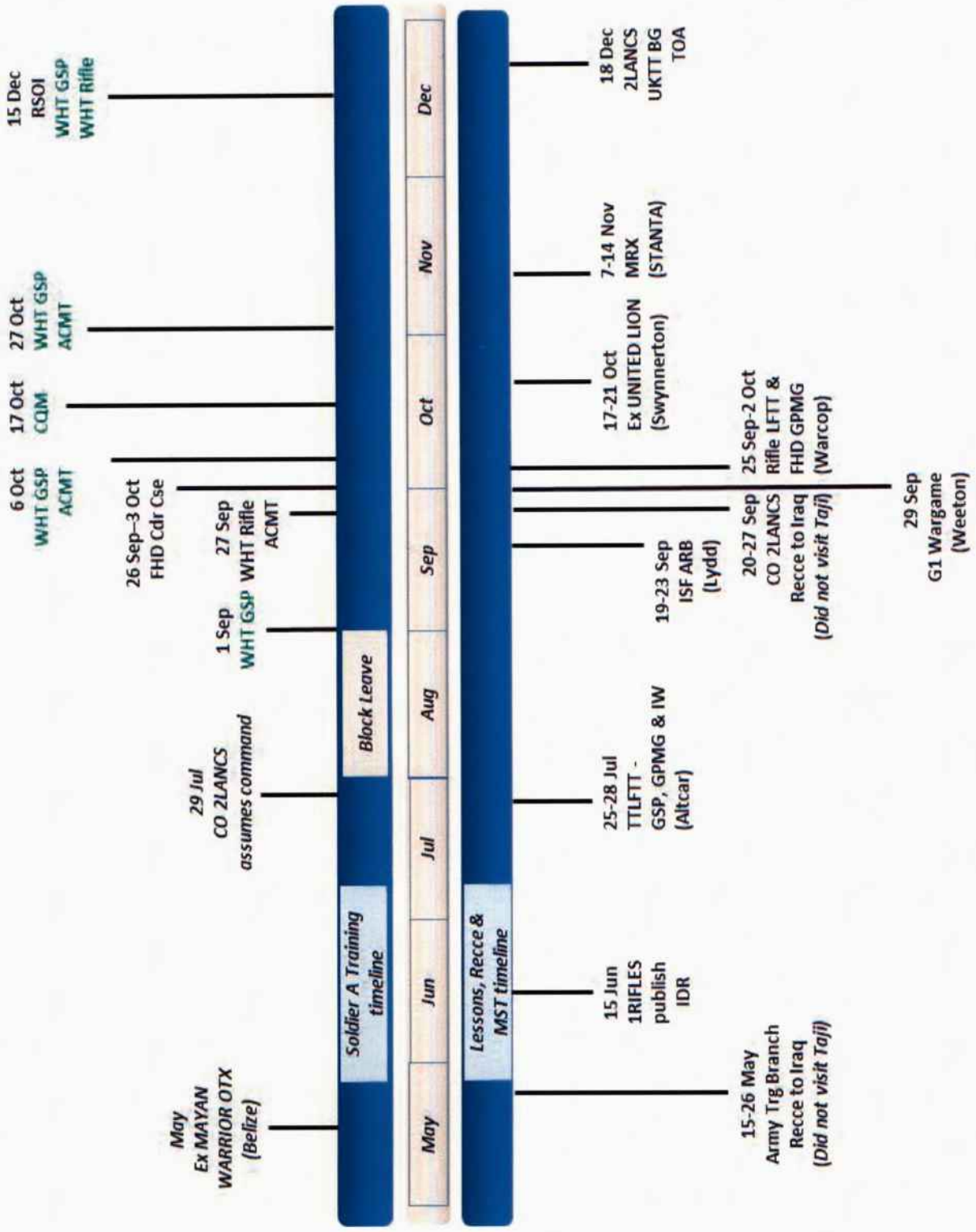
1.3.52. The Forensic Post-Mortem Report, dated 21 Mar 17, gave the cause of death of LCpl Hetherington as "Gunshot wound to the abdomen". Exhibit 041

Occurrence Timelines

1.3.53. Annex A provides details of individual and collective PDT. Annex B provides the sequence of significant events on 2 Jan 17.

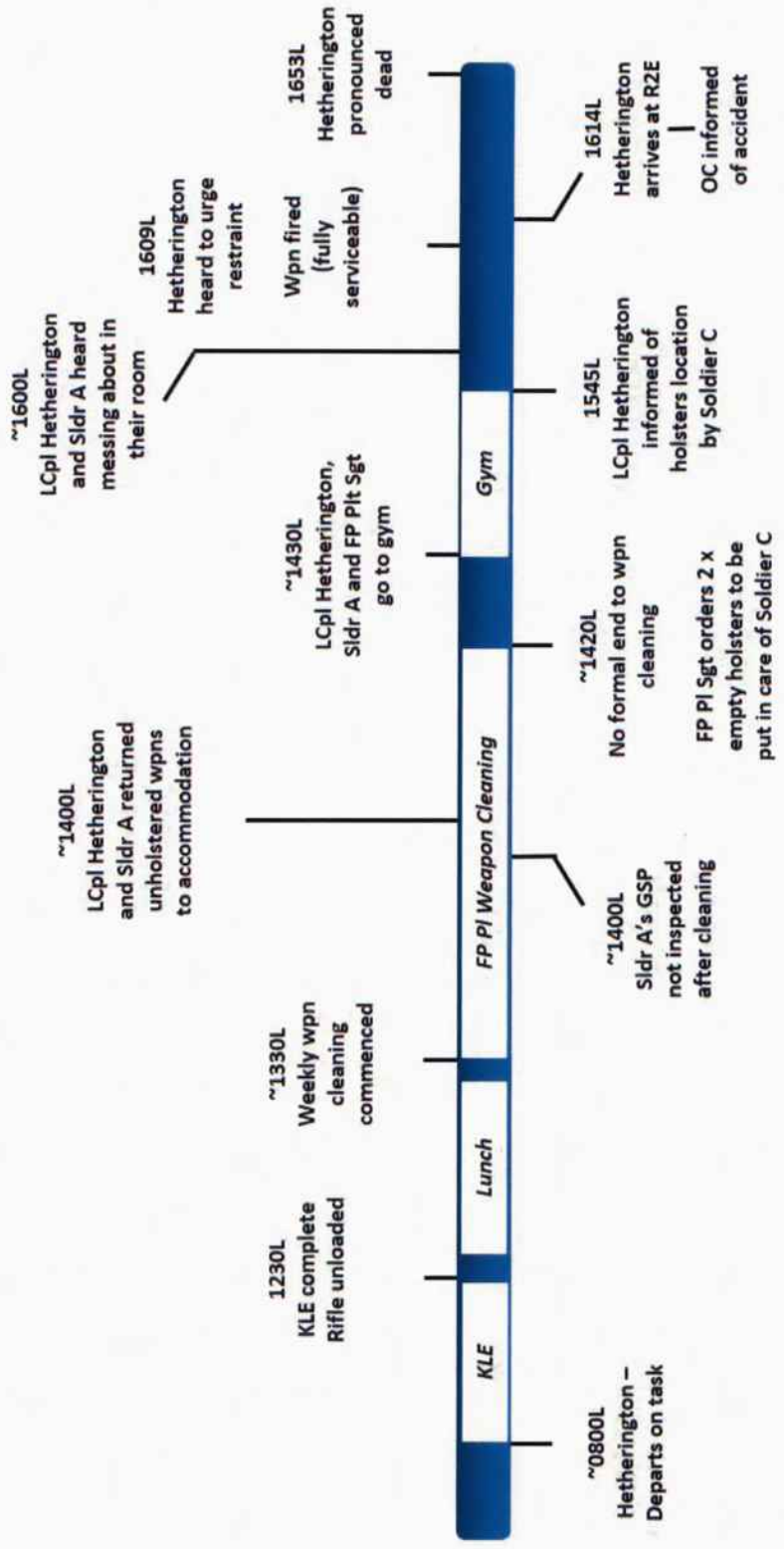
ANNEX A TO
2 LANCS_TAJI_SI_Part_1.3

Individual and Organisational Pre-Deployment Training – May to Dec 16



ANNEX B TO
2 LANCS_TAJI_SI_Part_1.3

Timeline of Events – 2 Jan 17



PART 1.4

Analysis and Findings

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PART 1.4 – ANALYSIS & FINDINGS

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Annex

Introduction

1.4.1. This Service Inquiry was convened on 20 Jan 17 to investigate the circumstances surrounding the death of LCpl Hetherington. This death was not the first accident in Defence caused by the unintentional discharge of a firearm. Indeed, just 6 months prior to LCpl Hetherington's death another Infantry soldier negligently fired his pistol in the same accommodation block in Taji, on Operation SHADER, slightly injuring 2 soldiers. Exhibit 039 Exhibit 040

1.4.2. Death or injury through live fire training is the top safety risk identified by Army Command[1]. Although the overwhelming majority of firearms handling is conducted safely, by the majority of Service personnel, the majority of the time, the Panel observes that in the past 10 years, 6 fatalities and 48 injuries have been recorded as resulting from the unintentional discharge of Service rifles. This compares with 3 fatalities, 37 injuries and 61 Near Misses from the unintentional discharge of 9mm pistols, despite significantly lower rates of carriage and usage[2].

1.4.3. Policy, supervision and self-discipline combine to moderate the fallibility of Service personnel. To attribute the accident solely to the errors of any individual would be quick and easy to accept, however, this is too simple and naïve an approach to accident causation. This report examines the wider context of the occurrence to determine if the conditions for this fatal accident were created by a combination of individual actions and omissions, latent organisational weaknesses and cultural factors.

1.4.4. **Conditions of the Inquiry**. Soldier A is the only witness to the shooting of LCpl Hetherington. The Service Prosecution Authority requested the Panel did not interview Soldier A due to potential conflict with the parallel criminal prosecution. Consequently, until access to Soldier A was granted in Mar 19, the analysis to determine the causal, contributory and broader organisational factors of the accident was based on the presumption that it was the outcome of an unintentional discharge of Soldier A's GSP by Soldier A.

The Human Factors Analysis and Classification System

1.4.5. It is well established that accidents cannot be attributed to a single cause or, in most instances, a single individual[3]. Rather, accidents are likely to be the end result of a number of causes[4], only the last of which are the unsafe acts which lead directly to the injury or death. Human Factors (HF) influence the working of complex and potentially hazardous systems significantly and must, therefore, be central to any investigation.

1.4.6. To assist the Panel with structuring the report, and readers to appreciate the full range of causation, Shappell and Wiegmann's comprehensive framework

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[1] DSA Annual Assurance report 2016/17, Annex C.

[2] Figures extracted from the Munitions Incident Database (MID). The MID Cell receives and collates details of all Accidents and Incidents involving Ordnance, Munitions and Explosives (OME) across Defence.

[3] Heinrich, Peterson & Roos, 1980 in Shappell SA & Wiegmann, DA. *The Human Factors Analysis and Classification System – HFACS.* FAA Civil Aeromedical Institute, Oklahoma City & University of Illinois at Urbana-Champaign, Institute of Aviation, Savoy, Illinois, Feb 2000.

[4] Reason J. *Human Error.* Cambridge: Cambridge University Press; 1990.

for identifying and analysing human error has been used. Shappell and Wiegmann[5] developed Professor James Reason's 1990 'Swiss Cheese' model[6] into the Human Factors Analysis and Classification System (HFACS). Since its publication in 2000, this framework has been used within the military, commercial and general aviation sectors to systematically examine the underlying causal factors and improve accident investigations through systematic, data-driven intervention strategies and objective evaluation of intervention programmes. To have greater utility, the Panel adapted the original HFACS model to be specific to the context of this Service Inquiry. In addition, the Panel benefited from the support and expert opinion of a MOD HF Psychologist Special Advisor whose independent report is referenced throughout the analysis.

'Swiss Cheese' model

1.4.7. Working backwards from the event itself, Reason describes a spectrum of latent weakness, with each layer interacting and influencing the others. Breaches in defences that allow the accident to occur are represented as "holes in the Swiss Cheese", as illustrated in Figure 1. Where they align, by circumstance or failures of design, these holes turn into a seam through the defensive layers that allows unsafe acts to occur. The model is particularly useful in accident investigation as it forces investigators to look beyond the individual act.

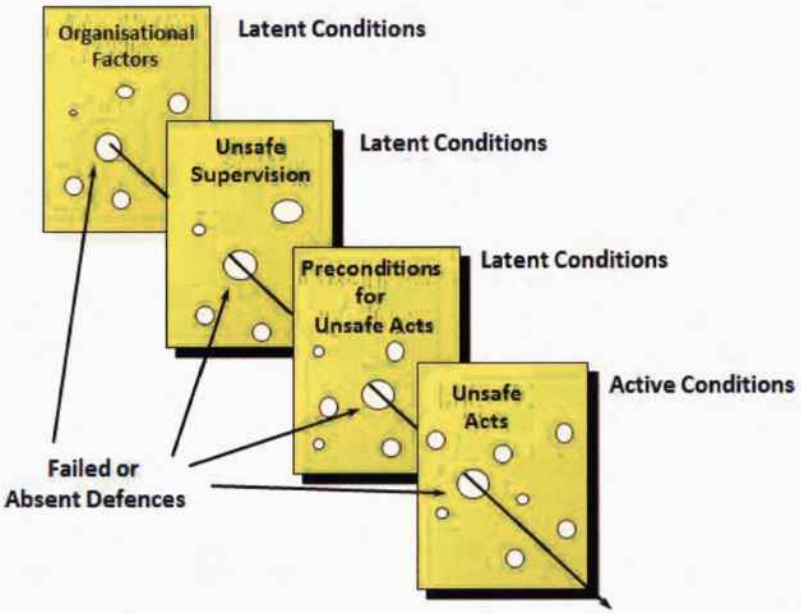

Figure 1: Reason's 'Swiss Cheese' Model of Accident Causation

1.4.8. **Latent Conditions**. Latent conditions can lead to failures in organisational and managerial spheres and their adverse effects may take a long time to become evident. They may lie dormant or unseen for hours, days, weeks or even longer until, singly or in combination, they adversely affect the outcome of group or individual actions. Although occurrences of this nature may never be eliminated completely, the Panel believes that with the correct identification and analysis of root causes, and timely interventions to address them, the frequency of accidents may be reduced.

[5] Shappell & Wiegmann, 2000.

[6] Reason, James (1997). '*Managing the risks of organizational accidents*'. Aldershot: Ashgate. ISBN 1840141042.

1.4.9. **Breached Defences**. Use of Reason's model permits a structured approach to assess each factor and understand the root cause of the event. Understanding where weaknesses exist and viewing these through the layers of the individual, the environment, the supervision and organisational context, allows for a systematic assessment of an organisation. By identification of where the rules, orders, practices and procedures designed to assure the safe system of work failed, or were breached, the model allows targeted recommendations to prevent or reduce the likelihood of reoccurrence.

Categorisation of Error

1.4.10. The original HFACS model was created to assess aviation accidents. The Panel has modified this model and terminology to better assess Human Factors performance issues within the context of the Land domain. The categories below demonstrate the defensive layers used to form the structure of this report.

a. **Unsafe Acts**. Unsafe Acts can be classified into 2 categories: Errors and Violations[7], as illustrated in Figure 2. Errors represent the mental or physical activities of individuals that fail to achieve their intended outcome. Violations refer to the wilful disregard for the rules and regulations that govern safety. To increase the detail required of accident investigations and inquiries, these 2 broad categories were expanded to include Skill-based and Decision errors[8].

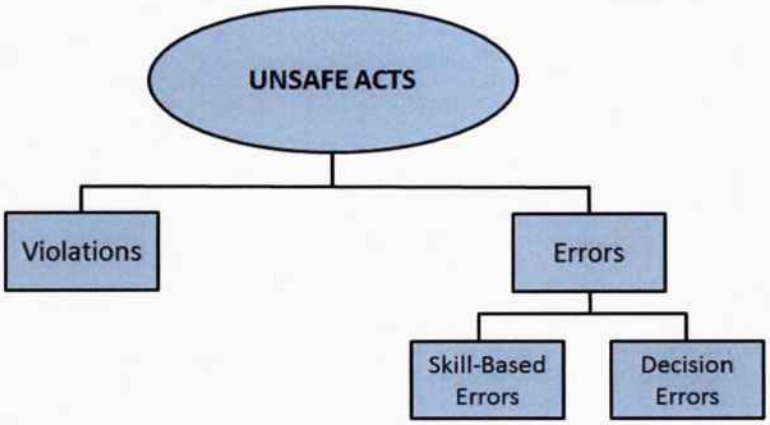

Figure 2: Unsafe Acts

b. **Preconditions for Unsafe Acts**. These factors set the conditions for the unsafe act. They may include the physical environment, the technology or tools used, psychological states and physiological factors of the individual which can influence human performance and behaviour, as illustrated in Figure 3.

[7] Reason, 1990.
[8] Shappell & Wiegmann, 2000.

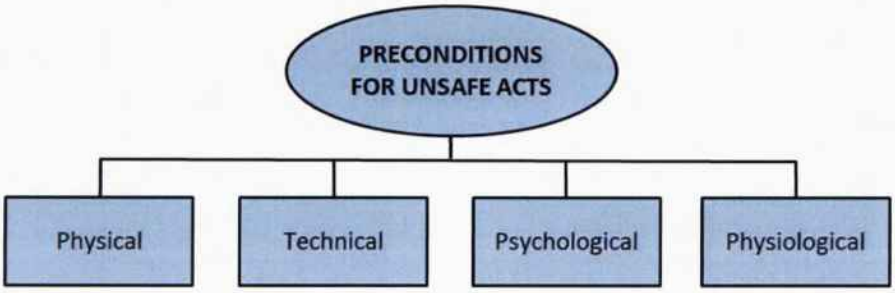

Figure 3: Pre-Conditions for Unsafe Acts

c. **Command Influences**. Within an organisation there are levels of supervision which enable and safeguard safe systems. In this report, supervisory activities or precautions that did not optimise a safe environment are categorised as Command Influences, as illustrated in Figure 4.

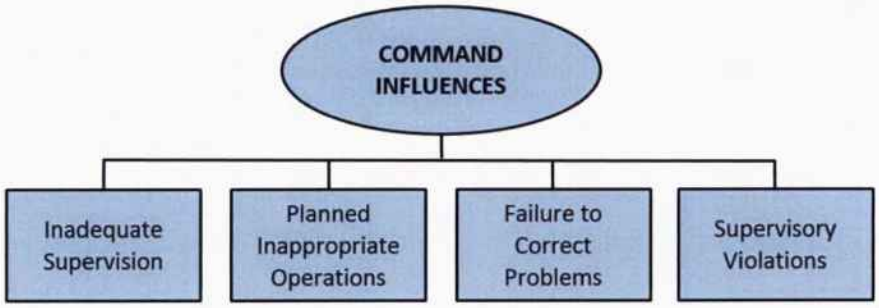

Figure 4: Command Influences

d. **Organisational Influences**. At the macro level, organisational strategy, behaviours and cultural maturity, all of which are affected by context, can influence performance and safety. These factors are almost certainly beyond the control of the individuals directly involved in the occurrence, but are subject to the consequences of influence at the organisational level. Although these influences may appear distant from the action of the individuals involved in the accident the factors identified set the conditions for weaknesses to emerge and remain throughout the system, as illustrated in Figure 5.

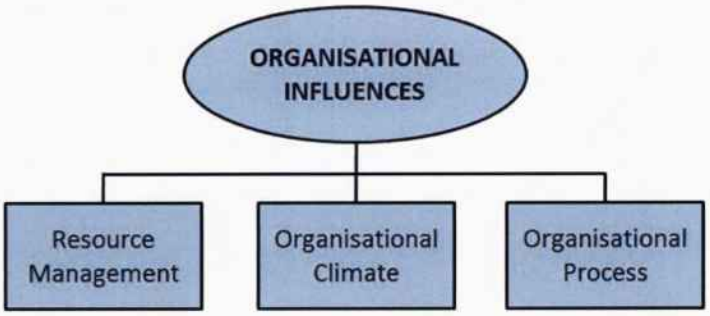

Figure 5: Organisational Influences

Occurrence Factor Categories

1.4.11. The impact of each factor, and its relationship to the occurrence are categorised using the following terms: Causal, Contributory, Aggravating and Other Factors. This taxonomy permits coherent trend analysis and learning from Service Inquiries to increase the likelihood of prevention.

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

b. **Contributory Factors**. Contributory factors are those factors which ***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 Factors**. Aggravating factors are those factors which ***made the final outcome of an accident worse***. However, aggravating factors do not cause or contribute to an accident. In the absence of the aggravating factor the accident would still have occurred.

d. **Other Factors**. Other factors are those which, 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**. These are points or issues, identified by the Panel during the investigation, that ***are worthy of note to improve working practices or promote best practice***, but do not relate directly to the accident.

Safety Culture Framework

1.4.12. The International Atomic Energy Agency defines Safety Culture as "that assembly of characteristics and attitudes in organisations and individuals which establishes that, as an overriding priority, safety issues receive the attention warranted by their significance"[9].

1.4.13. The Safety Culture of an organisation determines its approach and response to managing safety. It is considered as "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation's health and safety management. Organisations with a positive Safety Culture are characterised by communications founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures"[10].

1.4.14. The Defence Safety Authority (DSA) definition of Safety Culture is "an enduring set of values, norms, attitudes, and practices within an organisation concerned with minimising exposure of the workforce, and the general public, to

[9] "Safety Culture" – A report by the International Nuclear Safety Advisory Group (Safety Series No.75-INSAG-4), Vienna, 1991.
[10] Advisory Committee on the Safety of Nuclear Installations HF Study Group: Third report - Organising for Safety, HSE Books, 1993

dangerous or hazardous conditions. In a positive Safety Culture, a shared concern for, commitment to, and accountability for safety is promoted"[11].

1.4.15. **Engaged Safety Culture**. In 2006, 14 Service personnel died as a result of a catastrophic mid-air fire in a Royal Air Force (RAF) Nimrod on a routine mission over Afghanistan. Sir Charles Haddon-Cave's report into the accident demonstrated that although it was technical failure waiting to happen, the deeper causes of the accident were organisational and managerial[12]. In order to prevent reoccurrence, Haddon-Cave recommended that the RAF address these latent weaknesses through the creation of an *'engaged safety culture'*[13].

Figure 6: The 5 sub-cultures of an engaged Safety Culture

His model, as illustrated in Figure 6, is based on Reason's 4 critical elements that interact synergistically: Just, Reporting, Learning and Flexible Cultures[14] and the addition of a fifth element, a Questioning Culture.

a. **Just Culture**. A Just Culture is "an atmosphere of trust where people are encouraged, and even rewarded, for providing safety-related information, and it is clear to everyone what is acceptable and unacceptable behaviour" [15]. In 2009, the Chief of Defence Staff stated of a Just Culture, "To me, such a culture is based on trust. ... It should promote a sense that [people] will be treated fairly and with integrity while we investigate why mistakes have been made to make sure we get things right next time. But it is not a blame-free regime where no-one is ever held to account. Everyone must be clear where the line is drawn between acceptable and unacceptable behaviour"[16].

[11] DSA 01.4v1, Master Glossary, 2017 found at http://cui6-uk.diif.r.mil.uk/r/660/04/02/DSA014/Forms/Grouped%20by%20Category.aspx

[12] Haddon-Cave, Charles. *The Nimrod Review, Chapter 27 - A New Safety Culture*, p569-574. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229037/1025.pdf.

[13] LTC Tracy Dillinger, PsyD, Office of Safety and Mission Assurance, NASA, Washington DC in evidence to The Nimrod Review, 2009, p.573, 27.11.

[14] Reason, James. *Managing the Risks of Organizational Accidents*, December 1997.

[15] Haddon-Cave. Op Cit.

[16] Sir Jock Stirrup, *Desider Magazine*, Jan 2009.

b. **Reporting Culture**. A Reporting Culture is "an organisational climate where people readily report problems, errors and Near Misses"[17]. However, it is the accurate recording of these events which is essential to understand errors, enable trend analysis and generate appropriate interventions.

c. **Learning Culture**. An organisation with a Learning Culture encourages continuous learning and recognises that systems influence each other. Constant learning elevates and empowers individuals and teams, thereby opening opportunities for continuous transformation. A Learning Culture is required to develop as a Learning Organisation. With it, "the willingness and competence to draw the right conclusions from its safety information and the will to implement major safety reforms"[18] based on analysis and learning will be effective.

d. **Flexible Culture**. If heavily reliant on complex processes, with highly prescriptive procedures and rigid or ill-defined chains of command, organisations will inevitably struggle to cope with the challenges of change or novel circumstances. Agile organisations must be flexible to respond to changing circumstances and hazards to achieve strategic goals consistently. A Flexible Culture is one "that can adapt to changing circumstances and demands while maintaining its focus on safety"[19] and an essential enabler for successful adaptation. This hinges on the ability to learn effectively from shared experience.

e. **Questioning Culture**. Haddon-Cave reflects that "The keystone of a strong Safety Culture is a vital fifth element, namely a Questioning Culture. At all stages of the safety pilgrimage it is vital to ask questions… [as they are] the antidote to assumptions, which so often incubate mistakes"[20]. Albeit sometimes painful, difficult and not immediately productive, it is vital to think and question rather than accept convenient assumptions or follow procedure slavishly. The Government recognises that a Questioning Culture and spirit of fair challenge is essential for good decision-making. Indeed, the Iraq Inquiry (Chilcot Report) states that the best antidote to assumptions and 'groupthink' is reasonable challenge[21]. A healthy organisation is one in which challenge is expected and accepted in order to highlight and explore alternative options[22].

1.4.16. According to Haddon-Cave, these 5 cultures develop from an essential foundation of leadership commitment, open communication and effective decision-making. Together, they form a safety-conscious, informed and, above all, engaged organisation and Safety Culture with the following characteristics:

a. Leadership commitment.

b. Open communication.

c. Just environment.

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[17] Haddon-Cave. Op Cit.

[18] Ibid.

[19] Ibid.

[20] Ibid.

[21] Reasonable Challenge: A Guide. MOD, 2016. http://defenceintranet.diif.r.mil.uk/libraries/corporate/DIBS/20170405-Reasonable%20Challenge%20the%20Guide.pdf

[22] *Lessons still to be learned from the Chilcot Inquiry*. HoC Public Administration & Constitutional Affairs Committee, 27 Feb 17. https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/656/656.pdf

d. Involvement of everyone at all levels of the organisation.

e. Learning throughout the organisation.

f. Effective decision making process.

g. Follow up, feedback and reporting.

h. Critical thinking and questioning.

1.4.17. To maximise utility, the 5 cultures above must be as mature as possible and training, development and innovation must be valued and supported in an open and encouraging environment. Such are their interdependencies, weakness in any one of the foundations or cultures introduces fragility into the whole system. This erodes trust which, in turn, erodes beneficial behaviours. This report combines the Reason model of accident causation with that of an engaged Safety Culture to help examine and understand any latent weaknesses that set some of the pre-conditions for this accident to happen.

Guidance for the Reader

1.4.18. **Probabilistic Language**. The probability terminology detailed in Figure 7 is provided by DAIB to clarify the terms used to communicate uncertainty and provide consistency across Defence accident reports. It is based on terms published by the Intergovernmental Panel on Climate Change (IPCC) in their Guidance Note for Consistent Treatment of Uncertainties[23] as well as the Australian Transport Safety Bureau (ATSB) in their paper on Analysis, Causality and Proof in Safety Investigations[24].

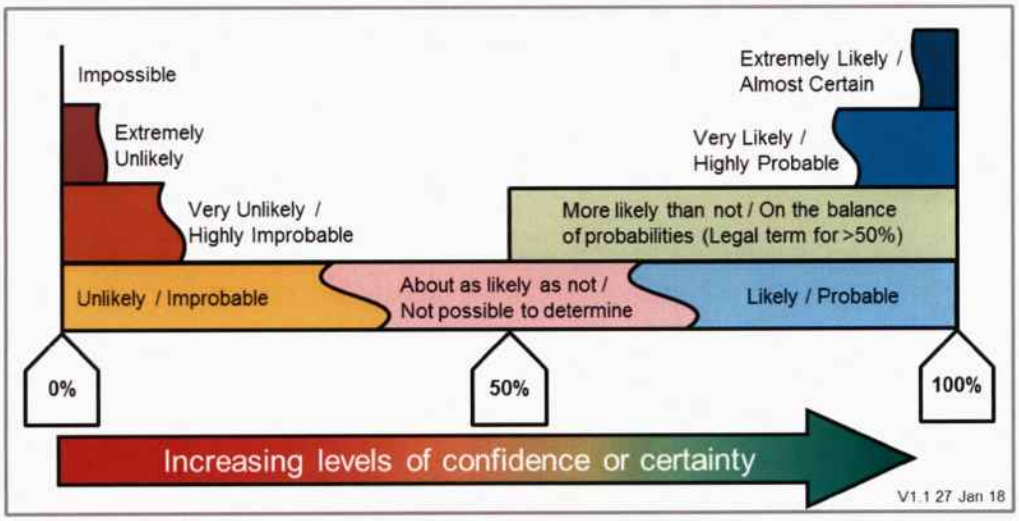

Figure 7: Probabilistic Terminology

1.4.19. **Chapter structure**. This report starts with the death of LCpl Hetherington. From this decisive act, the actions or inactions that contributed to it are examined. The analysis in this report has been written in 5 main Chapters, each corresponding to one of the phases of HFACS analysis:

[23] https://www.ipcc.ch/pdf/supporting-material/uncertainty-guidance-note.pdf.
[24] https://www.atsb.gov.au/media/27767/ar2007053.pdf.

a. Chapter 1 – The Occurrence.

b. Chapter 2 – Unsafe Acts.

c. Chapter 3 – Preconditions for Unsafe Acts.

d. Chapter 4 – Command Influences.

e. Chapter 5 – Organisational Influences.

f. Chapter 6 – Summary of Findings.

1.4.20. **Factor flags**. At the start of each Chapter, the reader will find a pictorial representation of the Chapter content, with colour-coded reference to the key factors (Figure 8). To ensure it is readable, it does not contain every Other factor or all 32 Observations and as such it is for guidance only; a full list of all factors and observations can be found in Chapter 6, Summary of Findings.

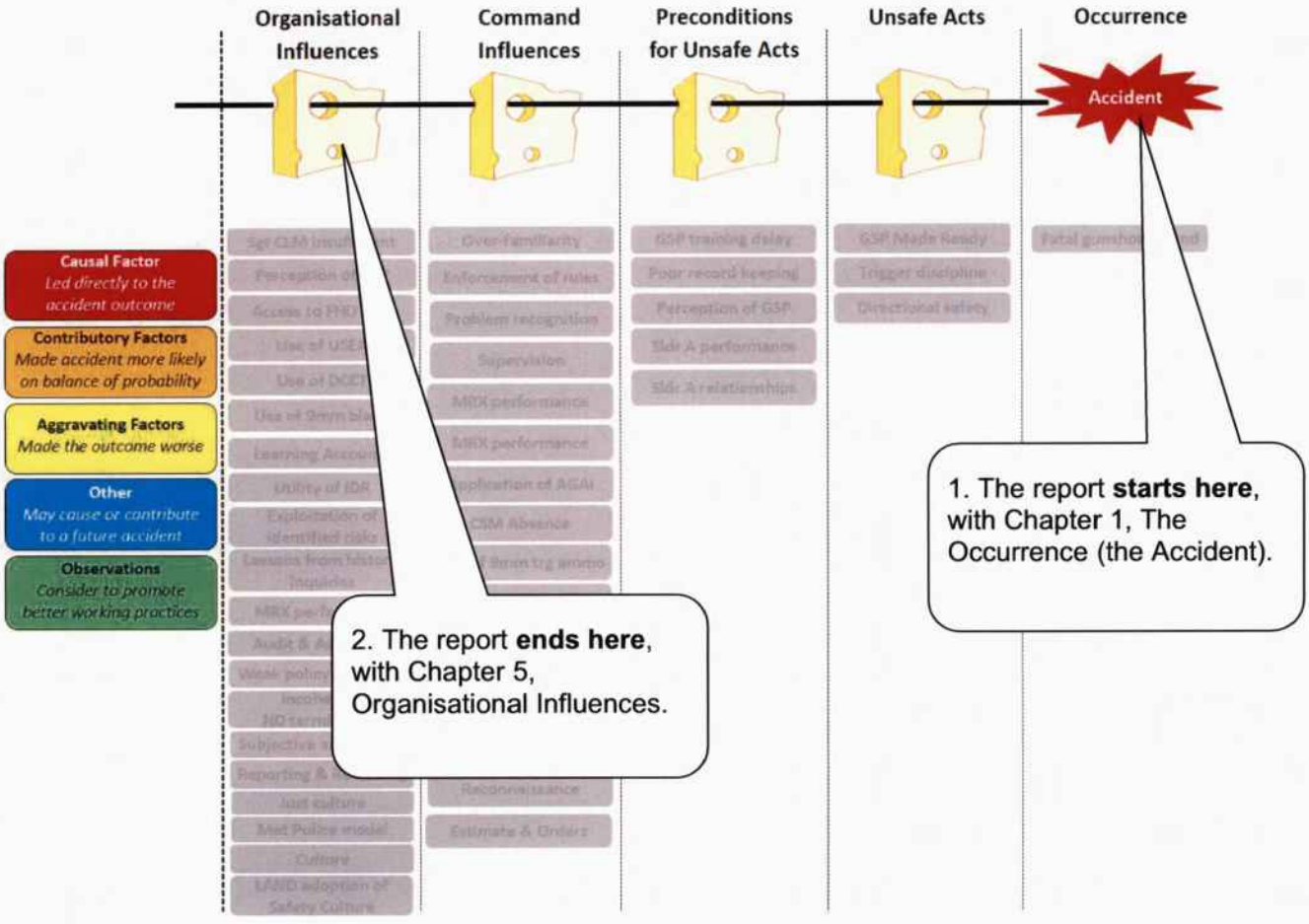

Figure 8: Camp Taji accident analysis

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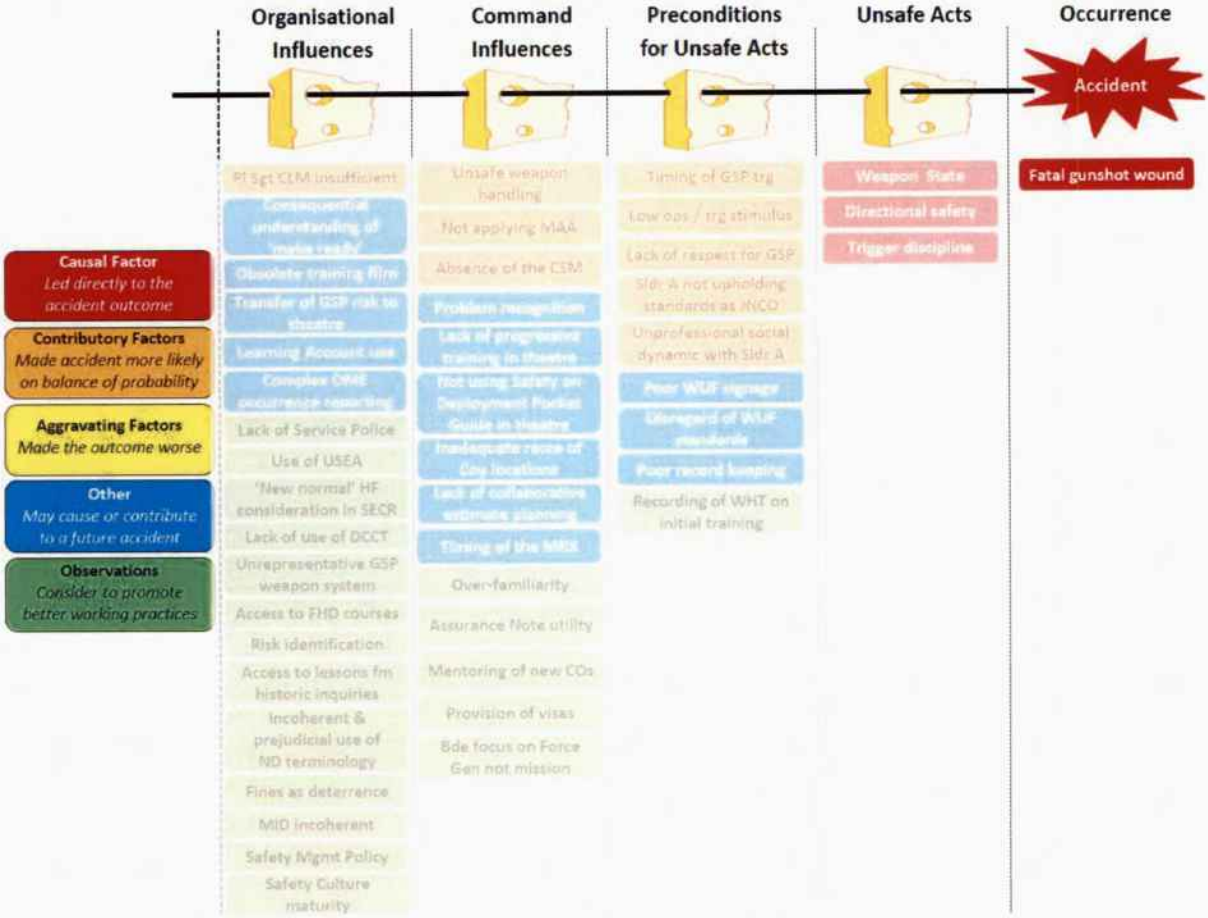
Chapter 1 – The Occurrence



1.4.21. **Chapter overview**. This first Chapter describes simply the factual detail of the accident itself and provides a causal factor which led directly to the unfortunate outcome.

1.4.22. Following a visit to the gymnasium on the afternoon of 2 Jan 17, LCpl Hetherington and Soldier A returned to the accommodation they shared at approximately 1545hrs to relax prior to a briefing. A pistol shot was heard at approximately 1609hrs. Medics arrived on the scene quickly and administered first aid. LCpl Hetherington was extracted rapidly to the local Coalition medical facility. Despite immediate surgery, he was pronounced dead at 1653hrs.

1.4.23. LCpl Hetherington sustained a catastrophic injury consistent with a gunshot wound to the upper centre of his abdomen from a single 9mm bullet. The bullet passed through LCpl Hetherington in a slightly downwards trajectory, exiting the centre of his upper back. The Panel conclude that the injury sustained as a result led directly to LCpl Hetherington's death and was a **Causal** factor. The bullet then penetrated the accommodation wall 158cm above the floor. Exhibit 041 Exhibit 042

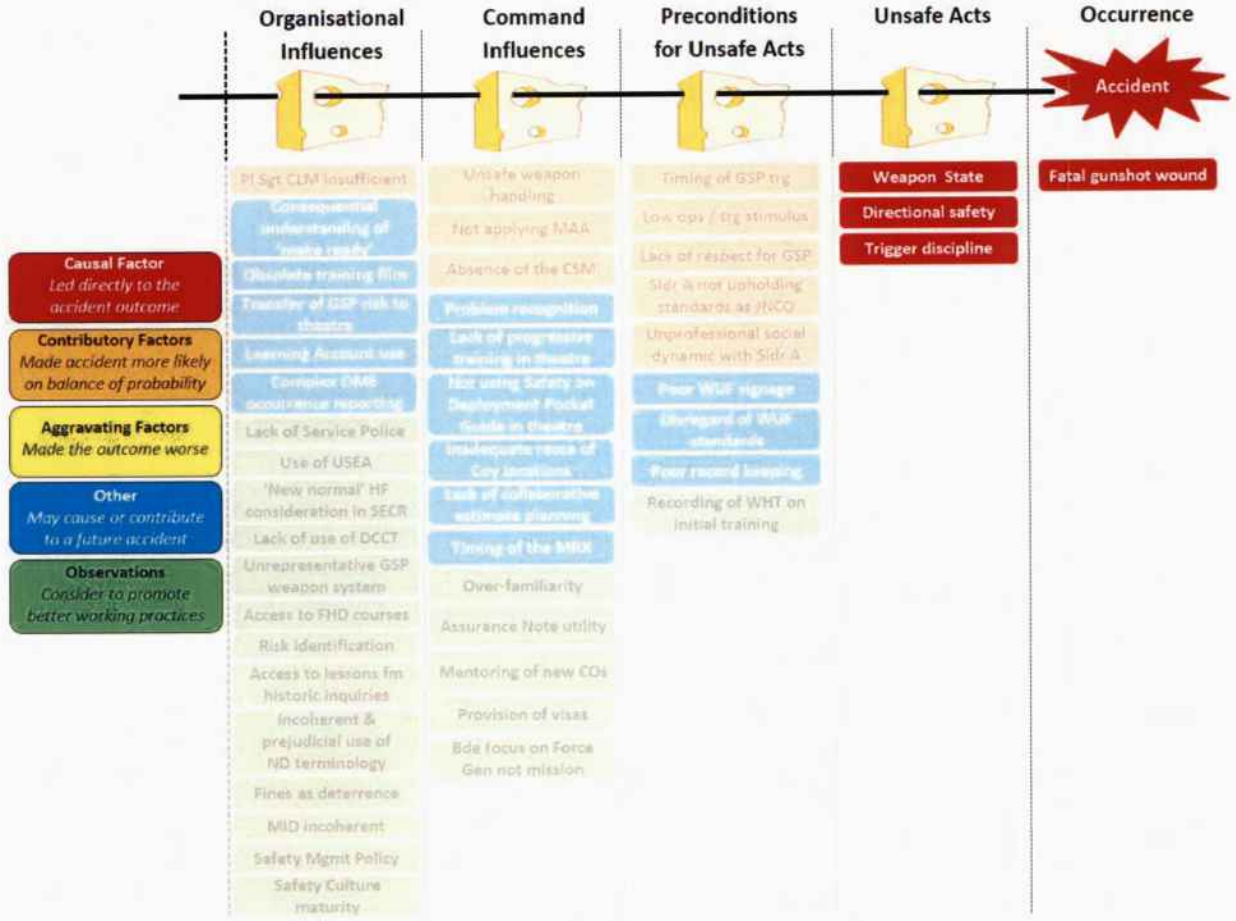
1.4.24. Based on the path of the bullet, Special Investigation Branch (SIB) forensic ballistic modelling concluded that LCpl Hetherington was stood on his Exhibit 042

bed when hit by the bullet and that the bullet was discharged from an elevated position, approximately 40cm from the entry wound.

1.4.25. The Forensic Scientist report confirmed that the weapon from which the round was fired was Soldier A's GSP. Both the weapon and the 9mm ammunition in the magazine were fully serviceable, functioned as expected and passed all subsequent testing with appropriate responses. Exhibit 042

1.4.26. Due to a parallel Royal Military Police (RMP) investigation, the Panel were unable to interview Soldier A prior to Mar 19 but were provided access to witness evidence by the SIB. On this basis, the Service Inquiry was conducted on the hypothesis that the discharge of the GSP was unintentional. As a consequence, Human Factors analysis was considered the most appropriate route to examine the unsafe acts, wider command influences and organisational factors.

Chapter 2 – Unsafe Acts



1.4.27. **Chapter overview**. A sequence of errors and violations of policy and normal process, by key actors in theatre on 2 Jan 17, breached numerous defences in the hours before the accident. This culminated in unsafe and inappropriate weapon handling that led directly to LCpl Hetherington's death in their shared room. This Chapter examines weapon handling policy and procedures and then the actions of Soldier A, specifically his handling of his GSP immediately prior to the accident. Three causal factors were identified that led directly to the accident: Weapon state, Directional safety and Trigger discipline.

Policy and Standing Orders for weapon handling

1.4.28. Defence policy provides guidance on when to open fire for the protection of human life[25] and orders for countering insider threat were extant for Op SHADER[26]. In addition, UKTT(Taji) Standing Orders (SO) defined rules for the safe carriage and control of weapons for UK personnel in Camp Taji.

Exhibit 043
Exhibit 023

1.4.29. **Rules for Safe Handling**. Soldiers are taught that they are responsible, at all times, for the safe handling of their weapons[27]. It is mandatory to teach

[25] JSP 398 Part 2 (V2.0 Mar 17) Annex D – known as Card Alpha.
[26] Directorate Land Warfare, Doctrine Note 15/11. Op CARDEL – Countering The Insider Threat.
[27] DCC Training, Vol II, Skill at Arms, Personal Weapons, SA80A2, Ch1, p.1-58.

these rules verbatim to all soldiers at their first encounter with a weapon. These precautions are regarded as safety critical. The rules are common to all Small Arms Infantry weapon systems but are crucial to the GSP which, by nature of its short barrel, can be pointed more easily in a potentially dangerous direction. As such, the following is taught[28]:

a. On picking up a pistol, keep the muzzle pointing in a safe direction and carry out Normal Safety Precautions (NSP). Place the pistol in the holster or hand it over as applicable. When placing the pistol into the holster ensure the pistol is inserted correctly to prevent unintentional cocking of the pistol.

b. Do not draw the pistol from the holster without good reason.

c. The pistol is to be unloaded before being left where another person could handle it.

d. Never place the finger inside the trigger guard unless intending to fire the pistol.

e. Never point the pistol at anyone in fun.

f. After examination always point the pistol in a safe direction when operating the trigger.

g. Do not pull the trigger indiscriminately.

h. At night, particular care is to be taken to ensure that the condition of the magazine and chamber is known during unloading or making safe.

i. When handing over the pistol on operations the recipient is to be told the state of the pistol i.e. 'Loaded' or 'Ready'. The recipient is to repeat back the state and if correct the pistol is handed over ensuring the muzzle is pointing in a safe direction[29].

1.4.30. **UKTT(Taji) Standing Orders**. In Camp Taji, Army policy and training for safe weapon handling were supported by UKTT(Taji) Standing Orders (SO). These directed that personnel keep both their rifle and pistol loaded, but not Made Ready[30]. Only in the face of a potential threat to life would they be expected to Make Ready without a direct order. Once weapons had been cleaned they were to be reloaded at the Weapon Unloading Facility (WUF)[31] under supervision. Neither LCpl Hetherington nor Soldier A complied with this order, in contravention to the local SOs; Soldier A stated that he inserted a magazine into his pistol en route to his room. Failure to follow procedures culminated in the unsafe act.

Exhibit 023

Witness 025

[28] DCC Training (Trg), Vol II, Skill at Arms (SAA), Personal Weapons, GSP L131A1, Ch1, p.1-8 to p.1-9.

[29] These safety precautions are printed in red in training publications indicating that it is mandatory and safety-critical to teach them verbatim to students.

[30] *"The weapon is 'Ready to fire' when there is a round in the chamber and the firing pin assembly is cocked".* DCC Trg, Vol II, SAA.

[31] The Weapons Unloading Facility (WUF) is more commonly referred to as the 'Loading or Unloading Bay'.

The 3 Causal Factors

1.4.31. **Weapon state**. Noting that Soldier A's GSP discharged, it must have been Made Ready to fire and the trigger mechanism must have been operated. The GSP is Made Ready by pulling back fully, then releasing, the top slide. This feeds a 9mm round from the magazine into the chamber. Soldier A was unable to recall with certainty how and when the GSP was Made Ready. The Panel considered 5 scenarios in which the state of Soldier A's weapon could have changed from Loaded to Made Ready: Prior to weapon cleaning; During weapon cleaning; At the WUF; When holstering the pistol or In the room. Witness 025

a. **Prior to weapon cleaning**. In theory, Soldier A's weapon could have been in a Made Ready state for some time before the accident. If this had been the case, however, it would have come to light while conducting NSP immediately prior to weapon cleaning, or during the weapon's disassembly. The Panel believes that it is very unlikely Soldier A's GSP was Made Ready in this manner. Witness 005

b. **During weapon cleaning**. The Panel believes that it is extremely unlikely that a single 9mm round was placed into the chamber of Soldier A's GSP during weapon cleaning. There is no evidence to suggest that Soldier A's GSP was tampered with during weapon cleaning. If a round had entered the chamber by any means this would have been obvious during the Function Test which should be conducted immediately after re-assembling the GSP[32]. The Panel believes that it is very unlikely Soldier A's GSP was Made Ready in this manner. Witness 006

c. **At the WUF**. The GSP could have been Made Ready by accident when loading at the WUF. However, Soldier A cannot recall using the WUF following weapon cleaning, instead loading his pistol en route to his room. There is no evidence to suggest that Soldier A Made Ready at either the WUF or while en route to his room. The Panel believes that it is very unlikely Soldier A's GSP was Made Ready in this manner. Witness 025

d. **When holstering**. Although exceptionally difficult to achieve, a loaded GSP can be Made Ready if holstered incorrectly. However, as Soldier A and LCpl Hetherington left weapon cleaning without their holsters they could not have holstered their weapons[33]. For this reason, the Panel believes that Soldier A's GSP could not have been Made Ready in this manner. Witness 006

e. **In the room**. Soldiers should know the state of their weapon at all times. Soldier A stated he was 'messing about' with his GSP in his room prior to the accident, cocking the GSP and playing with the magazine. If Soldier A had made a procedural error in his weapon handling drills by cutting and splicing sequences from different drills while messing around, contrary to orders and established teaching, it is possible that he could have lost awareness of his weapon state. In the absence of a compelling alternative hypothesis, the Panel believes it is very likely that Soldier A unwittingly Made Ready his GSP in the room while playing with it. Witness 025 Witness 009

[32] DCC Trg, Vol II, Ch 1, p.1-12.

[33] Holstering the GSP is the last formal step of the GSP load drill.

1.4.32. The Panel believes that Soldier A lost awareness of his weapon state, probably through the mis-application of weapon handling drills, inadvertently making his GSP ready to fire, which was a skill-based error. The Panel concludes that this was a **Causal** factor.

1.4.33. **Directional safety**. From Week 1 of basic training when recruits are introduced to the SA80 rifle, policy dictates that soldiers are taught that the muzzle should always be pointed in a safe direction. In addition to GSP training, Soldier A had been trained in a range of Infantry weapon systems (covered in the next Chapter) and as such the Panel is certain that he would have known this rule. The Panel concludes that the weapon was pointed in an unsafe direction and that this was a **Causal** factor.

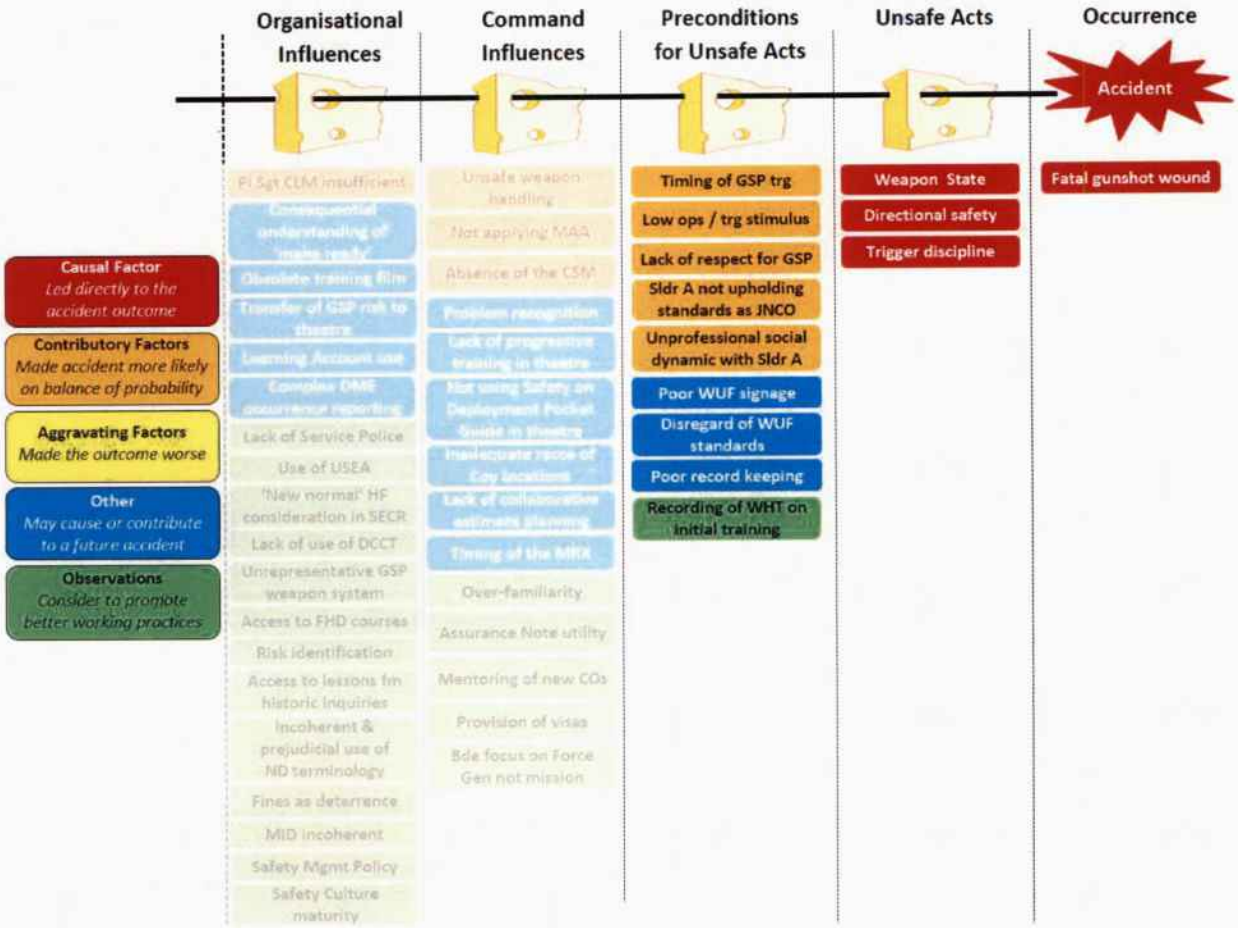
1.4.34. **Trigger discipline**. The trigger of a firearm should only be operated on 2 occasions: to engage a target or as part of an approved drill. Trigger discipline is taught and reinforced robustly from the earliest of stages of Skill At Arms training. The serviceability of Soldier A's GSP is examined in detail in the next Chapter, however, as a round was discharged it is known that the trigger mechanism was operated. The Panel concludes that lack of trigger discipline was a **Causal** factor.

1.4.35. **Conclusion**. The Panel notes that in this case, Soldier A failed to follow 7 of the 9 Rules for Safe Handling. Significantly, his GSP was Made Ready to fire, pointed in an unsafe direction and the trigger operated. The Panel concludes that adherence to the Rules for Safe Handling[34] would have prevented this accident. The Panel **observes**, however, that within the Rules for Safe Handling there is no direction as to when a soldier may Make Ready, and that a more explicit reference would reinforce the significance of the action.

1.4.36. **Recommendation**. Head of Capability, Ground Manoeuvre (HoC GM) should amend weapon handling procedures, within Skill at Arms training, to specify the circumstances when a pistol is to be Made Ready, in order to clarify and augment the Rules for Safe Handling.

[34] DCC Trg, Vol II, Ch1, p.1-10, Rules for Safe Handling.

Chapter 3 – Preconditions for Unsafe Acts



1.4.37. **Chapter overview**. This Chapter looks specifically at the factors which set the conditions for the accident to occur. These include the physical environment of Camp Taji, a technical consideration of the GSP, weapons training policy and its application, the psychological state of Soldier A and physiological factors. The Panel considers that these factors can influence human performance and behaviour and that some acted as preconditions for Soldier A's unsafe acts. Five contributory factors were identified: Timing of GSP training, the Operational tempo on Op SHADER, the Perception of the GSP and the Performance of Soldier A, both as an individual and in his relationships with others.

Physical Factors

1.4.38. **Weather**. In Iraq, January is characterised by daily highs of around 16°C throughout the month, rarely exceeding 20°C, and lows of approximately 6°C. On 2 Jan 17, the weather was bright and cloudy with a slight wind of 8mph and there was a noon high of 14°C. On this basis the conditions were consistent within environmental seasonal norms and comfortable operating parameters; the Panel concludes that the weather was **not** a factor.

1.4.39. **Camp Taji**. Camp Taji contained a mix of American, ANZAC and British forces all working to support the development of the ISF and Police. The Coalition camp is separate from the ISF camp, both of which are separated from the training area and ranges. For an operational location, Camp Taji is comfortable. All Coalition soldiers have access to excellent dining facilities, a gymnasium, showers, communications and welfare facilities, including easy access to the internet. The UKTT(Taji) accommodation [redacted] Although high ambient daytime temperatures are common in summer, air conditioning is used extensively throughout the buildings. On the basis that Camp Taji was not an austere location and offered excellent facilities for rest and entertainment, the Panel concludes that the living environment was **not** a factor. However, living conditions that were not as austere as expected is considered in greater detail under Psychological Factors later in this Chapter.

Witness 010
Witness 014
Witness 001

1.4.40. **Communal accommodation**. UKTT(Taji) personnel lived together in a neat compound with accommodation pods [redacted]. The Den was used as both a private space for soldiers to relax when off duty and also for briefings and weapon cleaning. [redacted]. On the basis that it was functional, well-sited and protected, the Panel concludes that the standard of the communal accommodation was **not** a factor.

[redacted]

Figure 9: Plan of UKTT(Taji) accommodation

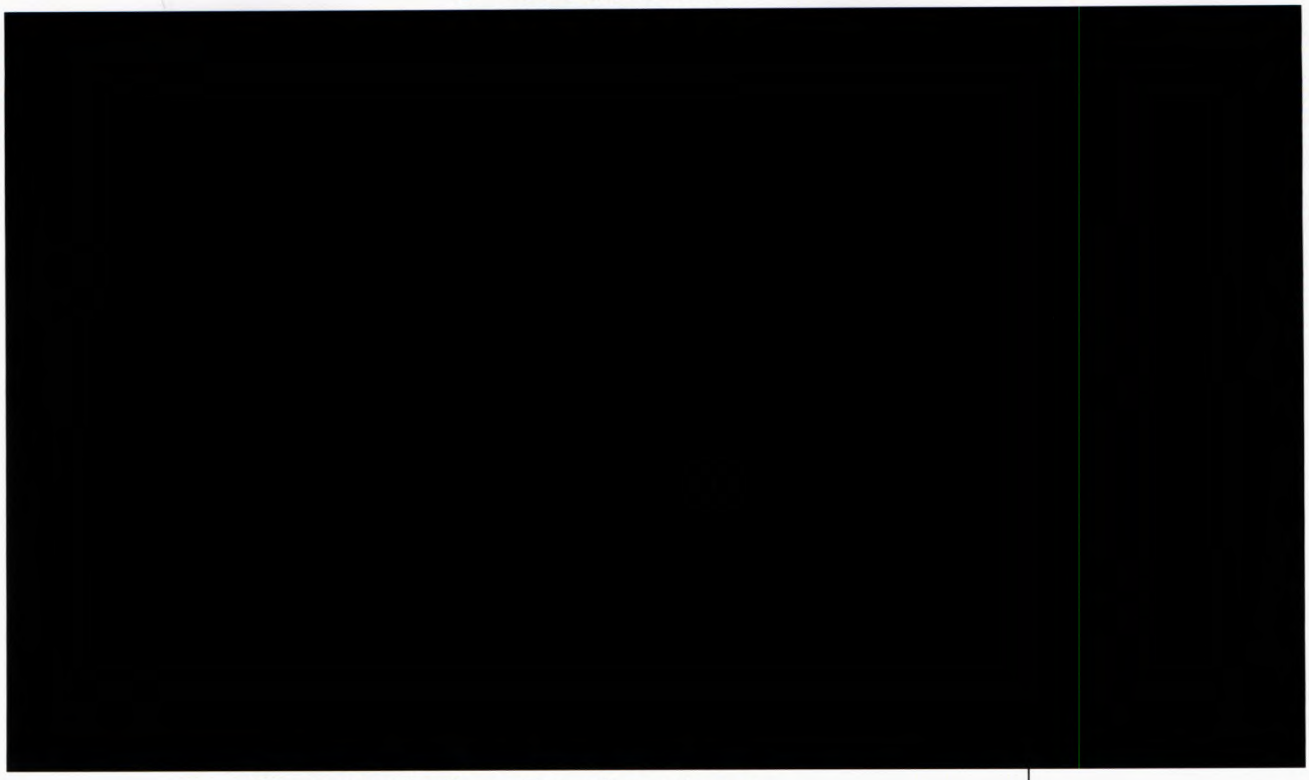


Figure 10: The Den - From the entrance

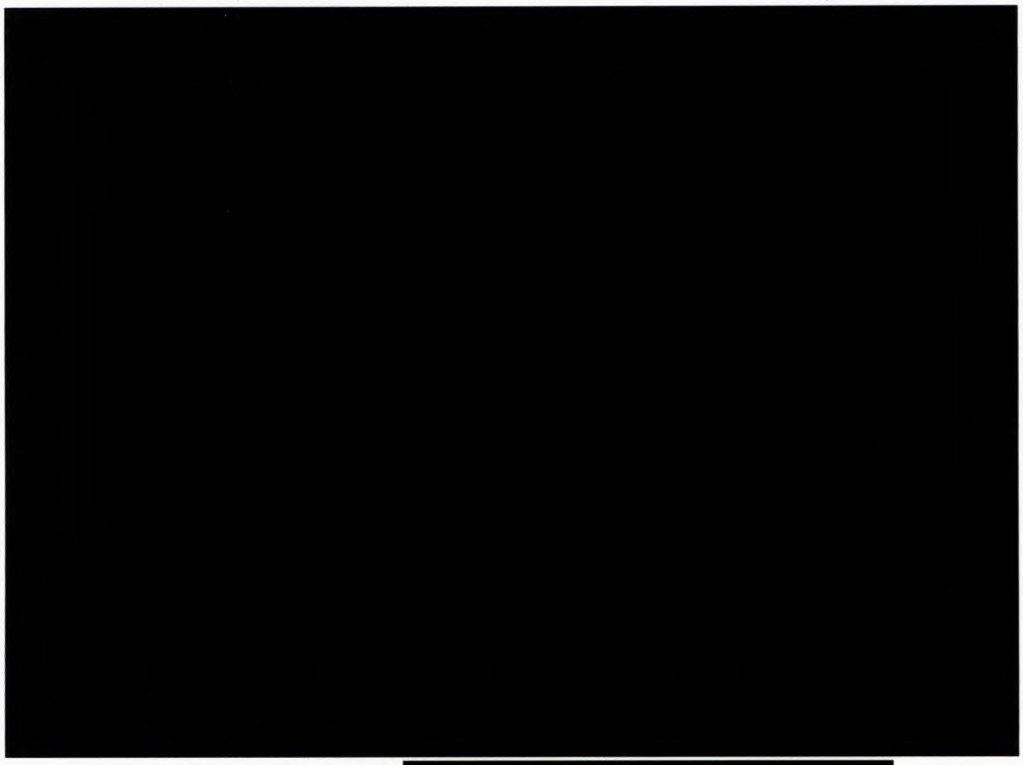


Figure 11: The Den - [redacted]

1.4.41. **Personnel accommodation**. UKTT(Taji) personnel shared purpose built 'container accommodation' as 2-bed rooms, [redacted]. Inside each room were 2 single beds, a cupboard and chests of drawers, as shown in Figure 12. It was not uncommon for rooms to contain televisions and small refrigerators. The accommodation was well lit, with a 240V power supply through British

sockets, air conditioning and wireless internet. The Panel concludes the standard of personnel accommodation was **not** a factor, however, the allocation and supervision of soldiers within their rooms is considered in greater detail under Platoon level supervision in Chapter 4.

Figure 12: Room [redacted], Pod [redacted], UKTT(Taji) accommodation

1.4.42. **Weapon Unloading Facility**. The WUF, illustrated in Figures 13 and 14, [redacted]

Figure 13: The Weapon Unloading Facility

Figure 14: The Weapon Unloading Facility [redacted]

1.4.43. UKTT(Taji) was established in early 2016. 2 LANCS inherited the WUF on Transfer of Authority (ToA) from 1 RIFLES in Dec 16. Figures 13 to 15 indicate the standard of the WUF as found by the Panel in Mar 17. It is acknowledged that although UKTT(C) BG did focus on improving UK

Exhibit 008

infrastructure across the theatre, raising ~40 Statements of Requirement during their tour, the Panel believes it is highly unlikely the condition of this WUF was improved between ToA and their visit in Mar 17. Exhibit 117

1.4.44. Despite the permanence of UKTT(Taji), the WUF remained a relatively temporary structure with little physical or conceptual investment. Two issues relating to safety signage are worthy of note.

a. **Location**. The rifle and GSP loading and unloading procedures, in Figure 15, rather than being directly in front of the WUF to assist soldiers conducting NSPs and their supervisor, were taped to the adjacent blast wall. The words were far too small to read from behind the weapon handler. If a supervisor were to stand close enough to read the procedures s/he would almost certainly be forward of the weapon handler(s) and unable to simultaneously read from the instructions and observe the weapon drills.

b. **Content**. The GSP loading and unloading procedures displayed were not approved weapon handling drills[35], but a corrupt and inaccurate version of rifle procedures. As an unofficial blend of different procedures, they referred to the rifle's 'holding-open device' and 'bolt release catch' and they made no mention of drawing or reholstering the GSP, both essential steps in conducting proper GSP safety procedures.

[35] DCC Trg, Vol II, Ch 1, p.1-20.

Figure 15: Load and Unload Procedures at the Weapon Unloading Facility

1.4.45. Whilst the WUF was functional, the signage was unauthorised and inadequate. The Panel notes that the policy for siting and construction of WUFs[36] currently contains no definition of acceptable standards in deployed locations or if and where weapon handling instructions should be mounted. The Panel concludes that inappropriate signage was an **Other** factor.

1.4.46. **Recommendation**. Defence Ordnance Munitions and Explosives (OME) Safety Regulator (DOSR) should update JSP 403, Volume 2, Chapter 32, Weapon Unloading Facilities, to clarify if and where instructions for safe weapon handling should be positioned in order to reinforce the importance of safe weapon handling and effective supervision.

1.4.47. In the Panel's opinion, the disregard for the standard of the WUF did not reinforce in the minds of the FP PI, including Soldier A and LCpl Hetherington, the professionalism necessary for safe weapon handling. The Panel concludes that

[36] JSP 403 Vol II, Edition 3, Change 6, Ch 32, p. 1, WEAPON UNLOADING FACILITIES (WUF) dated Feb 12.

this is likely to have contributed to Soldier A's poor respect for the GSP and was an **Other** factor.

1.4.48. **Recommendation**. Chief Safety (Army)[37] should make refererence to Joint Services Publication (JSP) 403 for WUFs in Operational Safety presentations and the Safety on Deployment Pocket Guide in order to reinforce the importance of safe weapon handling and effective supervision.

Technical Factors

Weapon Serviceability

1.4.49. Soldier A's GSP was in date for its Mandatory Equipment Inspection and no faults had been reported prior to the incident. Immediately after the incident, the pistol was inspected by a military Class 1 Armourer who stated that no faults were found and confirmed that it was fully serviceable. Exhibit 021 Exhibit 045 Exhibit 046

1.4.50. An independent inspection on 13 Apr 17 by a Forensic Scientist for the RMP SIB found that Soldier A's GSP, its magazines and rounds were fully serviceable and the trigger pull was within the expected tolerances for a Service pistol. It was the opinion of the Forensic Scientist that the fired cartridge case had been fired from Soldier A's GSP and the weapon performed as expected. The Panel concludes the serviceability of Soldier A's GSP was **not** a factor. Exhibit 042

Weapon System Safety

1.4.51. Brought into service in 2013, the Glock 17 was designed to operate quickly and does not have an externally applied safety catch. According to the initial requirement justification[38], the decision to procure the GSP was to give UK forces an advantage in engaging and suppressing an enemy in Close Quarters Battle (CQB). It was believed that replacing the L9A1 Browning, L105A2 SIG 226A2 and L47A1 Walther with the GSP as a single personal defence weapon for all arms would simplify training and improve capability. Exhibit 047

1.4.52. The Safety and Environmental Case Report (SECR) for the GSP assesses the design of the weapon and does not consider ammunition or the man-machine interface. The Duty Holder's ALARP[39] statement in the SECR reads, "the weapon system does not expose personnel, the general public or the environment to unacceptable risk". However, within its hazard and risk analysis, 'Failure to adhere to operational procedures' and 'Human Factors' are both listed as causes of hazard against 'Unintentional Discharge'. It is noteworthy that the GSP Fielding Plan considered there to be no significant personnel integration issues. This assessment of risk is based on the GSP safety system consisting of three elements: the GSP design, the holster and policy, education and training. Exhibit 049 Exhibit 047

[37] Was Chief Environment and Safety Officer (CESO) (Army) in 2017.

[38] Fielding Plan v1.1 for Glock 17 9mm pistol (ARMYHQ/EQPT/CE/L131A1).

[39] As Low As Reasonably Practicable.

Internal safety design

1.4.53. The Glock 17 is designed with three internal mechanisms that disengage in sequence as the trigger is operated, and are reactivated when the trigger is released. Illustrated in Figure 16, they are:

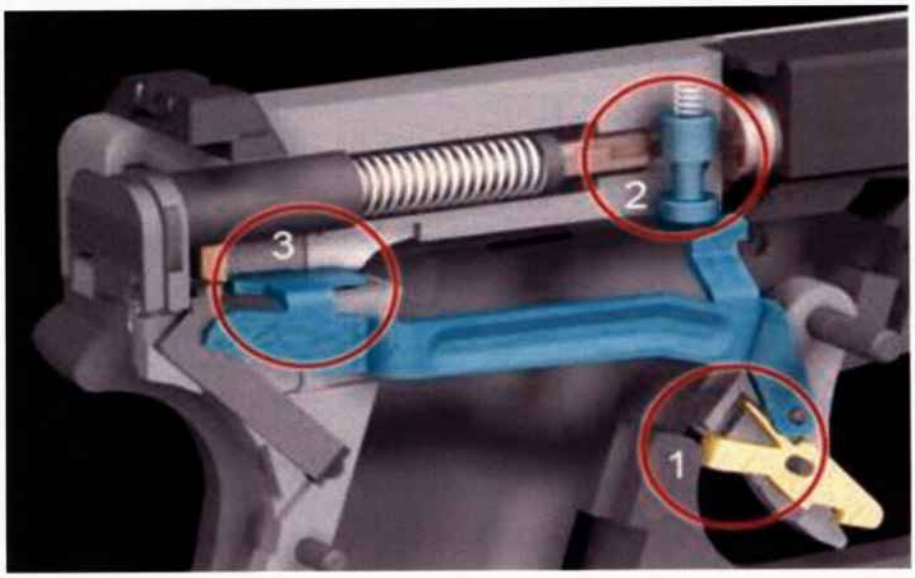


Figure 16: Glock 17 internal safety system

a. **Trigger Safety (1)**. The external safety is a small lever incorporated into the trigger that prevents the trigger from moving far enough to the rear to fire the pistol, unless the trigger safety is fully depressed. This safety mechanism requires linear pressure of 2.5 kg to be applied across the whole trigger for the weapon to fire.

b. **Firing Pin Safety (2)**. The firing pin safety consists of a pin with a small internal spring, projecting into a cut-out on the firing pin, this acts as a physical impediment preventing the firing pin from striking the base of a chambered round. Only pulling the trigger will disengage the firing pin safety, thereby allowing the firing pin to move far enough forward to strike the base of the chambered round.

c. **Drop Safety (3)**. The drop safety physically prevents the firing pin from being released unless, or until, the trigger is pulled. The drop safety disengages only when direct rearward pressure is applied to the trigger. Exhibit 048

1.4.54. The internal safety mechanisms deactivate sequentially if the correct linear application of pressure is applied to the trigger. They do not act as a barrier to prevent operation of the trigger but prevent inadvertent operation of the weapon through jarring or dropping. The Panel acknowledges that there is no externally applied safety catch on the GSP to act as a barrier to fire the weapon. Noting that pistol Negligent Discharges (ND) have not been prevented by external safety catches, and that reported NDs remain broadly consistent across the Land domain with old and new pistol types, the Panel concludes that the design of the GSP is **not** a factor. The holster and self-discipline combine to prevent inadvertent operation of the trigger. Exhibit 049 Exhibit 050

The Holster

1.4.55. The holster is an integral part of the GSP safety system. It is mandatory that the GSP is carried in an issued holster. It can be worn on the thigh, hip or elevated to be worn on body-armour safely and comfortably, at the same time allowing the pistol to be readily accessible. Although there are other variants available for aircrew and specialist users, only the type depicted in Figure 17 was permitted for UKTT(C) BG. Exhibit 048

Figure 17: GSP, magazine, leg holster and lanyard correctly fitted

1.4.56. The moulded shape of the holster guarantees a perfect fit for the GSP. As the GSP is holstered, it is locked into place by 2 mechanisms. A lanyard of heavy duty coiled cord is fitted for added security. As the trigger mechanism is covered, the GSP cannot be inadvertently fired from the holster. Exhibit 048

1.4.57. Using the holster, the GSP can be carried in one of 3 conditions:

a. **Unloaded**. In this condition no magazine is fitted to the weapon nor is any ammunition present in the weapon.

b. **Loaded**. In this condition a magazine is fitted in the weapon and the chamber is clear.

c. **Made Ready**. In this condition a loaded magazine is fitted and a live round is carried in the chamber of the weapon.

1.4.58. The Panel notes that the holster is a defensive barrier to prevent inadvertent operation of the trigger. It is a critical element in the GSP safety system and as such needs to be recognised by all users and embedded in learned behaviours. The Panel concludes that the design of the GSP holster is **not** a factor. Failure to recognise the significance of the holster is considered in detail under Platoon level supervision in Chapter 4.

Weapon Policy

1.4.59. **Operational Shooting Policy (Small Arms)**. All Service personnel are trained to a standard where they can apply marksmanship principles and deliver effective Small Arms fire in accordance with their role. Pistol training policy is set by HQ Small Arms School Corps (SASC) on behalf of HoC GM and is articulated in the following publications:

a. Dismounted Close Combat Training - Volume I Skill at Arms - Individual Training Operational Shooting Policy (OSP) - Personal Weapons (DCC Trg Vol I).

b. Dismounted Close Combat Training - Volume II Skill at Arms (Personal Weapons) General Service Pistol L131A1 (DCC Trg Vol II).

c. Dismounted Close Combat Training - Pamphlet No 21 - Training Regulations for Armoured Fighting Vehicles, Infantry Weapon Systems and Pyrotechnics (DCC Trg PAM 21).

1.4.60. **Mandatory Small Arms training and testing**. Common to all Small Arms skills development is a logical syllabus of education, training and testing in accordance with the standards laid down in Operational Shooting Policy[40]. This progression is mandatory and not only breeds confidence in the soldier, but also trust in his team. For those instructing, it provides consistency and a Defence standard for weapon handling skills. It consists of the following 5 progressive stages:

a. **Weapon Handling Test (WHT)**. The purpose of the WHT is to test individual personal weapon handling skills in line with operational safety and the weapon handling requirement. To stay current, a WHT is to be conducted bi-annually (every 6 months).

b. **Live Fire Marksmanship Training (LFMT)**. This is the introduction to Live Firing where firers become familiar with their individual aiming points; for the GSP, this is for ranges out to 25 metres.

c. **Annual Combat Marksmanship Test (ACMT)**. The ACMT is the annual shooting test for all Service personnel. Firers engage a variety of targets from different firing positions out to the battle range of their weapon. These tests ensure the foundations for transition to and execution of LFTT.

d. **Transition To Live Firing Tactical Training (TTLFTT)**. Operational shooting skills are developed beyond the basic standards achieved in LFMT. TTLFTT on the GSP comprises both CQM and firing under Chemical Biological Radiological and Nuclear (CBRN) conditions.

e. **Live Firing Tactical Training (LFTT)**. This is the culmination of training the soldier as a 'battle-shot[41]'. It brings together and practises all operational marksmanship skills.

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[40] DCC, OSP Vol I, Pers Wpns, Ch 1.

[41] There are five stages to training the battle shot each of which is sequential with progression dependent on achieving satisfactory standards at each level.

GSP training and testing

1.4.61. **Instructional lessons**. Training to operate the GSP is carried out by Skill At Arms Instructors through a series of instructional lessons. There are 4 periods of instruction, totalling 4 hrs of lessons:

a.	Safety, stripping, cleaning and assembling	1hr 20 mins
b.	Magazine filling, load, unload and make safe	40 mins
c.	Firing from combat positions, use of cover and CQB	1hr 20 mins
d.	Immediate action and stoppage drills	40 mins

1.4.62. **Practice periods**. Practice periods enable the facts and skills taught in the instructional lessons to be revised and developed. There are 3 practice periods, totalling 3 hours 20 minutes:

a.	Stripping, assembling, loading, unloading and handling	1 hr 20 mins
b.	Firing from combat positions and CQB	1 hr 20 mins
c.	Immediate action and stoppages	40 mins

1.4.63. **Comparison**. There are 17 instructional lessons for the SA80 rifle totalling 23 hrs 40 mins of lessons, and 8 hrs 20 mins of practice periods. The contrast between the SA80 rifle and GSP can be explained because all UK Service personnel are first introduced to Small Arms with the SA80 rifle and it remains the individual weapon for the majority of personnel. Due to this previous experience personnel may require less time to assimilate GSP skills. In the Panel's opinion, the quantity of mandated GSP instruction is sufficient for a less complex weapon that is trained after the SA80 rifle.

Small Arms competence

1.4.64. British Army doctrine recognises that "Shooters, more than any other group, suffer from delusions of competence"[42]. The Panel believes that this may in part be due to a confusion between competence[43] and skilled performance. According to the GSP training pamphlet, the "measure of a soldier's competency is passing the WHT"[44]. Successful completion of the GSP WHT permits a soldier to live fire to ACMT standard. According to the Military Annual Training Tests (MATT) 1, Personal Weapon Training policy statement, "there is a minimum acceptable standard of both weapon training and shooting that accompany the dual requirements of operational effectiveness and safety". GSP "competence and confidence is achieved ... through the WHT and ACMT"[45]. Passing the ACMT provides an indication of firing competence with the GSP, at the time of the

[42] DCC Trg, Vol IV, Ranges, Marksmanship Coaching, p.3-13.

[43] *Competence* is defined as "sufficiency of qualification; capacity to deal adequately with a subject" in Oxford English Dictionary online. *Competent* is "having the necessary ability, knowledge, or skill to do something successfully". It is also used to describe a satisfactory level of capability, which is "acceptable though not outstanding", or a legal authority for use.

[44] DCC Trg, Vol II, Skill at Arms (Personal Weapons), GSP L131A1 p.v.

[45] MATT 1, Personal Weapon Training – Policy Statement, Issue 10, dated Apr 2018.

test. The Panel considers that, if passed, these two tests are a poor guide to a soldier's future performance with the GSP. The Panel believes that although qualified, current and competent, a soldier's true level of expertise and likely performance with the GSP is not well understood. The Panel **observes** that sub-units conducting their own GSP training and WHT do not benefit from external assurance and this introduces additional risk and the opportunity for a 'paper pass'[46]. Exhibit 051

1.4.65. **Competence as a WHT pass**. The Army does not record with purpose the progress towards the achievement of GSP competence. For example, the Panel could find no evidence of records of whether an individual soldier has completed all the basic instructional lessons and practice periods. In order to ensure minimum safety standards are met on a range, it is mandated that Range Conducting Officers confirm that all users have passed a WHT prior to live firing[47]. The policy does not mandate that a check be made to confirm that an individual has completed all the basic instructional lessons and practices. If a soldier can pass a WHT, they are permitted to conduct live firing. In the process of this inquiry, a Panel member was allowed to fire the GSP, having passed a WHT at the back of a range, without completing all of the formal lessons or practice periods. Although declared competent and achieving ACMT standard, the Panel member completed all mandatory GSP training at a later date to improve his competence. The Panel **observes** that without a means to record and demonstrate successful completion of lessons and practice periods, the chain of command is only able to refer to a soldier's WHT as the first evidence of GSP competence. This fails to incentivise completion of all basic lessons and practice and, as such, introduces unnecessary risk to all stakeholders.

1.4.66. **Competence as an ACMT pass**. First-time pass rates for the Rifle ACMT have risen consistently across the Army in recent years and much effort has been made to increase weapon handling skills and marksmanship. This is being pursued through the reinforcement of Operational Shooting Training Teams across the Field Army, better coaching and increased emphasis on marksmanship to improve skills. The Panel has no evidence, however, of whether pass rates or scores for the GSP ACMT are being recorded routinely across the Field Army. Without such data for use by firers or the organisation, it is difficult to analyse levels of competence or performance trends. In Mission Specific Training (MST), unlike the SA80 rifle, the GSP is only trained to ACMT, not LFTT. The Panel notes that if the FP PI had been trained to GSP LFTT standard in MST, a higher degree of confidence in shooting competence could have been attained. Exhibit 051

1.4.67. **Recommendation**. The Army Inspector should audit how the Army records the completion of GSP instructional training and achievement of GSP ACMT and LFTT in order to assure GSP competence.

1.4.68. **GSP marksmanship excellence**. There is recognition within the specialist user community that, despite being assessed as competent, some of those attempting selection are inexperienced and unfamiliar with the GSP. This has led to the introduction of additional pistol training prior to elements of specialist user selection that includes expert coaching, in small groups, in a live fire environment. It is of no surprise to specialist instructors that after this concentrated training, applicants are more confident and competent in weapon handling and shooting. The Panel concludes that to achieve high performance Exhibit 052

[46] A 'paper pass' is a colloquial term used to describe an assessment that is signed as complete without the correct test conditions or procedures being observed.

[47] DCC, OSP Vol I, Pers Wpns, Ch 8, para 8-08 .

with the GSP requires frequent and concentrated periods of training and practice, in small groups, with expert instructors. In the opinion of the panel, the pursuit of professional excellence in this manner is also likely to increase respect for the weapon and breed an Army-wide appreciation of GSP marksmanship. When and how GSP training is delivered is considered in greater detail in Chapter 5 and a recommendation presented.

1.4.69. **Incentivising GSP marksmanship**. The Panel believes that when compared with other core skills such as physical fitness, recognition and reward to create and celebrate a culture of shooting excellence is weak. Although there are plenty of in-barracks ranges, opportunities to fire regularly are difficult to find for those not at Regimental Duty as there is no simple booking mechanism. Noting that the Army is the profession of (small) arms, the internal narrative about the importance of marksmanship appears insignificant. The Army has a badge to be worn on No. 2 Dress to recognise rifle marksmanship, but it is not widely seen. The Panel notes that in Jun 18, a series of metallic marksmanship badges to be worn with working dress were introduced[48] to promote rifle marksmanship and recognise shooting excellence. The Panel **observes** that a badge to recognise and reward GSP marksmanship would both assist the development of a culture of Skill at Arms excellence and increase respect for the pistol. Exhibit 051

1.4.70. **Recommendation**. HoC GM should enable SASC to promote, reward and recognise GSP marksmanship excellence, across all ranks, in order to elevate the importance of GSP marksmanship as a core skill.

Application of Weapon Training Policy

1.4.71. **GSP training policy**. Unlike other Infantry weapon systems, the GSP is not taught to soldiers during their basic training. The point at which pistol training is delivered, competence achieved and individuals qualified is delegated to units by Field Army Training Branch through Workplace Training Statements. Delegated pistol training is assured by HoC GM as the Army Competent Advisor & Inspectorate in line with Army Command Standing Order (ACSO) 4001[49]. Exhibit 053 Exhibit 054

Soldier A - Basic Training

1.4.72. Soldier A enlisted into the Army on 17 Mar 13, and commenced his Combat Infantryman's Course (CIC). Although a complete record of WHT dates could not be provided, between Apr and Sep 13, he was trained and qualified on the following Infantry weapon systems and pyrotechnics: Exhibit 055 Exhibit 056 Exhibit 019

a. Rifle SA80 L85A2.

b. Underslung Grenade Launcher L17A2.

c. Light Machine Gun L110A2.

d. General Purpose Machine Gun L7A2.

[48] Army Briefing Note 61-18 'Army Marksmanship Badges', 26 June 2018.

[49] Army Command Standing Order 4001 - The Policy for Army Competent Advisors and Inspectorates. Hd GM is appointed as ACAI for GM Combat, including: Small Arms & Infantry Support Weapons Policy (Including range management qualifications, field firing, Small Arms Equipment Policy and Pyrotechnics Equipment Policy).

e. Grenade High Explosive L109.

f. Grenade Smoke L72 and L83.

g. Rocket Flare L54A4 and L16A1.

h. Trip Flare L10.

i. Flare Kit 16mm.

1.4.73. Further WHT passes on all the weapons and pyrotechnics named above are recorded for Soldier A on 27 Sep 13, the date of his arrival at 2 LANCS. Exhibit 019

1.4.74. The Panel **observes** that Soldier A's Competency Profile recorded by the Army Personnel Centre aggregates all WHT passes for each weapon system and pyrotechnic and records them as 27 Sep 13. Although convenient, it is not a true representation of when a soldier passes his WHT for each weapon type during CIC and thus his initial currency is based on his arrival at his Bn not time since passing the WHT.

Soldier A - Continuation Training

1.4.75. In the period from 6 May 14 to 6 May 15, WHT passes are recorded for Soldier A on a variety of weapons. This demonstrates continued currency and competence with the Infantry weapon systems taught on his CIC. The Panel has found no evidence of WHTs being recorded between 7 May 15 and the commencement of MST for Op SHADER on 31 Aug 16. Exhibit 055

1.4.76. Due to gaps in training records, the Panel believes that record keeping of Small Arms training and qualification was insufficient to provide the Army with accurate information about when, and to what standard, soldiers acquired competency and qualification. The Panel concludes this was a demonstration of poor record keeping and was an **Other** factor. However, the Panel believes that the scope and content of basic and continuation training, for those Infantry weapon systems taught to Soldier A, was sufficient and was **not** a factor.

1.4.77. **Recommendation**. HoC GM should ensure accurate record keeping of all weapons training and qualifications is achieved at the start of a Service Person's career and maintained accurately throughout, in order to improve accountability and assurance.

Soldier A - Pre-Deployment Training

1.4.78. The first record of Soldier A passing his GSP WHT is on 1 Sep 16. This is 3½ years after his enlistment and first exposure to the SA80 rifle and other weapon systems. Soldier A is recorded as having passed 4 further GSP WHTs in the 4 months prior to the accident, on the following dates: Exhibit 019

a. 6 Oct 16 - Ranges, Weeton Barracks.

b. 17 Oct 16 - Sub-unit Combined Arms Exercise, Swynnerton.

c. 27 Oct 16 - Ranges, Weeton Barracks.

d. 15 Dec 16 - UKTT(Taji), Iraq.

1.4.79. The 2 LANCS FP PI leaders consider the unit did more than sufficient weapons training in preparation for Op SHADER and that Soldier A had met the required standard of GSP proficiency demanded by the Army. The Panel conclude that frequency of passing a WHT is not correlated to future behaviour. Witness 001 Witness 014 Witness 015 Witness 006

1.4.80. **In-theatre weapons training**. On arrival in theatre members of UKTT(C) BG completed a Reception, Staging and Onward Integration (RSOI) training package. This included an opportunity to zero their individual SA80 rifles. Between RSOI and 2 Jan 17, GSPs were not fired because the in-theatre training ammunition had been allowed to expire and no resupply had been arranged by 1 RIFLES. Witness 016 Exhibit 061 Witness 002 Witness 014

1.4.81. **Conclusion**. Soldier A arrived in theatre 3½ months after his first exposure to the GSP. The Panel concludes that although trained and qualified, his familiarity with the GSP, relative to all other Infantry weapon systems, was emergent. The timing of GSP training for Soldier A limited his familiarity with the GSP; this was a **Contributory** factor. A recommendation concerning how and when GSP training is delivered is considered in greater detail in Chapter 5.

In-Theatre Weapon Carriage

1.4.82. **In-theatre weapon carriage policy**. The Field Army Op SHADER MST Directive defines minimum training requirements for personnel deploying as a UKTT and specifically for Force Protection. The Op SHADER policy for the carriage of weapons on Op SHADER was reiterated in the 1 (UK) Div Force Generation (FGen) Order, issued on 12 Jul 16. This specified that in the following areas: Exhibit 062 Exhibit 002

a. [redacted]

b. **Broader Iraq**. Personnel must deploy with a Long Barrelled Weapon and/or Short Barrelled Weapon.

c. [redacted]

The Panel believes the Op SHADER weapon carriage policy was modifiable to reflect existing threats and was **not** a factor.

1.4.83. **UKTT(C) BG weapon carriage policy**. 1 (UK) Div was responsible for generating the suitably qualified and experienced personnel (SQEP) to fill the requirement for Op SHADER and the Mission Training and Mobilisation Centre (MTMC) assured how effectively the training objectives were met. However, once deployed, the actual laydown and details of weapons carriage were the responsibility of the chain of command in the operational theatre. [redacted]. As UKTT (Taji) was located with, and TACON to, the ANZAC Task Group, the Panel

[50] [redacted]

believes it was appropriate that CO 2 LANCS decided to reflect the locally authorised weapon carriage policy and was **not** a factor.

UKTT(Taji) Standing Orders

1.4.84. SOs exist as continuous operating instructions and procedures to ensure personal and collective safety, maintain standards and define actions in response to well-defined events. Those for UKTT(Taji) included direction on conduct, dress and behaviour, with a focus on the reputation of the British Army within the multi-national environment. Three aspects of these SOs are considered pertinent: Exhibit 023

a. **Weapon carriage**. In Camp Taji, GSP were to be carried in the issued holster by all personnel at all times. [redacted] Exhibit 023 At other times, the GSP were to be locked in a cabinet within bedrooms and the room door locked when left unattended. Soldier A admitted that this was not observed on 2 Jan 17 when he and LCpl Hetherington left their GSP on their beds. At the time of the accident, SA80 rifles were to be held in the Foxhounds (FHD) when not required for training. This direction was subsequently changed such that SA80 rifles were kept [redacted]. Witness 025

b. **Weapon loading and unloading**. All weapons were to be loaded and unloaded under supervision at the WUF. Additional guidance was provided for the FP Pl regarding their role and conduct on tasks as sentries - the sentries are commonly known as Guardian Angels. Exhibit 023

c. **Weapon cleaning**. The order in use dated from 23 Jan 16[51]. The key aspects of the weapon cleaning and equipment care regime defined were as follows: Exhibit 063

(1) Unloading is to be carried out at the unloading bay[52] only.

(2) Unloading is to be supervised at all times, regardless of rank.

(3) Weapons are to be fully cleaned once a week.

(4) All cleaning is to be supervised.

(5) Function tests are to be conducted and supervised.

(6) Once weapons are cleaned they are to be re-loaded at the unloading bay under supervision.

(7) To ensure accountability, NCOs are to carry out a daily 5% cleanliness and serviceability check of weapons and a weekly 100% check of weapons is to be carried out by an officer and the record retained by the Company Quartermaster Sergeant (CQMS).

1.4.85. In Dec 16, the SOs being used by 1 RIFLES were in the process of being reviewed. This process continued after the ToA to 2 LANCS. A number were re-issued following the death of LCpl Hetherington; the SO for weapon cleaning was re-issued on 5 Jan 17 to specifically order all weapon cleaning to be supervised Exhibit 023

[51] J5/BPC (I)/UKTT/04.

[52] Referred to as the WUF in this report, the UKTT SOs use the term "unloading bay".

and checked by a Junior Non-Commissioned Officer (JNCO), with a Senior Non-Commissioned Officer (SNCO) providing oversight.

1.4.86. In line with the 2 LANCS intention to update operational orders once they had established themselves as the UKTT(C) BG, a full review of all UKTT(Taji) SOs was conducted. These were re-issued on 18 Feb 17, standardising the format. The Panel considers this review to have significantly improved the clarity of the orders. The Panel believes that the policy and direction provided for the carriage of weapons and the orders promulgated for the conduct of personnel in UKTT(Taji) were **not** a factor. However, the application of these SOs, in particular the control of the processes, is relevant and considered in greater detail in Chapter 4. Exhibit 062

Psychological Factors

Threat environment

1.4.87. According to the MOD HF Psychologist, the perception of threat was relevant to this accident. Personnel interviewed from 2 LANCS were keen to deploy to Iraq in order to gain operational experience. However, expectations of Op SHADER were arguably rooted in the high intensity operations of recent British involvement in Iraq and Afghanistan. Exhibit 063

1.4.88. Although no deployment to Iraq is without risk, Camp Taji was a comparatively benign operational environment. Insider threat and indirect fire were identified as risks but there was no indication that members of FP Pl were particularly concerned about any specific threat. Many of those interviewed stated that they had not felt threatened at all during their time in Iraq and considered Camp Taji to be extremely quiet and relaxed. At interview, a number of FP Pl soldiers stated that they had joined the Army to do "real soldiering" on kinetic operations but, in this deployed role, were bored. The Panel considers there was a juxtaposition between the benign threat environment and the expectations of some members of FP Pl. Exhibit 063 Witness 008 Witness 001 Witness 005 Witness 010 Exhibit 063

Operational tempo

1.4.89. UKTT(Taji) daily life was not pressured and was described by many as routine and boring. The FP Pl was tasked to provide Guardian Angels to the training teams. At the time of the accident, they conducted these tasks up to 3 times per week, with each task taking no more than 6 hours. This was described by a FP Pl soldier as neither interesting nor appealing, and by another as neither busy nor hard. No training of the Iraqis occurred at night and the FP Pl had no programme to train themselves at night. [redacted] BG HQ did direct sub-unit continuation training but this did not overcome the desire within FP Pl for more creative and challenging training opportunities. On 2 Jan 17, there was one Key Leadership Engagement (KLE) task for UKTT(Taji), in which Soldier A was not involved. He had the opportunity to play a game of FIFA football in his room for one hour prior to mandated weapon cleaning and then went to the gymnasium. The Panel considers that the quantity of operations and meaningful training, between deployment and the accident, was insufficient to nurture and nourish the fighting spirit of the FP Pl soldiers. Witness 025 Witness 017 Witness 009 Witness 018 Witness 004 Witness 004 Witness 019 Witness 025 Witness 001 Witness 025 Exhibit 034

1.4.90. A 1997 study for the British Army confirmed that boredom and monotony can be a significant component of stress on operations[53]. The MOD HF Psychologist concluded that a low degree of stimulation, in a low threat environment, in conjunction with a desire for a more kinetic tour, could have set the conditions for immature individuals with high impulsivity and lack of controlled aggression to mess around with their pistols. The Panel believes that, in early Jan 17, a light tempo of training and operations which did not fully stimulate the soldiers, in what was perceived as a benign threat environment, was a **Contributory** factor. Exhibit 063 Exhibit 067

1.4.91. **Recommendation**. Chief of Joint Operations (CJO) should include 'boredom through a lack of stimulus' in the Permanent Joint Headquarters (PJHQ) Operational Risk Register in order to expose this as a significant risk on operations and enable appropriate mitigation activity and proactive management.

Perception of the pistol

1.4.92. It was recognised by CO UKTT(C) that young soldiers in particular would be attracted to messing around with their GSP, based on its novelty and how handguns are portrayed in the media. This was apparent in 3 separate but regularly cited opinions expressed about the GSP by members of the FP Pl at interview: Witness 003 Witness 020

a. As a newly introduced weapon system that is easy to use, the weapon represented a novelty to some young soldiers. Witness 021 Witness 002 Witness 005

b. The weapon was perceived as having a high social value, being perceived as a 'gangsta' or 'street' weapon, in language that mimics criminal sub-culture dialogue. Soldier A also used the phrase "[redacted]" to describe posing with the weapon. The Panel presumes this is in relation to an American rapper of the Hip-Hop genre who was injured in a shooting incident. Witness 014 Exhibit 036

c. In contrast to the old Browning pistol[54], the Glock GSP was perceived as 'plastic' and like a 'new toy', in reference to the significant use of polymer components. Witness 022 Witness 019

1.4.93. The MOD HF Psychologist concluded that introduction to a new weapon 3 months prior to a deployment, with intermittent use, might have been sufficient to train a degree of skill, but was unlikely to have been sufficient to decrease the novelty factor of the weapon. Due to its comparative novelty, its high social value, portrayals in the media, and its familiarity as a childhood toy, the GSP is likely to provide an enticing and appealing temptation for some personnel to handle unnecessarily. Additionally, the inability to fire the GSP as a weapon during the first few weeks of deployment meant that personnel only handled it during WHTs and cleaning. The Panel believes that not being able to live fire the GSP is likely to have maintained its novelty factor for some individuals. Exhibit 063

1.4.94. The Panel considers that rather than being seen as a functional tool, the GSP was perceived by some individuals in the FP Pl, including Soldier A, as an

[53] Harvey, J. *Operational Stress in the British Army*, DERA, 1997.

[54] Pistol Automatic 9mm L9A1.

attractive novelty in contrast to the SA80 rifle. A lack of respect for the GSP is therefore deemed to be a **Contributory** factor.

1.4.95. Soldier A recognises that the holster removes the attraction of the weapon and believes that had his GSP been holstered rather than just left on his bed, he is less likely to have played with it. The Panel considers that, on an individual basis, common perceptions of pistols, as portrayed in the media, could be countered by greater exposure to the GSP and opportunities to live-fire in a professional environment. In turn, an individual's familiarity with the GSP positively influences skill levels. This report includes several recommendations for Defence to reconsider the timing of GSP education and training to improve skill levels and mitigate the social perceptions of pistols. These are considered in greater detail in Chapters 4 and 5. Witness 025

Soldier A's behaviour

1.4.96. The Panel heard corroborative statements that at times, Soldier A did not act professionally, was lazy and complaining. Predominantly, these refer to him failing to display the standards expected of a JNCO. Examples included the poor preparation of kit and time-keeping, not shaving and scruffiness, details that undermined the respect in which he was held. Some of his superiors considered his manner was not befitting a JNCO (considered in Chapter 4). Witness 004 Witness 008 Witness 010

1.4.97. Soldier A's peer group commonly referred to his social immaturity and some commented that they would avoid him as a result. Soldier A was considered as petulant and not well-mannered; one Kingsman described how he would, on occasion, shout and scream at people with outbursts of temper even for trivial events. As an example, several members of the FP Pl recounted that, having tumbled over a football, Soldier A became immediately irritable and stormed off the pitch, kicking the ball away. Witness 007 Witness 018 Witness 015 Witness 015 Witness 015 Witness 017 Witness 019

1.4.98. Soldier A was assigned to Blenheim Coy where there was a strong CSM who could provide him direction and guidance within the Coy's programme of professional training. Despite his promotion to LCpl his occasionally temperamental and disruptive behaviour continued. Witness 002

1.4.99. The Panel determined that Soldier A's attitude and behaviour, as observed by members of FP Pl, weakened his authority as a LCpl. Witness 004 Witness 005

Soldier A's acceptance of responsibility

1.4.100. Soldier A was considered a good field soldier, but poor in barracks. He was assessed on a Potential NCO (PNCO) Cadre and on this he met the standards to achieve promotion to LCpl. As a condition of his LCpl rank, Soldier A was trusted and given responsibility. Specifically, in the loading and unloading of weapons, Soldier A was authorised to supervise, and be supervised by, another LCpl; this is referred to as 'peer-supervision'. However, when 2 individuals of the same rank and similar experience supervise each other, the supervisory 'authority gradient' is removed. Witness 005 Exhibit 025 Witness 005

1.4.101. Noting the orders to do so, the FP Pl presumed that at completion of weapon cleaning on 2 Jan 17, LCpl Hetherington and Soldier A would have supervised each other to complete weapon loading drills at the WUF. The Panel believes this either did not occur or their 'peer-supervision' was too relaxed and inadequate. The MOD HF Psychologist concludes that Soldier A displayed many Exhibit 023 Witness 015 Exhibit 063

of the characteristics found to be related to higher risk taking. Not upholding the safety and professional standards required of JNCOs was a **Contributory** factor to this accident.

1.4.102. **Recommendation**. Chief Safety (Army) should direct a review of the policy and implementation of 'peer-supervision' as currently authorised, in order to determine if it is an appropriate mechanism for checking safety critical activity.

Soldier A's relationship with LCpl Hetherington

1.4.103. Soldier A and LCpl Hetherington were very close friends and were described as inseparable sidekicks. This, however, could lead to an unprofessional social dynamic. Like brothers, their friendship sometimes led to bickering and mockery and they could antagonise each other to the point of physical aggression. Witness 015 Witness 005 Witness 002 Witness 014 Witness 017

1.4.104. When together, the impact of their behaviour would on occasion affect others. Over the course of several visits to a 'drive-thru' local to Weeton Barracks in 2016, their behaviour upset a civilian employee which led to a complaint. LCpl Hetherington understood the implications of their actions and addressed this without question with a formal apology. This was in contrast to the non-committal attitude displayed by Soldier A. Witness 004

1.4.105. After the PNCO cadre, 6 Sept 15 to 23 Oct 15, it was recognised by the Bn chain of command that Soldier A and LCpl Hetherington would benefit from separation. They were posted to different Coys in order to maximise their potential. However, in Spring 2016, during re-organisation for Op SHADER they were both placed in Blenheim Coy prior to an exercise deployment to Belize. The Panel believes Soldier A and LCpl Hetherington negatively influenced each other. This relationship was exacerbated by their confinement to Camp Taji and sharing a room which reduced the opportunity of relief from each other's company. The behaviours displayed in their relationship were a **Contributory** factor. Exhibit 025 Exhibit 071

1.4.106. Although no recommendation is made here, soldier management is considered in greater detail under 'Supervision' in Chapter 4.

Physiological Factors

1.4.107. **Physical fatigue**. The accident occurred within the first month of the tour. The Panel assess that the FP Pl were relatively fresh, having had nutritious meals and the opportunity for at least 8 hrs sleep per night in air conditioned accommodation. The accident occurred in the afternoon following a relatively quiet morning. The Panel did hypothesise that Soldier A could have suffered from fatigue in his arms and hands following a physically demanding session in the gymnasium, which may have affected his fine motor control. However, he had been working on his leg muscles on the day of the accident and did not stay in the gymnasium for long. In addition, Soldier A confirmed he had had few distractions on the day of the accident that may have led to fatigue or stress. The Panel is satisfied that fatigue was **not** a factor. Witness 019 Witness 025

1.4.108. **Medical**. There is no record that Soldier A had illness prior to deployment. He was fully employable and confirmed that he was not suffering Exhibit 072 Witness 025

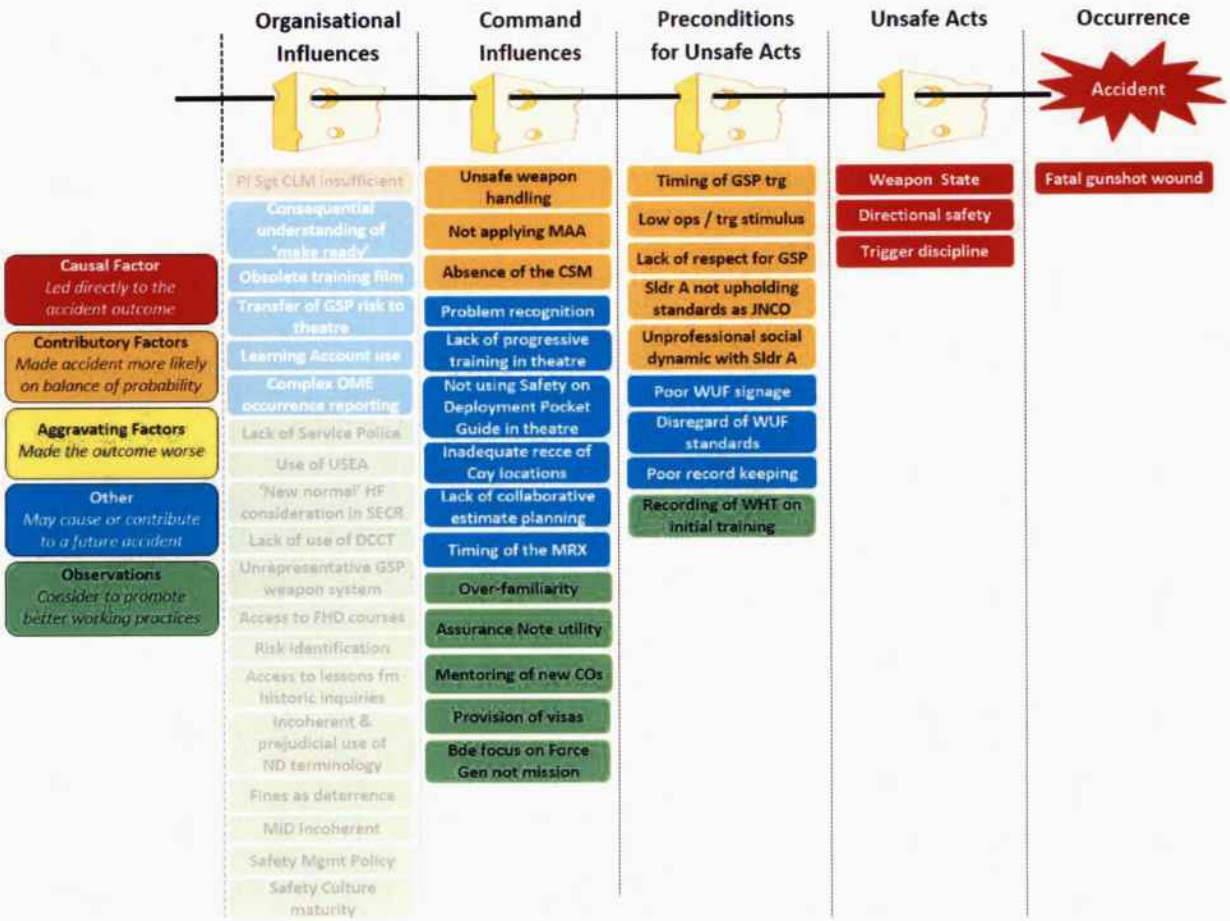
from any illness at the time of the accident. The Panel is satisfied that medical illness was **not** a factor.

1.4.109. **Alcohol**. There is no medical record that Soldier A had alcohol dependency prior to deployment. Alcohol was not available in Camp Taji and Soldier A confirmed that no alcohol was consumed. The Panel is satisfied that alcohol was **not** a factor. — Exhibit 072 Witness 025

1.4.110. **Narcotics**. There is no medical record of use, or addiction to, illicit drugs by Soldier A prior to deployment. There was no suspicion voiced by his peers and colleagues during interviews and Soldier A confirmed that he had not taken illicit drugs during the operational tour. A blood sample was not taken from Soldier A on the day of the incident due to the absence of a qualified SIB RMP and their request that the US Military Police did not assume responsibility for the case. The Panel determines that narcotics were **not** a factor. — Exhibit 072 Witness 025

1.4.111. **Other recognised stressors**. The Panel recognises that there are other emotional stressors that could have affected Soldier A on 2 Jan 17. These include influences such as financial worries, breakdown of personal relationships, bereavements or legal disputes. No concerns of this nature were raised by his peers during the course of the inquiry and Soldier A confirmed that no such factors influenced his state of mind or behaviour in early Jan 17. The Panel determines that other recognized stressors were **not** a factor. — Witness 025

Chapter 4 – Command Influences



1.4.112. **Chapter overview**. Command at all levels in the Army requires a combination of leadership and management. In order to maximise potential, commanders must set the standard, provide guidance and supervision, motivation and discipline, and accept responsibility. They must know their soldiers and equipment and appreciate the consequences of both their actions and inactions. All soldiers, regardless of rank, are taught command, leadership and management and are expected to know of the Army Sergeant Major's 'Green Lines'[53] and uphold the Army's Leadership Code[54]. The Panel notes, however, that safety is not included in this doctrine as a fundamental function of leadership. The Code makes no mention of safety nor a leader's responsibilities for Duty of Care. This Chapter looks specifically at latent weaknesses in leadership and supervision throughout the hierarchy of command, from the Platoon to higher organisational levels. Three contributory factors were identified: unsafe standards of weapon handling, not applying the formal process of Minor Administrative Action (MAA) of disciplinary action and the absence of the Company Sergeant Major (CSM).

[53] Neither policy or doctrine, the 'Green Lines' are a guide to help all NCOs and the soldiers under their command. They are based on the values and standards of the British Army as well as the experience of the Army Sergeant Major.

[54] *The Army Leadership Code, An Introductory Guide*, Sep 2015 and in Chapter 5, *Army Leadership Doctrine*, 2016. NB 'Safety' is only mentioned twice in *Army Leadership Doctrine*, on both occasions taken from Field Marshall Slim's definition, within Selfless Commitment.

Platoon Level Supervision

1.4.113. The FP PI in UKTT(Taji) was led by the PI Comd, a young and inexperienced junior officer on his first operational tour. He was supported by the PI Sgt as the PI 2IC. They were responsible for the leadership and management of 18 Infantrymen and one Medic. The PI Sgt was supported in his role by the PI JNCOs. The role of JNCOs on Op SHADER was to assist the chain of command with administration and to operate as commanders, both in FHDs and on foot.

1.4.114. Despite the presumed leadership inherent within the PI, the following 5 issues all serve to illustrate that supervision and management were insufficient to prevent the sequence of events that led to the accident. These were: Leadership dynamic, Over-familiarity, Poor military judgement, Problem recognition and Management of Soldier A.

Leadership dynamic

1.4.115. The PI Sgt was held in high esteem by the Bn and well liked by his soldiers. He was described by his OC as a dynamic and inspirational leader who operated well under pressure. He was considered an excellent mentor by his subordinates; he led by example, was well-respected professionally and presented a model of physical robustness, encouraging LCpl Hetherington to improve his fitness. In the reporting period to Nov 16, he was recommended for promotion at the earliest opportunity. The Panel considers that, relative to other Sgts in the Combat Arms, the FP PI Sgt was young and had limited experience. In support, and recognising the rank hierarchy, the PI Cpls deferred to the authority of the PI Sgt's rank and position and did not question witnessed behaviours. The MOD HF Psychologist considers that such was the degree of reverence for the FP PI Sgt that, in the absence of the CSM, his decisions were not challenged effectively. The Panel considers that the FP PI would have benefitted from an open Questioning Culture.

Witness 010
Witness 002
Witness 007

Exhibit 073
Exhibit 063

Witness 017

1.4.116. During this inquiry, the Panel identified a number of occasions on which PI level supervision displayed weakness. These are considered in greater detail in the sections that follow and under 'Command Leadership and Management' in Chapter 5.

Over-familiarity

1.4.117. [redacted] Statements taken during interview revealed a perception that Soldier A capitalised on his friendship [redacted] to escape repercussions for low personal standards, as described under 'Psychological Factors' in Chapter 3.

Witness 010
Witness 009
Witness 001
Witness 018
Witness 017

1.4.118. [redacted]

Witness 017
Witness 004
Witness 018

1.4.119. [redacted] Exhibit 063 Witness 017

1.4.120. [redacted] Witness 006 Witness 017

The Panel **observes** that unchecked over-familiarity negatively influenced supervision.

Poor military judgement

1.4.121. On 2 Jan 17, there were 2 examples of poor military judgement relating to the GSP safety system that supervision did not prevent or correct.

a. **Unsafe weapon handling**. There was no formal close to the weapon cleaning activity on 2 Jan 17. LCpls and above were permitted to supervise one-another and were trusted to depart when complete. It was presumed that Soldier A and LCpl Hetherington would complete their mandated weapon cleaning drills correctly and use the WUF to reload their GSP. However, failure to re-holster their GSP as part of the load drill was in contravention of training and the extant in-theatre SOs. The Panel believes that this was an example of weak supervision. Exhibit 210 Witness 006 Witness 008 Exhibit 023 Witness 006

b. **Incomplete safety system**. Towards the end of the weapon cleaning session, the last 4 members of FP Pl became aware that 2 empty holsters had been left behind. Although this represented 2 incomplete weapon safety systems and that, as a result, it was extremely likely that 2 of their colleagues had failed to complete their weapon handling drills completely, there was no immediate reaction. The Panel considers that this was not seen as a risk. There was ample opportunity to supervise the return of the holsters and re-establish the safety systems: Witness 006 Witness 005 Witness 008 Witness 019

(1) Under the direction of the FP Pl Sgt, the holsters were secured in the room of Soldier C. It was the FP Pl Sgt's intention to identify the owners at the Pl Orders Gp at 1700hrs. Realising they did not have their holsters, LCpl Hetherington returned to the Den but could not locate them. Witness 006 Exhibit 034 Witness 025

(2) The FP Pl Sgt then proceeded to the gymnasium with Soldier A, LCpl Hetherington and Soldier D. Both the FP Pl Sgt and Soldier D were aware of the empty holsters but did not discuss the issue with Soldier A or LCpl Hetherington while at the gymnasium. Witness 006 Witness 005

(3) After returning to the accommodation, LCpl Hetherington met Soldier C and was told where to find the holsters. However, neither LCpl Hetherington nor Soldier A chose to collect them. Witness 008

1.4.122. With hindsight, all those questioned on the subject recognised how appropriate it would have been to immediately call in the Pl, reunite the holsters Witness 006 Witness 017

with the weapons and understand why they had been overlooked. The means to do this existed and could have been achieved quickly.

1.4.123. The Panel determines that there was no recognition that the empty holsters represented incomplete weapon systems or the significance of the behaviours that had led to the holsters remaining behind. As a consequence, there was no decisive action to address the issues immediately or to use them as an opportunity for learning. This also demonstrates a lack of Questioning Culture within the FP PI. The Panel concludes the lack of action to address unsafe standards of weapon handling was a **Contributory** factor.

1.4.124. **Recommendation**. HoC GM should reinforce the importance of the holster as a critical element of the GSP safety system within OSP in order to increase safe behaviours and elicit corrective action when unsafe practices are identified.

Problem recognition

1.4.125. The Panel believes a Safety Culture will only exist if all individuals, regardless of rank, actively pursue error detection and prevention. A workforce must, therefore, actively seek out and recognise problems; if problems are not seen, a workforce will never consider how to solve them and act accordingly.

1.4.126. The lever-arch file in Figure 18 is an example of failing to recognise a problem and thereby accepting low standards[57]. It was found on the edge of the Den by the Panel during their visit to Taji in Mar 17, open, unsecured and accessible from the adjacent road. Left by 1 RIFLES and dated Aug 16, the file contained sensitive and personal information on serving British Army personnel, weapons and FP routines, as illustrated at Figures 18 and 19.

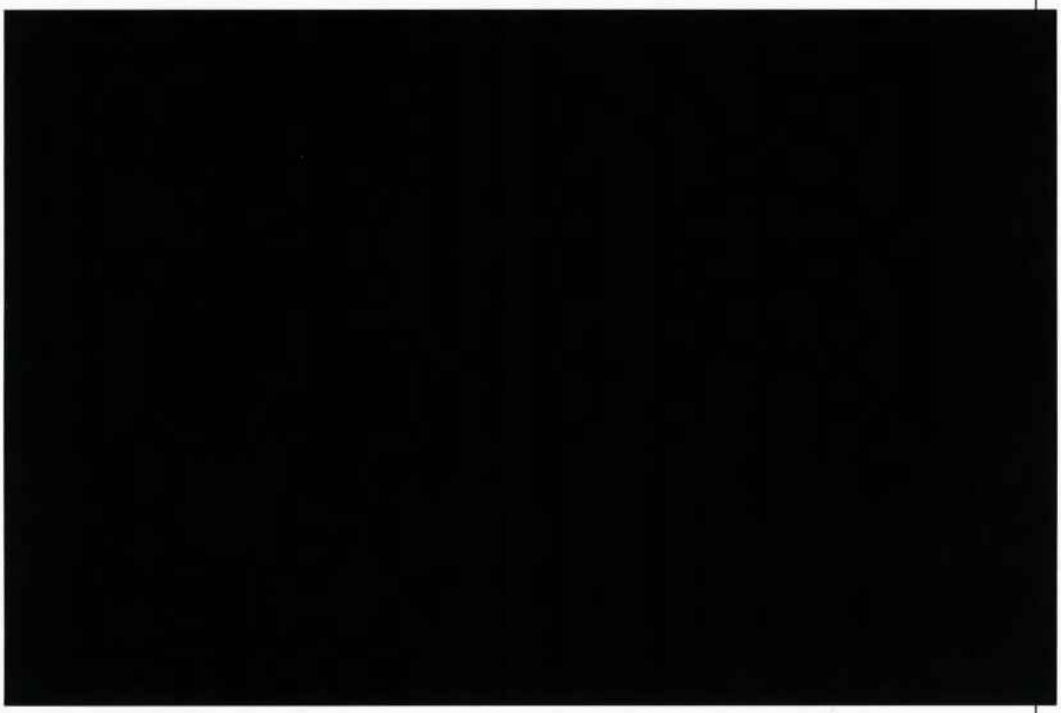


Figure 18: Personal information left unsecured in UKTT(Taji)

[57] The Panel considers this an example of "The standard one walks past is the standard one accepts", attributed to Governor of New South Wales and former Chief of the Australian Defence Force, General David John Hurley.

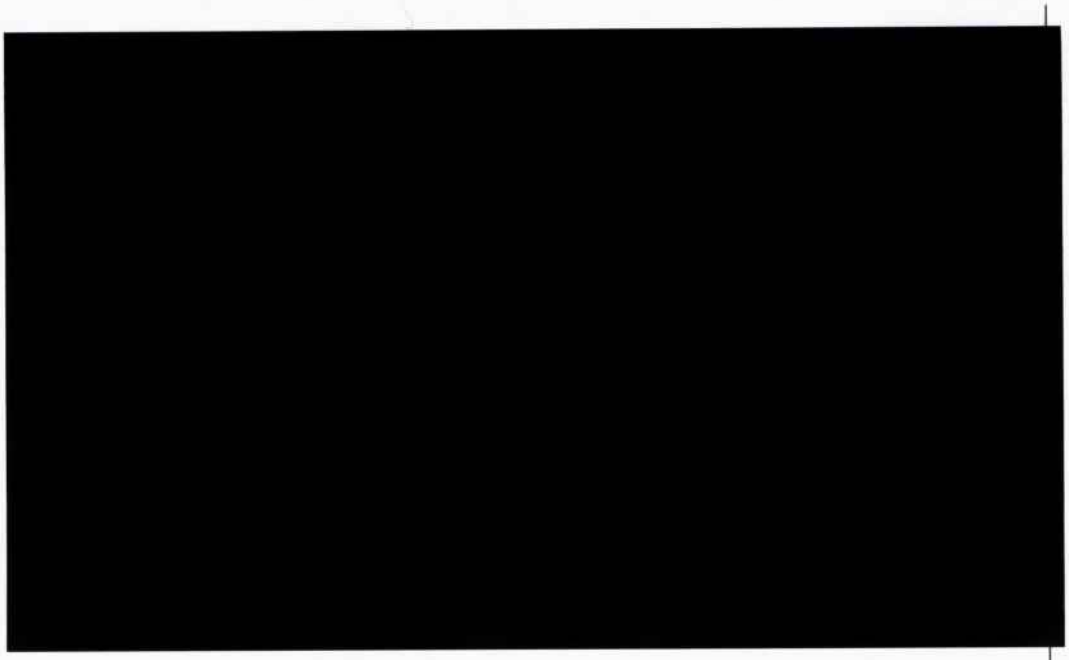


Figure 19: 'OFFICIAL' documentation left unsecured in UKTT(Taji)

1.4.127. The Panel concludes that in an environment that demands soldiers are permanently armed with loaded pistols to protect against insider attack, consistently overlooking an unsecured file containing sensitive information, indicates that the FP PI did not have a mature culture of problem-seeking and resolution. This was an **Other** factor.

Management of Soldier A

1.4.128. It is not enough to know their soldiers, commanders must lead and manage them. In this case, the performance and character of Soldier A, and his relationship with LCpl Hetherington, were very well known to the FP PI chain of command. As Soldier A prepared to depart his barracks for Iraq, the CSM warned him that he needed to mature and the tour would offer an opportunity to demonstrate this. The Panel notes this was a highly prescient remark. Witness 004

1.4.129. Despite the fact that the Bn chain of command recognised that Soldier A and LCpl Hetherington would benefit from separation, on arrival in theatre, they were allowed to choose to share accommodation. This arrangement was not an active decision on the part of the supervisory chain. The FP PI Comd, Sgt and CQMS were passive observers of the process of room allocation and saw no risk in the pairing. However, this created an off-duty environment in which the only person capable of monitoring and mentoring Soldier A was his best friend. Witness 006

1.4.130. The chain of command did not recognise the opportunity presented to develop their soldiers through shared accommodation. The Panel considers that by not pairing Soldier A, for at least some of the tour, with a more responsible Cpl, or with a Kingsman[58] to challenge him as a role model, the PI chain of command missed an opportunity to develop Soldier A as a JNCO. Witness 006 Witness 007

[58] A private soldier in the Duke of Lancaster's Regiment.

1.4.131. Throughout 2016, Soldier A's behaviour and performance in barracks presented the chain of command with a series of opportunities to intervene with a personal development plan[59]. The Panel has seen no evidence of any such plan being established for Soldier A. The management of Soldier A through the application of Minor Administrative Action (MAA) is examined in greater detail in Company level supervision and a recommendation presented.

Company Level Supervision

1.4.132. During his time in command, from Mar 15 through to deployment on Op SHADER 4, the OC was reported to have performed above the standard expected and was graded very highly. Under his command, Blenheim Coy received praise for a 6 week Coy Gp exercise in Belize, deployment to Kenya and making an outstanding contribution to flooding relief in the north of England. Following this training, Blenheim Coy were engaged in a comprehensive programme of PDT in the 6 months prior to deploying.

Exhibit 074
Exhibit 075

1.4.133. Despite the quantity of training prior to deployment, this section of the report specifically focusses on 2 exercises to balance impressions: Exercise UNITED LION and the Mission Rehearsal Exercise (MRX). In addition, this section considers another 7 issues relating to Coy level supervision.

Exercise UNITED LION

1.4.134. It was recognised at the All Ranks Brief (ARB) by the future UKTT(Taji) and UKTT(Besmaya) OCs that the only planned opportunity for their re-grouped Force Elements to train together was at the MRX, immediately prior to deployment. As a result, OC Blenheim Coy planned a self-directed, integrated sub-unit exercise with elements of 26 Regiment, Royal Engineers (RE) and 101 Regiment, Royal Engineers in Swynnerton in mid-Oct 16. The Panel **observes** that this exercise proved to be an excellent opportunity for the sub-unit commanders and soldiers to learn how the other Force Elements operated and was essential for successful re-grouping and integration in theatre.

Witness 023

Exhibit 003

Mission Rehearsal Exercise

1.4.135. The final training exercise conducted by those deploying to either Taji or Besmaya on Op SHADER 4 was their Misson Rehearsal Exercise (MRX) in Thetford, from 7 - 16 Nov 16. This was the final opportunity for an external audit of the command and control of the newly formed Coy Gps prior to deployment. The MRX was split into 2 phases by the MTMC staff: a Collective Skills Phase (3 days) and a Rehearsal Exercise (4 days) designed to replicate theatre conditions and challenges as closely as possible. These 2 phases were separated by a 24hr window for the training audience to develop, practice or test any tactics, techniques and procedures.

1.4.136. In a letter to Comd MTMC, copied to 42 Inf Bde and OCs dated 8 Nov 16, CO 2 LANCS identified areas for further training focus by Blenheim Coy on the MRX. These included: Command and Control, Ops Room Training, Standard Operating Procedure (SOP) confirmation and Patrol Procedures. He

Exhibit 077

[59] E.g. Army General Administrative Instruction (AGAI) 67, 3 Month Warning Orders can be used for this purpose.

explained that this additional training would be completed in the margins of MTMC training and would be delivered by the Coy HQ.

1.4.137. In contrast to Blenheim Coy's reputation and good performance in prior training, evidence demonstrates that during the MRX:

a. Despite the CO's direction for further training and the real-life exercise requirement for those being trained to provide command and control in their UKTT training locations, OC Blenheim Coy appeared reluctant to establish an Ops Room. The Coy did respond and establish an Ops room despite the requirement not replicating the actual TACON arrangements in Camp Taji. — Exhibit 077, Exhibit 078, Witness 001, Exhibit 079

b. Due to the poor establishment of Ops Room command infrastructure and procedures, the UKTT(Taji) sub-unit at times failed to maintain situational awareness and demonstrated an ineffective control of information, events and personnel. — Exhibit 080, Exhibit 007, Exhibit 079

c. The CSM was criticised for his over-confident and dominant manner which was considered incongruous to the subtle nature and requirements of the future role in Iraq. Rather than empower his NCOs to fulfil their responsibilities, it was noted that to achieve the high standards he expected, he assumed too many of their roles. The Directing Staff (DS) counselled the OC about his approach to this situation. — Witness 007, Exhibit 078, Exhibit 081

d. Blenheim Coy carried GSPs but no accompanying magazines and therefore could not conduct dry weapon handling drills. — Witness 006, Witness 023

e. FP PI soldiers, including Soldier A, messed about with their unloaded pistols. Several soldiers were reprimanded verbally for unnecessary and unauthorised drawing of their GSP. — Witness 017, Exhibit 184

f. An arrogance to training was displayed by some key individuals. — Exhibit 080, Exhibit 083

g. While both UKTT(Taji) and UKTT(Besmaya) Coy Gps were assessed in the same manner, the DS had to intervene and re-set the second phase to ensure UKTT(Taji) successfully completed all the training serials. — Witness 024, Exhibit 081

1.4.138. Both Coy Gps completed the MRX having achieved the standards necessary. When measured against Joint Training Requirements and Collective Training Objectives, as defined in Annex E of the Op SHADER Mission Specific Training Directive, the Coy Gps were assessed as GREEN, with no significant training risk. The Coy Gps achieved this end state, however, in very different styles. — Exhibit 085, Exhibit 020, Exhibit 086, Exhibit 062, Exhibit 081

1.4.139. Of particular note was the positive approach and performance of the RE OC and 2 LANCS 2IC who were responsible for commanding UKTT(Besmaya) and who embraced the MRX positively, improved continuously and performed well throughout the training. — Exhibit 020, Exhibit 007, Witness 024

1.4.140. In contrast, the command team of the UKTT(Taji) Coy Gp were perceived to have entered the MRX with an over inflated self-belief, an unimpressive approach to training and a command climate and leadership dynamic that became a concern to MTMC staff as the training progressed. In the Panel's opinion this approach could have derived from their success throughout — Exhibit 080, Witness 024, Exhibit 083

the training exercises of 2016, previous operational experience, the OC's former role as SO3 Training Plans within Operational Training Advisory Group[60] and the realisation that deployment was imminent and inevitable.

1.4.141. The Panel notes that on 14 Dec 16, after a year of MRXs and training a large number of Coy Gps, Assistant Chief of Staff Training (ACOS Trg) wrote in 'Observations from Training 2016', that "*A worrying observation has been noted that too many of the senior cohort of officers and SNCOs have adopted an "arrogance to training", with individuals believing that past operational experience has already prepared them for the next operation. This attitude can influence the level of engagement of the whole unit under training and in turn the ability to learn".* Exhibit 087

1.4.142. The Panel concludes that although not specific to Blenheim Coy, the performance of the Coy Gp was reflected in the comments of ACOS Trg. Despite numerous examples of good performance, the command climate and approach to training, immediately prior to deployment, warranted concerned comment from MTMC. This independent third-party assessment is described in the following section and recommendations are presented. Timing of the MRX is considered in greater detail under Higher level supervision and a recommendation presented.

Mission Training & Mobilisation Centre Assurance Note

1.4.143. The MTMC produces an Assurance Note at the end of every MRX. The Assurance Note written following the MRX for UKTT(Taji) and UKTT(Besmaya), ISF ROTO 4, dated 21 Nov 16, was the first to contain an assessment of command climate and approach to training and contained the following final paragraph: Exhibit 020

***"Command culture and approach to training**. The command culture in one of the Coy Gps was positive and defined by strong leadership which enabled mission command. As a result the Coy Gp performed well throughout the training. In the other,* [redacted] *a lack of understanding of the operating environment and an erroneous self-assessment of capability.* [redacted] *Notably, Op SHADER is a multinational, multi-cultural environment which requires diplomacy and a gentle touch. In many of the coalition locations the UK is not the lead and is reliant on support from other nations.* [redacted] *was compounded by additional weaknesses in the Coy CoC [chain of command]. These have been briefed to the relevant CO. However, the majority of the training audience approached the training with a positive and receptive manner. The willingness to learn was apparent across all ranks and the training audience exploited this training opportunity fully."*

1.4.144. This paragraph was written by MTMC DS with input from the MRX instructors and it was edited by Comd MTMC. The Panel observes that the anonymised nature of the text allowed the report to be interpreted differently, even by those who contributed to its writing. It is an amalgam of thought and despite the importance of the criticism, it is ambiguous. Therefore, any mitigating action, or intervention to improve culture or attitude to training at the unit level, could not be well designed. Exhibit 007 Exhibit 088 Exhibit 081

[60] The Operational Training Advisory Group was the predecessor organisation to MTMC.

1.4.145. The Panel believes the following 4 factors undermined the purpose of the commentary on command culture within the Assurance Note: Exhibit 020

a. The anonymous style seeks to protect individuals from direct criticism. It is very likely that an underlying preference within the Army to shield command personnel from open professional criticism hinders direct reporting. This dilutes the benefit that could be gained from increased transparency. Exhibit 020 Exhibit 089

b. The obscuration of identifying details removes transparency and undermines the opportunity to intervene in a timely and meaningful manner. Exhibit 090

c. The focus on one individual's approach to training detracts from the more significant concerns. The sentence "*This individual's attitude and behaviour was **compounded by additional weaknesses in the Coy CoC**"* neither explains nor explores the command culture of the Coy Gps. Witness 003 Exhibit 091 Exhibit 081

d. The criticism of command culture and approach to training was not briefed verbally to Comd 42 Inf Bde or CO 2 LANCS at the After Action Review (AAR)[61]. Exhibit 044

1.4.146. The Panel believes that to understand and learn from the performance of troops under training, and thus future levels of risk when deployed, it is not just the achievement of these standards at the end of the MRX that must be reported, but also the degree of progress, attitude and effort required to achieve them.

1.4.147. The Panel **observes** that, as written, the Assurance Note did not deliver useful commentary on command culture or any recommendations for interventions to ensure standards of Coy level supervision.

1.4.148. **Recommendation**. Head of Warfare Development should ensure that the Mission Training and Mobilisation Centre Assurance Note is specific, transparent and written in straightforward language, to include an assessment of attitude, effort and progress made, in order to ensure that the chain of command understands a unit's strengths and weaknesses.

Application of Minor Administrative Action

1.4.149. The formal process of Minor Administrative Action (MAA) exists to rehabilitate, censure or initiate sanctions to correct professional or personal failings. It is used by the chain of command to safeguard or restore the operational effectiveness and efficiency of the Service, using command authority[62]. In 2 LANCS, the authority to administer MAA was delegated to JNCOs. Witness 003

1.4.150. CO 2 LANCS had some concerns with the administration of disciplinary action within the Bn, recognising that JNCOs, in particular, required education in the use of MAA. As such, the Bn established a programme of education and development; formal JNCO education and training, which included the application of MAA, occurred between Jun and Sep 16. Witness 003 Exhibit 008

[61] Comd 42 Inf Bde and CO 2 LANCS attended the AAR on 16 Nov 16.

[62] JSP 833 Minor Administrative Action, Part 1 – Directive, paragraph 1.4 (v2.2, Jan 17).

1.4.151. The CSM acknowledged that JNCOs were the subject of more disciplinary issues than Kingsmen. He had spoken to the FP PI Sgt about this and his belief that friendship between ranks could suppress the application of formal MAA. Witness 004

1.4.152. The Blenheim Coy command hierarchy reported administering Army General Administrative Instruction (AGAI) actions regularly[63]. [redacted] Witness 006 Witness 006 There was thus a belief in the Coy that discipline was carried out appropriately.

1.4.153. However, testimony has been gathered from across the Coy of numerous instances when Soldier A's behaviour fell below the standard required of a Serviceman and JNCO. In the Panel's opinion these occasions merited application of MAA by the Coy chain of command:

a. Soldier A would repeatedly arrive late for work by up to 1 hour, having failed to shave and his dress and deportment were often considered poor by all ranks. Witness 018 Witness 008 Witness 019 Witness 010

b. [redacted] Witness 007 Witness 025

c. During the MRX in Nov 16, Soldier A was caught with LCpl Hetherington engaging in a 'quick draw' competition with unloaded pistols. Soldier E approached Soldier A and LCpl Hetherington and administered a verbal reprimand for drawing their weapons without good reason. Witness 008 Witness 017 Witness 005 Exhibit 184

1.4.154. Soldier A was spoken to repeatedly by the CSM on account of his poor attitude and standards of behaviour, but this was not formally documented. Witness 004 Despite all these instances, [redacted] Exhibit 092 Witness 025 The Panel believes that the cumulative effect of breaches of discipline by Soldier A presented the Coy chain of command with opportunity to use a 3-Month Warning Order as a personal development plan. Exhibit 093

1.4.155. In interviews, FP PI JNCOs stated that they had low confidence in the effectiveness of AGAI action and were reluctant to use it. Instead, they preferred to address minor disciplinary issues with verbal reprimand and to escalate interventions informally. The Panel believes that the reluctance to use the AGAI system was based on a poor perception of its application and utility. Witness 025 Witness 009

1.4.156. In addition, Kingsmen and JNCOs perceived the existing disciplinary process to be unjust. Some individuals received harsh penalties for minor indiscretions while more frequent offenders received no punishment. The Panel believes that this suppressed the reporting of occurrences and eroded trust in the chain of command. Witness 023 Witness 010

[63] AGAI 67 is a a sub-set of The Queen's Regulations for the Army 1975 and is used to safeguard or restore the operational effectiveness and efficiency of the Army. It can lead to the application of MAA at unit level with sanctions such as extra duties.

1.4.157. The Panel considers that CO 2 LANCS' plan to educate his Bn in the application of MAA was appropriate. However, the Panel concludes that either the application of MAA action was not undertaken as frequently as believed or it was recorded inadequately. In either case, individuals were not afforded the protection of policy and the Coy was unable to act accordingly to improve individual performance. The Panel concludes that not applying the formal process of MAA to correct professional and personal failings made the accident more likely and was a **Contributory** factor.

1.4.158. **Recommendation**. Director of Personnel should determine and implement a method of more consistent application of Minor Administrative Action in order to deliver greater trust in the MAA process and drive higher standards of behaviour.

Absence of the Company Sergeant Major

1.4.159. The CSM had high expectations of his troops. He was highly thought of within the Bn, was a significant presence within Blenheim Coy and exerted robust leadership over his soldiers in barracks and on exercise or operations. Due to [redacted] CSM had reason to delay his departure for a couple of weeks. The OC considered the impact of the CSM's temporary absence to be low and manageable and discussed this with the CO. Believing that it was the right thing to do for the CSM, and comfortable with the OC's recommendation to delay the CSM's deployment, the CO agreed. The CO and OC planned to review the situation should the requirement for the CSM to remain in UK persist.

Exhibit 094
Witness 001
Witness 007
Witness 003

1.4.160. In mitigation, the CQMS was directed to cover the role of CSM while also retaining his principal responsibilities. The Panel notes that the option to employ the UKTT(Taji) Artificer Quartermaster Sergeant (AQMS), a REME Warrant Officer Class 2, as the Acting CSM was considered but not taken.

Witness 014
Winess 003
Exhibit 083

1.4.161. The CSM flew into theatre on 31 Dec 16 and was conducting his in-theatre processing and training at the time of the accident. Having trained for Op SHADER with the CSM in role, the Panel concludes that his absence is very likely to have weakened the chain of command and the ability to maintain values and standards in UKTT(Taji). This was a **Contributory** factor.

Witness 004
Exhibit 095
Exhibit 007
Exhibit 088

1.4.162. **Recommendation**. MTMC should assess how Coy Gps manage the absence or loss of critical command personnel in order to test succession planning within deploying units.

Role of Company Quartermaster Sergeant

1.4.163. It is a commonly held opinion that the CQMS role is too burdensome to assume significant additional tasks[64]. On arrival in theatre, the OC delegated the responsibilities of CSM to the CQMS, who would normally stand in for the CSM during anticipated absences, with support from the AQMS. The delegation of the CSM's roles between the CQMS and AQMS was ill-defined. The CQMS was given no formal guidance or mentorship to prepare for the additional responsibilities and no additional staff in theatre.

Witness 001
Exhibit 096
Witness 002
Witness 014

[64] Operational Mentor and Liaison Team, Op HERRICK 8. *BAR Special Report – Learning from Conflict – Afghanistan*, Vol 4.2. p.32.

1.4.164. 1 RIFLES had provided UKTT(C) for over 12 months, yet their G4 preparations for the ToA in Camp Taji were considered incomplete by the Blenheim Coy Gp. Poor accounting practices and deficiencies were evident. The Panel believes this complicated the G4 handover and placed an unnecessary burden on the Blenheim Coy Gp. In the absence of the CSM, this also generated a significant amount of pressure on the newly arrived CQMS. Witness 001 Witness 002 Witness 014 Exhibit 061

1.4.165. The CQMS was over-burdened and acknowledged that he under-estimated the work required to establish the Coy Gp in Camp Taji, oversee the administration of G4 logisitics and fulfil the role of CSM. In addition, personal enmities and hostility, that resulted in an RMP investigation, necessitated that the CQMS keep to particular areas of Camp Taji until 1 RIFLES departed. This further undermined his ability to fully satisfy the supervisory responsibilities that had been delegated to him. Witness 014 Witness 026 Exhibit 098

1.4.166. The Panel concludes that the impact of the CSM's absence was under-estimated, conducting both roles over-stretched the CQMS and the supervisory framework of UKTT(Taji) was weakened until the arrival of the CSM.

Combined Joint Force Land Component Command - Iraq warning

1.4.167. In 2016, the ANZAC contingent in Camp Taji, while considerably larger than UKTT(Taji), was known by UKTT(Taji) to have had a number of NDs. While none had resulted in serious injury, the Panel presume these were a catalyst for the order issued by the US Commander of CJFLCC - Operation Inherent Resolve (OIR) to all his subordinate commanders on 24 Dec 16: Witness 001 Witness 002

[redacted] Exhibit 086

1.4.168. This was passed by UKTT(C) to all sub-units and was received by OC UKTT(Taji). The CJFLCC-I order was also briefed by the ANZAC Commander to the OC and Coy 2IC at a liaison meeting with the ANZAC Training Team. The guidance was then disseminated through the UKTT(Taji) daily Orders-Group. Exhibit 100 Exhibit 101

1.4.169. However, not all members of the BG or Coy remember receiving CG CJFLCC-I's warning. OC UKTT(Besmaya) believed that the quantity of incoming orders from multiple headquarters on different IT systems may have resulted in the significance of the warning being lost. Exhibit 083 Exhibit 098

1.4.170. The Panel has seen no evidence of any immediate actions taken as a result of the warning. However, after the accident, UKTT(Taji) SO 'Service Exhibit 023 Exhibit 102

Personnel Conduct and Dress' was re-issued on 5 Jan 17. The Panel notes that the amendment did not contain any significant changes and was fit for purpose.

1.4.171. The Panel determines that not all members of UKTT(Taji) heeded the warning issued by Comd CJFLCC-I; 9 days after receipt of this warning LCpl Hetherington died from a gunshot wound.

Progressive training in theatre

1.4.172. Demand for ISF training varied over time. FP tasks occurred frequently in the mornings only and Fridays most often remained free. There was no requirement to deliver training to ISF at night. As a result, between deployment and 2 Jan 17, there was capacity in the FP PI's weekly routine to commence their own professional development and training. Witness 019 Witness 017 Witness 007 Witness 004

1.4.173. Despite recognition in the Coy Gp that routine could lead to skills-fade, and the operational tempo to boredom, the focus of UKTT(Taji) remained on training delivery rather than utilising spare capacity for inventive and stimulating Continuation Training[65]. Witness 004 Witness 009 Exhibit 063

1.4.174. The UKTT(Taji) internal training programme focussed predominantly on the subject matter of Military Annual Training Tests. On a monthly basis, each member of UKTT(Taji) was to conduct: Witness 007 Witness 004 Witness 017 Witness 005 Witness 019

a. SA80 rifle grouping and zeroing.

b. GSP Point of Aim shoot (introduced post-accident when 9mm training ammunition became available)[66].

c. Refresher briefs on routine skills including: Counter-Improvised Explosive Devices (C-IED) drills, Chemical Biological Radiological and Nuclear (CBRN) drills, delivery of orders, Casualty Evacuation (CASEVAC), communications, first aid and battlefield casualty drills, contact drills and Equipment Care.

d. Physical training and tests.

1.4.175. A lack of enthusiasm with this approach to professional training was evident amongst the FP PI. Modest interaction with Coalition partners was not developed to maximise opportunities for training during periods of low operational tempo. The desire to develop new skills, exploit opportunities for online learning, train on newly-issued Infantry equipment, gain awareness of the doctrine or equipment of Coalition partners or train at night, was never fulfilled. Witness 007 Witness 009 Witness 005 Witness 019

1.4.176. High morale is built through tough, imaginative, interesting and progressive training[67]. The Panel believes that a lack of imagination and innovation within the Coy chain of command led to a reliance on the repetition of routine lessons and military skills training (e.g. MATTs) which dulled enthusiasm and did not provide a stimulating learning environment. Noting the low stimulus of the operational tempo at the time of the accident, the Panel concludes that not establishing an engaging programme for individual development and collective training was a lost opportunity. This was an **Other** factor.

[65] Army Leadership Doctrine, p47-48.

[66] Approximately 15 rounds per month per individual.

[67] Field Marshall Lord Bramall. *The Bramall Papers*. 2017.

1.4.177. **Recommendation**. D Pers should enhance how junior officers and SNCOs are taught the practice of creative training design in order to deliver interesting and innovative training that motivates soldiers.

Safety on Deployment Pocket Guide

1.4.178. PJHQ, with support from CESO(Army), published a pocket-sized aide-memoire[68] to provide a basic level of safety guidance for all personnel deploying on operations. Whilst not exhaustive, it focused on the most significant areas of functional safety encountered during deployed activities. These included: Commanders' responsibilities; the key aspects of a Safety Management System; Weapon Safety and an Operational Safety Checklist. Exhibit 103

1.4.179. The aide-memoire was referenced briefly during the Operational Safety presentation on the ARB and attendees were informed that they were available to take from boxes by the entrance. Thus, although not physically handed to the personnel interviewed, a copy of the aide-memoire was available for each individual deploying as part of UKTT(C) BG. Witness 006 Exhibit 104

1.4.180. All members of the FP PI interviewed confirmed that they had received or seen the aide-memoire. The Panel confirmed that copies were available in UKTT(Taji) HQ. When asked if they had used the information contained within the Pocket Guide on arrival in theatre, many claimed the aide-memoire was untouched and still in the plastic wallet in which their passport, medical documents and cheque book were also stored. The Panel found no evidence that the aide-memoire was used for reference or training by the FP PI. Witness 006 Witness 009 Witness 003 Witness 014 Witness 007 Witness 025

1.4.181. The Panel reviewed the Safety on Deployment Pocket Guide and believes that it is a good product but does not appear to have been utilised effectively by Blenheim Coy. The Panel concludes that not promoting the contents of the Safety on Deployment Pocket Guide, or its use as the basis for training in theatre, was a lost opportunity. This was an **Other** factor.

1.4.182. **Recommendation**. CJO should improve the promotion and usage of the Safety on Deployment Pocket Guide in order to enhance the effective dissemination and understanding of information relating to operational safety.

Battalion Level Supervision

1.4.183. Changes in the contemporary operating environment, including domestic expectations and resources available to Defence, have resulted in significant changes to Army organisations, processes and force-structures[69]. Noting that the complexity of achieving successful outcomes has increased[70], the Panel believes that there are extraordinary pressures on commanders at all levels.

[68] Edition 3, March 2014. Crown Copyright.

[69] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/654737/DSA_AAR_16-17_-_RT.pdf

[70] https://www.gov.uk/government/speeches/dynamic-security-threats-and-the-british-army-chief-of-the-general-staff-general-sir-nicholas-carter-kcb-cbe-dso-adc-gen

Complexities in Command and Control

1.4.184. Headquarters 42nd Infantry Brigade and Headquarters North West (HQ 42 Inf Bde and HQ NW) was established under A2020[71] in Jul 14 as a Regional Bde. Due to the requirements of Army structural change, the role of 42 Inf Bde was refined and Operational Command (OPCOM) of 2 LANCS was resubordinated from HQ 42 Inf Bde and HQ NW to 4th Infantry Brigade and Headquarters North East (4 Inf Bde and HQ NE) on 21 Nov 16. At any level, re-grouping is a significant challenge and adds friction. 1 (UK) Div planned in detail for the associated moves. Having force generated 2 LANCS, however, it was agreed between 1 (UK) Div and 4 Inf Bde that 42 Inf Bde would continue to assure the BG for operations. Exhibit 105 Exhibit 106 Exhibit 107

1.4.185. All new COs inherit the plans of their predecessors. In this case, when CO 2 LANCS arrived on 29 Jul 16, he inherited the Bn plans for deployment to multiple locations. He had few options and limited scope to alter these plans but he was in a position to shape their execution. Witness 003

1.4.186. Between Sep 16 and Jul 17, 2 LANCS was deployed on separate operations or fixed tasks to: Exhibit 108 Exhibit 001 Exhibit 008

[redacted]

1.4.187. The Panel believes that being tasked to 10 locations in 6 countries with multiple missions is highly likely to have detracted from unity of purpose and effort within the Bn. Complexity of command and control was increased further because the sub-units sat in separate command and control hierarchies. However, recognising the crucial nature of leadership in controlling an intentionally dispersed Bn, CO 2 LANCS instigated a series of conceptual study events. These commenced on 5 Sep 16, included Iraq focussed material as well as a G1 planning exercise, and concluded with officer education on 10 Oct 16. Exhibit 003

1.4.188. As an experienced officer and having attended the Commanding Officers' Designates Course, the CO recognised the importance of continual leadership development. The first piece of Operational Staff Work (OSW) written on his arrival was an Officer Education Fragmentary Order (FRAGO), which Witness 003

[71] A2020 Measure 13-012- Implementation Order: Re-designation of HQ 42 (North West) Bde as HQ 42 Inf Bde & HQ NW.

included the requirement for OCs to run at least 3 leadership development sessions for their officers, SNCOs and Cpls over the year. Although CO 2 LANCS provided this structure for his own subordinates, the Panel **observes** that despite the complex environment in which new COs can operate, the Army does not routinely provide formal mentoring or coaching during the first critical months of their command.

1.4.189. **Recommendation**. D Pers should consider implementing a mentoring regime, or similar, outwith the chain of command, to new COs, in order to help maximise talent and optimise efficiency and effectiveness.

Operational Planning

Introduction

1.4.190. Military planning is a command-led activity. While it can be achieved in isolation, it is acknowledged across Joint and Army doctrine that collaborative planning provides benefits for all stakeholders[72]. It is widely accepted that diversity of thought, experience and skills are essential to creative design and better decision making. Perhaps the greatest value of collaborative military planning is in creating a shared understanding; potentially this is more valuable that the plan itself. It is composed of 3 critical elements:

d. **Estimate**. This is a logical, scalable process of reasoning by which a commander, faced with an ill-structured problem, assesses risk and threat to arrive at a course of action to achieve mission success[73]. Starting with either a conceptual or physical reconnaissance, collaborative planning creates a common operational picture from which to achieve shared situational awareness, test ideas, identify opportunities to exploit, threats to mitigate, information to find and measures of effectiveness to develop[74].

e. **Operations process**. This places significant emphasis on the requirement to continually assess, test and refine a plan. Where there is likely to be a significant time gap between the initial preparation of a plan and its execution, a focussed effort to refine and adjust the plan to reflect changing circumstances may be required[75]. It was recognised by ACOS Trg in 'Observations from Training 2016', that there is still a lack of deduction pull-through to build and test plans; critical factors are missed and BGs fail to re-visit earlier steps in the planning process so do not refine Courses of Action. Exhibit 087

a. **Orders**. These include the detail necessary for subordinate commanders to be able to understand the context of the operation. They also need to understand the intent, extracting what it means for them and what it means for others[76]. For Op SHADER, UKTTs received operational orders, direction and guidance from both UK and CJFLCC-I HQ.

[72] ADP Land Operations, Ch 9-32.
[73] Ibid, Ch 9-28.
[74] AJP-5, Ch 1.
[75] ADP Land Operations, Ch 9-35.
[76] Ibid, Ch 9-30.

1.4.191. Within this framework, the Panel considered several aspects of operational planning by 2 LANCS that deserve further analysis to understand their potential impact on this accident. These are the reconnaissance, the back-brief, estimate, orders and G1 Wargame.

Reconnaissance

1.4.192. Experience suggests that once commanders become risk aware and understand the true picture for what they are responsible and accountable, they are better equipped to identify where dangers exist and develop more effective mitigation strategies[77].

1.4.193. CO 2 LANCS conducted a pre-deployment recce to UKTT(C) and UKTT(K) to visit CO 1 RIFLES in Erbil from 20 – 27 Sep 16. This coincided with a visit by Deputy Special Advisor to the Middle East, the Deputy Commander of the Combined Joint Task Force (CJTF) and Commander British Forces – Land (COMBRITFOR). This limited CO 1 RIFLES' ability to concentrate solely on the handover to 2 LANCS and restricted their movement in theatre. Exhibit 091 Exhibit 108

1.4.194. The limitations in the recce schedule were compounded by difficulties with intra-theatre travel and time available. Due to the location of UKTT(C) BG HQ, CO 2 LANCS was able to visit principal locations around Erbil, including the Manila Training Centre and Bnswala Training Area. There, he had the opportunity to speak with COMBRITFOR and Commander Kurdistan Training Coordination Centre. He did not visit CJFLCC-I HQ in Baghdad nor the 2 locations where his independent Coy Gps would be based: Besmaya or Taji. The Panel notes that CO 2 LANCS did visit all sub-unit locations during the handover period, prior to ToA. Exhibit 108

Reconnaissance – Visas

1.4.195. A lack of visas for other staff denied the officers who would assume command of UKTT(Taji) and UKTT(Besmaya) the ability to recce and physically assess their future locations prior to deployment. As a consequence, they were unable to appreciate their future physical environments, their operational orders or adjust and evaluate their Coy level plan for training against a refined set of OSW and observations from theatre, prior to deployment. Exhibit 003

1.4.196. While it is not a complicated process to obtain an Iraqi visa, the Panel acknowledges that applicants have little control over either the process or [redacted]. Noting that British Forces have been engaged on Op SHADER since Dec 14, [redacted]. Exhibit 109

1.4.197. 2 LANCS knew that they would be deployed to Iraq on Op SHADER 4 from early 2016. It is acknowledged that the 1 (UK) Div FGen Order was not issued until 12 Jul 16. Despite the tardiness of the formal Div FGen Order and noting the anticipated timescale of 5 weeks to grant a visa, sufficient opportunity existed to submit applications for key personnel to overcome delays in the application process. This would have permitted OCs' reconnaissance to their future locations. Exhibit 002 Exhibit 109

[77] DSA Annual Assurance Report, Apr 16 – Mar 17, para 63, p22.

1.4.198. The period Aug to Oct 16 was busy for PJHQ as they prepared to deploy an additional BG to theatre[78]. However, the same FGen Order covered all deployments for Op SHADER 4; PJHQ was aware of the additional demand and all units were given equal and adequate opportunity to apply for visas. Exhibit 109 Exhibit 002

1.4.199. Where it is likely that roles such as CO, Quartermaster, Ops Offr and OCs would wish to conduct reconnaissance, applications for visas should be made as soon as the FGen order has been confirmed. The Panel believes that the absence of visas and thus the ability to conduct sub-unit reconnaissance was caused by a combination of factors: a lack of knowledge and prioritised planning in 2 LANCS, [redacted] and a lack of support from PJHQ in recognising the importance of, and enabling, recces to sub-unit locations. The Panel **observes** that PJHQ could more effectively assist units with the provision of visas to facilitate the conduct of timely recces.

Reconnaissance – Range infrastructure

1.4.200. Operational Shooting Policy recognises that it is a command responsibility to ensure that sufficient training opportunities are available and an individual duty to achieve the highest possible standards of marksmanship[79]. During Op SHADER 3, it was believed that the ranges in Taji were not authorised for use. They were regarded as Operational Training Ranges (Emerging) by PJHQ and would not be classified as (Enduring) until resources could be made available to bring them to the standards for JSP 403 compliance. Nonetheless, approval for their use could have been requested from COMBRITFOR in his role as Range Authorising Officer[80]. Witness 020 Witness 016 Exhibit 110 Exhibit 111 Exhibit 112

1.4.201. Despite an ambition to do more, 1 RIFLES limited themselves to routine check zero shoots with the SA80 rifle and no GSP firing. Without a reconnaissance to Camp Taji, 2 LANCS inherited this misinterpretation of complex policy around range usage and this affected their subsequent approach to range training. In the Panel's opinion reconnaissance to operational locations must include consideration of Small Arms live fire continuation training that develops marksmanship throughout the operational tour. Witness 020 Witness 016 Witness 002 Witness 004 Witness 005

1.4.202. Blenheim Coy Gp deployed with sufficient competent, current and qualified personnel to plan, conduct and supervise live fire training, if resources were available. The Panel requested but has seen no evidence of any request being made to COMBRITFOR and no positive action by UKTT(Taji) to train their personnel beyond the routine monthly SA80 rifle zero and GSP point of aim shoots. The Panel believes this was a lost opportunity to prioritise the importance of marksmanship as a core skill. Exhibit 019

1.4.203. The Panel concludes that by not visiting all sub-unit locations during the pre-deployment recce, 2 LANCS did not fully understand the infrastructure and challenge potential limitations to activity. This undermined Blenheim Coy's ability

[78] This was the 4th Bn, The Royal Regiment of Scotland.

[79] DCC Trg, Vol I, p. iv.

[80] An SASC Quarter Master Sergeant Instructor (QMSI) deployed to Erbil to conduct an assurance visit in the period from 14 to 20 Jul 16. This visit did not include the ranges available to UKTT(Taji), and no assessment of the ranges was subsequently undertaken prior to Q3 2017. SASC QMSI advice is that trying to run the ranges as Operational Training Ranges (Enduring), thus making them fully compliant with JSP 403, would place an untenable burden on the relatively small UK footprint in each location. As a consequence, the ranges in Taji were classified as Operational Theatre Ranges 'Emerging', in accordance with JSP 403 Vol 1 Part 2 (para 166) and the DSA Range Safety Policy Letter 16-01 "Overseas Out of Area Live Firing Aide Memoire". Approval for their use was therefore to be requested from COMBRITFOR as the Range Authorising Officer.

to identify training opportunities and constraints in Camp Taji and was an **Other** factor.

1.4.204. **Recommendation**. CJO should direct that physical reconnaissance to independent locations is mandated whenever possible in order to minimise risk and maximise opportunities prior to deployment.

Back-brief

1.4.205. Considerations from CO 2 LANCS' recce were included in a post-recce back-brief to his command team and sub-unit OCs on 30 Sep 16. The content was appropriate to Op SHADER; subjects included the complex command and control structures, key personalities, an Iraqi human terrain narrative and details on key actors in theatre[81]. The brief included a reminder of the operational mission, an outline of risks and provided some responses to Requests for Information from some functional areas.

Witness 003
Exhibit 108

1.4.206. The UKTT(C) BG operated in 4 distinct locations. The operational and living conditions in Taji and Besmaya vary considerably from each other as well as from Erbil and Manila. Each location had different environmental factors, different coalition partners and different command and control arrangements. Each had different challenges, risks[82] and separate weapons carriage policies.

Witness 023

1.4.207. The content of the CO's brief was not a first-hand account of all sub-unit locations. The restrictions of the recce schedule forced the scope of the brief to concentrate on strategic content, Erbil and the north-east region. In the opinion of one sub-unit commander, the scope proved to be insufficient for his location.

Exhibit 108
Witness 023

1.4.208. In the Panel's opinion, sub-unit commanders, if unable to conduct a recce in person, should be given a thorough appreciation of their respective locations in order to understand and exploit opportunities and mitigate threats to their missions.

1.4.209. **Recommendation**. CJO should direct that whenever a physical reconnaissance cannot be achieved, other means must be provided to give units the character of their future location in order to minimise risk and maximise opportunities prior to deployment.

Estimate and Orders

1.4.210. 2 LANCS received no formal verbal operational orders from PJHQ, BRITFOR, 1 (UK) Div or 42 Inf Bde for their Op SHADER mission. However, the standing Op SHADER OSW[83] was available to 2 LANCS prior to deployment through PJHQ and, electronically, in Weeton Barracks.

Exhibit 110
Exhibit 044

1.4.211. In his role as CO UKTT(C), CO 1 RIFLES refined his BG Operational Orders (OpO) and Standing Orders specifically to bridge through the handover period and ToA with 2 LANCS. This was agreed in advance by CO 2 LANCS for Op SHADER 4, and was subsequently repeated with CO 2nd Bn, The Mercian Regiment (2 MERCIAN) for Op SHADER 5.

Exhibit 044

[81] ISF, KSF, Popular Mobilisation Forces (militias) and Daesh.

[82] Coalition partners in all locations had experienced accidents and NDs.

[83] Chief of the Defence Staff Directive, CJO OpO or BRITFOR OpO.

1.4.212. During his recce to Iraq, CO 2 LANCS read and reviewed the higher-level UK OSW and UKTT(C) BG OpO with CO 1 RIFLES. Both considered it fit for purpose to cover the initial period of the 2 LANCS BG's deployment. CO 2 LANCS conducted an estimate during the recce supported by his Ops Offr. The key deductions were shared on return to UK with his command team, including all OCs. The scope of the back-brief included the BG role, specific tasks and answers to questions posed prior to the recce. Exhibit 044 Exhibit 108 Exhibit 111 Exhibit 112 Exhibit 008

1.4.213. A collaborative estimate, based on UK and CJFLCC-I orders, was not carried out with the full command team and all OCs during pre-deployment preparation, and this was not required by 42 Inf Bde. Op SHADER 4 UKTT(C) BG Operational Orders were not issued verbally, or published, to commanders prior to deployment. The CO did issue 'Initial Operational Thoughts', directing sub-units, in their approach to MST, to develop their ability to identify and manage risk to small, isolated teams. Exhibit 044 Exhibit 108 Exhibit 111 Exhibit 113 Exhibit 005

1.4.214. The 2 LANCS BG Main Deployment Orders were issued on 14 Sep 16. These were followed by a Deployment FRAGO issued on 27 Oct 16 and an Op SHADER Deployment Order on 15 Nov 16. These orders provided direction and guidance for the process of deploying to theatre, not mission specific detail. Exhibit 108 Exhibit 114 Exhibit 115

1.4.215. CO 2 LANCS delayed further refinement of his Op SHADER BG Orders until after his BG was established in theatre, he had visited all sub-unit locations, met with key personalities and completed a further BG estimate. These were republished in late-Jan 17[84]. Exhibit 044 Exhibit 108

1.4.216. The Panel notes that the mission specific orders provided by 1 RIFLES were based on experience of operating continuously in the same locations for over 12 months. Although entirely suitable for their people and processes, it is very likely that their orders and operating procedures would not reflect exactly the strengths and weaknesses inherent in a different Bn, new to theatre.

1.4.217. The Panel believes that collaborative consideration, collective creation and BG publication of mission specific orders prior to deployment would have enabled commanders to better synchronise understanding, align decisions and optimise risk management. The Panel concludes that, rather than rely on existing OSW, conducting a collaborative BG estimate prior to deployment would have increased diversity of thought, the opportunity for learning through shared experience and the development of a common operational picture. In addition, conducting such an estimate and issuing UKTT(C) operational orders prior to deployment would have decreased the initial burden on BG staff and OCs in theatre. The Panel considers this was an **Other** factor.

1.4.218. **Recommendation**. CJO should direct that units conduct collaborative planning and produce mission specific orders prior to deployment in order to better mitigate threats and maximise opportunities.

G1 Wargame

1.4.219. Before deployment, CO 2 LANCS considered 3 scenarios which represented significant management risk: an operational death in Iraq, an operational death elsewhere and a substantial Compulsory Drug Test failure. He Witness 003

[84] These provided direction and guidance on the achievement of the mission.

instigated a G1 Wargame to better understand the administrative policy and processes to be used in Post Incident Management.

1.4.220. The exercise was attended by his command team and principal organisations from the Bn's chain of command. The event allowed the CO to direct additional G1 preparations and enabled the Bn 2IC, as Comd Rear Operations Group, to meet key G1 personalities and understand both policy and process. Exhibit 003

1.4.221. This exercise was considered to be a vital aspect of the Bn PDT and best practice by CO 2 LANCS. The 2 LANCS Initial Deployment Report (IDR) made note that those administrative processes which were tested, worked effectively. The Panel acknowledges the utility of conducting a G1 wargame. Witness 003 Exhibit 003

1.4.222. Despite these preparations, considerable procedural frustrations emerged within the UKTT(Taji) command staff during the post-incident management of LCpl Hetherington's death. These were influenced by: Witness 002

a. Difficulties locating LCpl Hetherington's next of kin based on the name and address recorded on Joint Personnel Administration (JPA). Exhibit 116

b. Lack of immediate access to SIB and morticians. Exhibit 037

c. Apparent errors in the Repatriation Plan, including difficulties in sourcing a coffin and flag. Exhibit 101

d. Offers of assistance from unknown units that confused the aftermath. Witness 002

e. Too much policy from PJHQ resulting in a lack of clear guidance or timely assistance to Coy HQ command staff. Exhibit 094

1.4.223. The Panel believes that the administrative difficulties experienced by the sub-unit in the aftermath of LCpl Hetherington's death were exacerbated by a loss of corporate knowledge, from PJHQ down, in dealing with death on operations. The Panel **observes** that the conduct of a specific G1 estimate promotes mutual understanding and best practice, but is dependent on appropriate representation from all stakeholder. In addition, placing greater emphasis on the structure of the G1 wargame, to include a 'death on operations' scenario that is exercised to the point of funeral, would develop the exercise into a more effective vehicle for practising incident management. Witness 003

1.4.224. **Recommendation**. CJO should direct force generating headquarters to commission J1 wargames, as appropriate, aligned to the theatre risk register, in order to improve operational Post Incident Management.

Higher Level Supervision

Brigade oversight

1.4.225. The Panel notes that 2 LANCS was force generated by a Bde HQ that would not accompany them to theatre and from which they would transfer in Nov 16, immediately prior to deployment. The new parent Bde would also not

accompany 2 LANCS into theatre and neither Bde had responsibility for the operational mission.

1.4.226. 2 LANCS was not issued mission specific orders for Op SHADER 4 by 42 Inf Bde. The Panel notes that the Bn relied upon extant OSW from theatre, received through PJHQ. Following his recce to Iraq, however, CO 2 LANCS back-briefed Comd 42 Inf Bde on his approach to MST. 42 Inf Bde did not oversee 2 LANCS estimate process or require a back-brief from the CO on his mission specific BG orders. The Panel **observes** that the focus of Bde level supervision was the force generation and deployment of 2 LANCS to multiple locations, rather than to consider and support subsequent operational activity. Exhibit 044 Exhibit 008

Timing of the Mission Rehearsal Exercise

1.4.227. Following a year of training activity, in the UK and abroad, the MRX was scheduled immediately prior to pre-deployment leave and embarkation. This was later in the PDT programme than the deploying units and MTMC would have wished and it provided insufficient flexibility for either Coy Gp to conduct further training should the standards on the MRX have been deemed unacceptable. The MRX could not have been earlier due to the requirement for the RE elements, who were essential to the UKTTs, to attend exercises in Italy and Germany to train with US engineering equipment. Exhibit 077 Exhibit 003

1.4.228. Between the end of the MRX and deployment, there was no opportunity for additional training and re-assessment. The MTMC DS recognises that the inevitability of deployment, and the limited scope for remedial training, may influence attitude and performance. Although this was also recognised in a 1 (UK) Div review conducted in late 2016 to clarify and sharpen the assurance of Force Preparation, it was too late to affect the PDT arrangements for 2 LANCS. The Panel concludes that programming an MRX without sufficient time for remedial training, if required, forces a course of action to deploy the unit whether appropriate or not. The Panel considers this was an **Other** factor. Exhibit 083 Exhibit 080 Exhibit 102

Provision of assurance

1.4.229. As illustrated in Figure 20, the formal route for assurance of training from MTMC to Commander Field Army (CFA), was through Training Branch, Field Army and General Officer Commanding (GOC) 1 (UK) Div. Separately, the force generating Bde Comd, in this case Comd 42 Inf Bde, would send a Confirmation of Readiness letter to the GOC based on his knowledge of the Bn and attendance at the MRX AAR. On behalf of CFA, the Army Directorate for Operations and Contingencies would confirm readiness to deploy to CJO. In late 2016, it was not common practice to provide COMBRITFOR with specific detail about the performance of Force Elements during PDT or their standard of readiness.

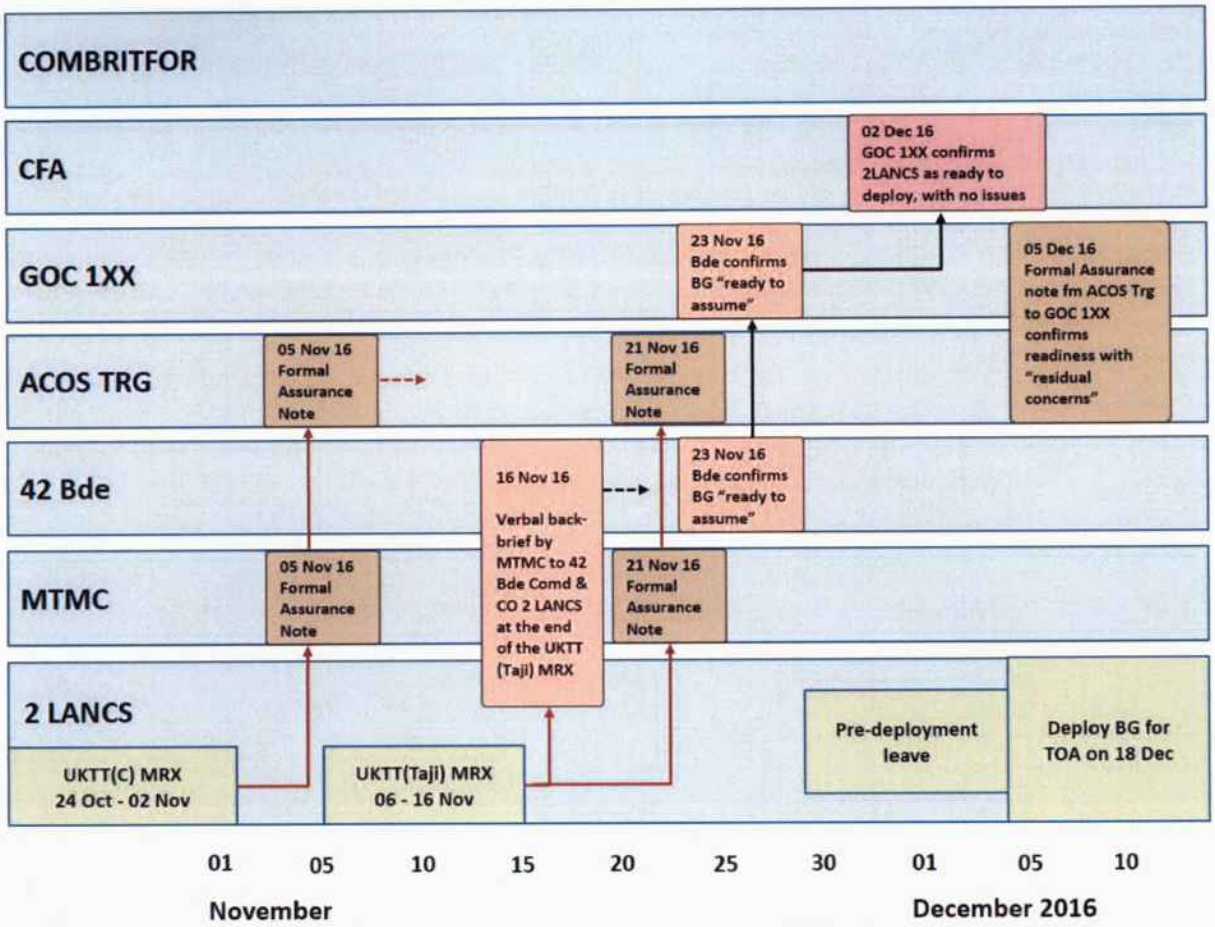


Figure 20: Route for 2 LANCS Operational Assurance

1.4.230. Assurance Notes were written by MTMC after both of 2 LANCS BG's MRXs. UKTT(Taji) and UKTT(Besmaya) Coy Gps attended the second MRX, from 06-16 Nov. Both UKTT(C) BG MRX Assurance Notes were sent from MTMC to ACOS Trg, Training Branch, HQ Field Army and both recommended the Force Elements as ready to deploy. However, as noted earlier, the Assurance Note issued on 21 Nov 16 stated that "there are residual concerns over a sub-unit's leadership and resultant culture. These have been briefed to the relevant CoC". Exhibit 118 Exhibit 107 Exhibit 020

1.4.231. The Panel determines that there was a discrepancy between the understanding of the concerns alluded to in the formal Assurance Note, and the understanding drawn from the MRX AAR by Comd 42 Inf Bde and CO 2 LANCS. A silent copy of the UKTT(Taji) Assurance Note was given to CO 2 LANCS before 28 Nov 16 and he discussed the contents with the Bde Comd by telephone. Although CO 2 LANCS agreed that the Coy had underperformed, both he and the Bde Comd believed the concerns were an aberration and focussed on one individual, in a snapshot of time. Despite Comd 42 Inf Bde's responsibility to confirm the Bn's readiness to deploy, failure to distribute the MTMC Assurance Note to him meant it did not inform his decision making and denied him the opportunity to address fully the concerns raised within it. Exhibit 095 Exhibit 107

1.4.232. Comd 42 Inf Bde regarded 2 LANCS as a thoroughly well-trained organisation which had attended to the training requirements in great detail and were thus ready for operations. In addition to the MRX, he confirmed the BG as Exhibit 089 Exhibit 107

ready to assume their Op SHADER mission as a result of his knowledge of the Bn's performance over the training year. Comd 42 Bde sent a Confirmation of Readiness letter to GOC (1) Div on 23 Nov 16 in which he remarked that "no significant training risk has been identified though 'work-on' points have been identified and CO 2 LANCS will be made aware of these". On this basis, GOC 1 (UK) Div declared to CFA on 2 Dec that 2 LANCS were trained and ready to deploy, 3 days before formal receipt of the Assurance Note from Trg Branch. In mitigation, COS 1 (UK) Div reminded the Panel that there was frequent and regular communication between 2 LANCS, 42 Inf Bde and 1 (UK) Div and, as it was presented, the issue of Blenheim Coy command climate did not warrant elevation to CFA. Exhibit 120 Exhibit 107

1.4.233. COMBRITFOR did not receive a copy of the MTMC Assurance Note. The Panel **observes** that the distribution of the Assurance Note was too narrow and believes that the distribution of the Note should also include the force generating Bde, PJHQ and COMBRITFOR in order that commanders are made aware of the strengths and weakness of units prior to deployment.

1.4.234. **Recommendations**. Head of Warfare Development should ensure that:

a. The Mission Training and Mobilisation Centre Assurance Note is issued to the Brigade Commander and Commanding Officer in sufficient time for them to act meaningfully on its content.

b. The MTMC Assurance Note is issued to COMBRITFOR in order to improve his understanding of incoming Force Elements and thus management of risk.

1.4.235. The Panel has seen detailed work by 1 (UK) Div to review and improve the processes of Force Preparation. This started at the request of GOC 1 (UK) Div in late 2016 and was staffed collaboratively with all stakeholders in order to add rigour to the conduct and assurance of force preparation. Noting the outputs of the Force Preparation Review to address the issues of late notice training deficiencies and programming of MRXs to avoid compressed training, and the content of subsequent MTMC Assurance Notes and Bde Confirmation of Readiness letters, the Panel is satisfied that the current assurance pipeline is robust and effective. Exhibit 121

Duty Holding

1.4.236. At the time of LCpl Hetherington's death, the DH chain for UKTT(Taji) was confusing, as illustrated in Figure 21. Domestic and operational chains existed in parallel, and there was no commonly agreed formal allocation of DH responsibilities. Indeed, both GOC 1 (UK) Div and CJO were the Operating Duty Holder (ODH) and depending on what staff work was given precedence the position of Senior Duty Holder (SDH) was also ambiguous. Exhibit 122 Exhibit 123 Exhibit 124

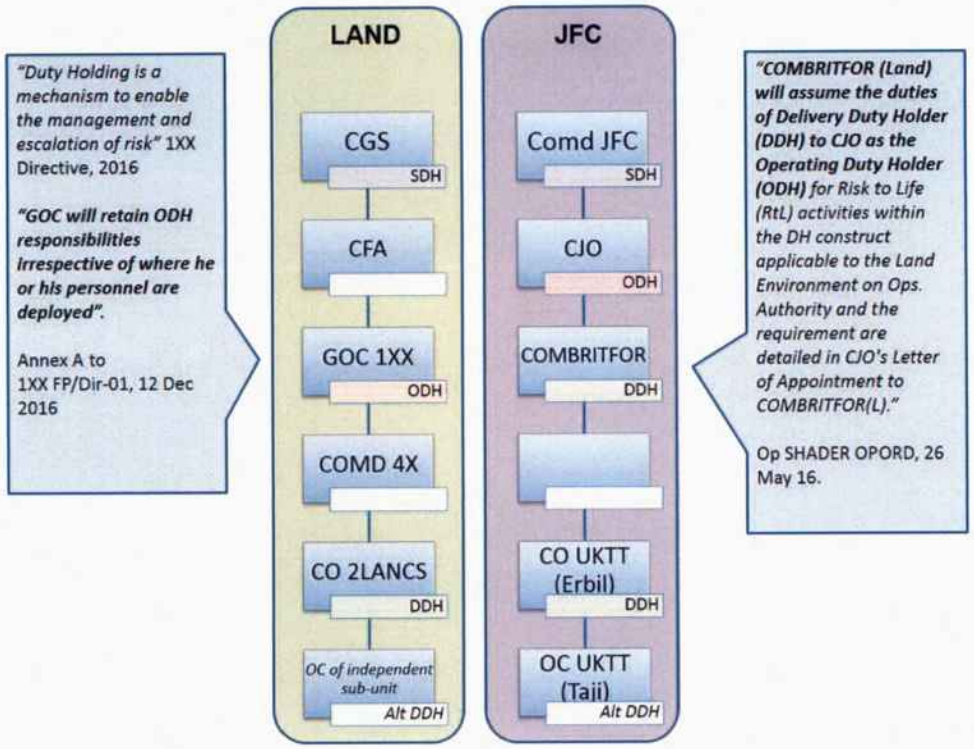


Figure 21: Duty Holding chains as at 2 Jan 17

1.4.237. The deployed CO noted in the 2 LANCS IDR that *"COMBRITFOR is the [Delivery Duty Holder] DDH rather than the CO. This removes an element of mission command from the unit level. Recommendation: The DDH should be reviewed; COs have the staff to manage some risks in terms of mitigation and control measures. HQ BRITFOR have this issue in hand".*

1.4.238. It is acknowledged, however, that all Service personnel, irrespective of theatre and throughout their respective chains of command, retain the obligation of Duty of Care. As such, the Panel believes that clearly defined and well understood DH responsibilities, particularly as a unit transfers from non-operational to operational duties, would clarify the management and escalation of risk. However, the utility of DH has to be commonly understood to add real value. Despite the ambiguity of the DH hierachy in which UKTT(Taji) sat at the time of the accident, the Panel concludes this was **not** a factor. Exhibit 125

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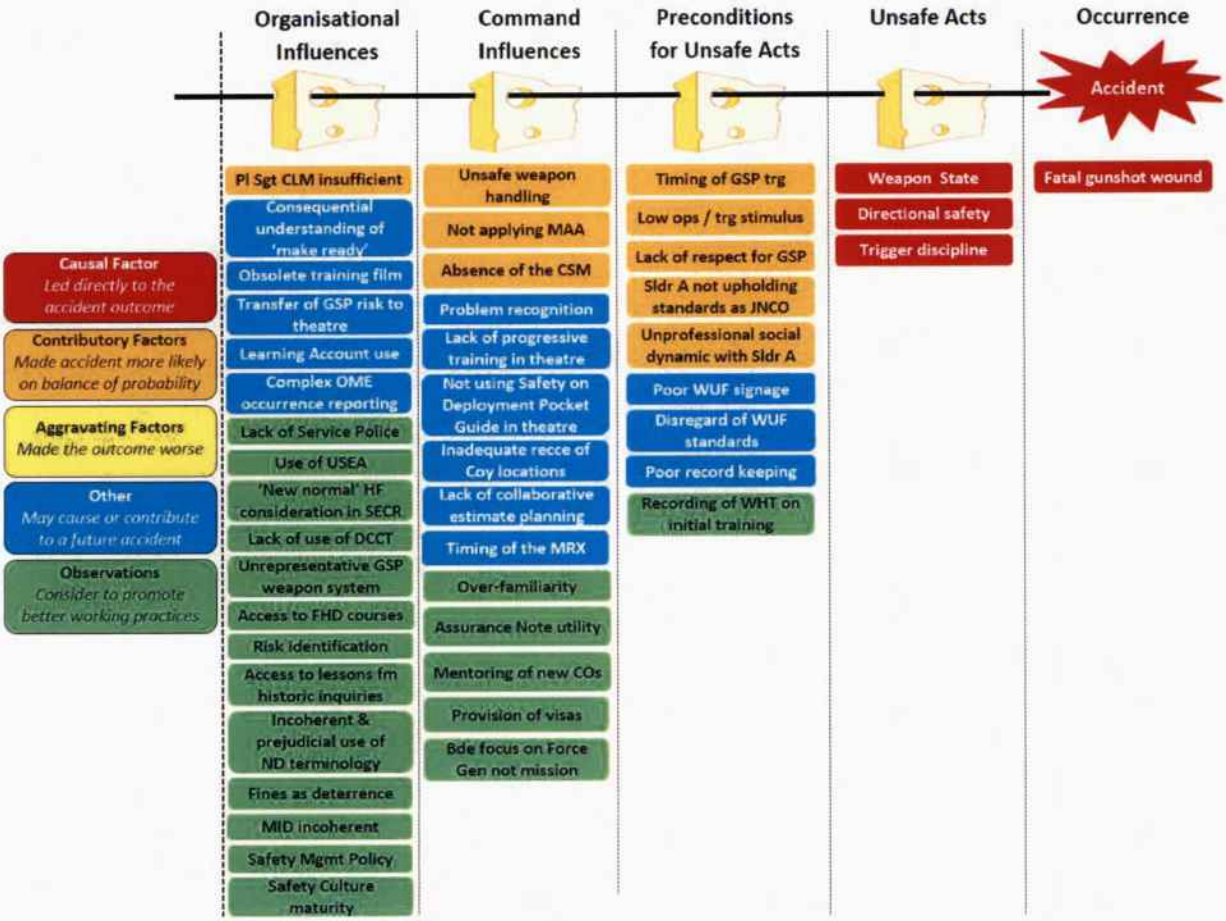
Chapter 5 – Organisational Influences



1.4.239. **Chapter overview**. Fallible decisions of upper-level management directly affect supervisory practices, as well as the conditions and actions of operators. Organisational influences can often go unnoticed but have a cumulative effect. The most elusive of latent failures often revolve around issues relating to: Resource management, Organisational processes and Safety Culture[85]. These form the framework of this Chapter. Amongst numerous organisational weaknesses, one contributory factor was identified - the effect of delaying the PI Sgt's Command, Leadership and Management (CLM) Part 3 training.

Resource Management

1.4.240. The organisational management of resources breaks down into 3 areas: Human, Equipment and Knowledge Resource Management.

[85] Weigmann & Shappell, Ibid. The HFACS model identifies 'organisation climate' as an organisation influence. However, the Panel considered Safety Culture as an equivalent structure.

Human Resource Management

Command, Leadership and Management

1.4.241. CLM training is delivered to JNCOs and SNCOs in 3 parts and is "designed as training in rank, not training for [the next] rank"[86].

a. CLM Part 1 (Substantiation) has to be completed within a year of promotion and a soldier is granted substantive rank on the successful completion of the course[87]. Soldiers will not substantiate in their new rank until they are deemed competent in CLM Part 1 for that rank and may not be considered for further promotion until all aspects of CLM are complete.

b. CLM Part 2 (In-Unit Training) supports soldiers in their new role. It consists of a limited amount of training delivered in context, in-unit. It should be carried out in conjunction with workplace induction procedures and must be completed within 3 months of assuming a new appointment. A record of completion of Part 2 is to be retained by the unit and recorded on JPA.

c. CLM Part 3 (Professional Development) is delivered in Army Education Centres. It is stated clearly in the CLM Handbook, that it should "...be attended within one year of becoming substantive in rank". Soldiers who fail to complete CLM Part 3 are not considered fully trained for the rank they hold.

1.4.242. However, there is a commonly held view among soldiers and Bn career management staff that CLM Pt 3 is a hurdle to be overcome in order to promote to the next rank, rather than a critical training requirement to perform in the current rank. To that end, CLM Part 3 is often delayed until necessary for eligibility to promote. Exhibit 126 Exhibit 029

1.4.243. Without Parts 2 and 3, a Sgt is less likely to perform to the highest standards as he will not have received the full training. The FP PI Sgt assumed the rank of Acting Sgt on 19 Jul 15 and achieved substantive rank on 1 Oct 15. He completed SNCO CLM Part 1 with King's Division Training Team on the 13 Nov 15. There is no JPA record of the FP PI Sgt having completed CLM Part 2 (In-Unit Training). At the time of the accident, some 14 months later, he had not completed SNCO CLM Part 3[88]. Exhibit 127 Exhibit 027 Exhibit 029

1.4.244. The Panel recognises that only with the appropriate education, training and development will the Army's foot soldiers be fit for purpose[89]. Yet it was evident during his interview that the FP PI Sgt had not been educated sufficiently to demonstrate appropriate comprehension of command, leadership and management for his role. In particular, during interview he did not appear to fully Witness 006 Witness 006 Witness 006

[86] Direction is provided in LFSO 3223, updated to Army Command Standing Order 3223 "Soldier Training and Education", 1st Ed, dated Apr 17.

[87] For regular soldiers, CLM Part 1 training and education courses are to be completed within 12 months of the start of the promotion year (for those informed of their selection for promotion prior to the start of the promotion year). For those selected during the promotion year from reserve lists, the Part 1 course must be completed within 12 months of the date of assuming their post in the higher rank, if after the start of the promotion year. For Reserve soldiers the PNCO training requirement must be completed within 12 months after selection for promotion; JNCO, SNCO and WO Part 1 training must be completed within 24 months after selection for promotion.

[88] FP PI Sgt completed Pt 3 in Oct 17 and is now eligible to promote to CSgt.

[89] Taken from Maj Gen GCM Lamb's keynote address to the Infantry conference, 2005 and reprinted in BAR 137, Summer 2005.

understand his role or that of the Pl Comd, he was unable to articulate the meaning of leadership or demonstrate the practical application of equipment management.

1.4.245. The Panel believes that the common approach to the achievement of CLM Part 3 denied FP Pl Sgt the opportunity to attend within the mandated timeframe. Although outside his control, delaying this education limited the FP Pl Sgt's competence. The Panel concludes this impacted on the command environment in the FP Pl and was a **Contributory** Factor.

1.4.246. **Recommendation**. D Pers should use CLM 19 to mandate that all 3 parts of CLM training are completed within one year of promotion, and hold chains of command accountable, in order to ensure that all soldiers are trained appropriately for their rank.

Reinforcing GSP lethality

1.4.247. The words within publications and used during Small Arms training have an effect on understanding and behaviours. Interviewees[90] were asked to define the task 'Make Ready'. In response, 100% described the mechanical actions associated with a round being chambered. Only 30% added a consequential definition that, in this state, the weapon was Made Ready *to fire* or Made Ready *to kill*.

1.4.248. In Rifle Lesson 15, Bayonet Fighting[91], the stated aim of the lesson is *"to teach the soldier how to attack and kill with the bayonet and methods of self-defence"*. This clear performance statement is reinforced with repetition when describing the 3 different methods of engaging an enemy with the bayonet; to *kill* a standing enemy, to *kill* an enemy on the ground and to *kill* a number of the enemy. This unambiguous language leaves the user in no doubt of the intent of the lesson or the lethal capability of the weapon.

1.4.249. The Panel notes that there is no use of the phrase '*to kill*' and only one mention of '*Ready to fire*' in DCC Trg Vol II and determines that this does not reinforce the consequential nature of the GSP as a lethal close quarters weapon.

1.4.250. Noting perceptions of the GSP described in Chapter 3, the Panel believes that the addition of the consequence of any action is important to understanding[92]. To that end, the Panel believes that when asked to define 'Made Ready', all weapon users should respond unprompted with both a mechanical and a consequential description. The Panel concludes that a poor comprehension of the risks posed by a made ready GSP was an **Other** factor.

1.4.251. **Recommendation**. HoC GM should amend DCC Trg Vol II, Personal Weapons – Pistol, to include a training objective that describes the consequences of making the GSP ready to fire, in order to increase comprehension of risks and GSP lethality.

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[90] 31 of 33 Army personnel interviewed were asked this question. Of those, 12 were ranked Pte-Cpl. The most senior rank interviewed was Lt Col.

[91] DCC Trg, Vol II, Ch 1, p.1-182.

[92] E.g. In a military mission statement, it is not the task itself, but the purpose, that carries the weight.

Developing an engaged Safety Culture

1.4.252. Those currently serving in the Army are likely to have seen one of 2 films produced to show the consequences of having a Negligent Discharge. 'It Could Be You' (1973)[93] was updated in 1987 as 'An Unthinking Moment' and released a year later[94]. These films were written, funded and produced to convey a powerful message. They are prescient in their description of the Human Factors that lead to Negligent Discharges. These are shown through a series of vignettes based on real occurrences and include the consequences suffered by the victims, families and colleagues. Exhibit 128

1.4.253. Despite being 30 years old, 'An Unthinking Moment' is still shown in basic training[95]. However, the Panel considers the film to be obsolete as it fails to show current weapon systems, including GSP and SA80 rifle, modern uniforms or best-practice. Royal Military Academy Sandhurst (RMAS) staff observe that cadets find the film amusing due to its out-dated content and style. The Panel believes that the significance of the message is highly likely to be lost as a result. Over 80% of those interviewed[96] could not remember ever seeing either film. Those who did were, in the main, the longer-serving officers and soldiers who had clear memories of these films and, more importantly, the message they delivered. Exhibit 129 Exhibit 128 Exhibit 230

1.4.254. The Panel believes that the Army's use of an obsolete training film does not inculcate respect for the GSP and is detrimental to the development of an engaged Safety Culture. This is considered an **Other** factor. Witness 025

1.4.255. **Recommendation**. HoC GM should replace 'An Unthinking Moment', for a tri-Service audience to reflect the nature of contemporary operations using this Service Inquiry as a vignette in order to reinforce the lethal nature of the GSP and help develop an engaged Safety Culture.

Access to training courses

1.4.256. 2 LANCS, as a light Infantry Bn, had to train and qualify sufficient personnel as vehicle commanders and crew for both FHDs and Civilian Armoured Vehicles. Aware of their operational commitment from early 2016, efforts were made to plan accordingly. However, due to current process constraints, the Bn was unable to receive additional resources (including priority places on driving courses and Foxhound Commanders' courses) until the Force Generation (FGen) Order was published in mid-Jul 16. Exhibit 131 Witness 001

1.4.257. This delayed training reinforced the impression that MST was compressed and impacted on the selection of personnel for Op SHADER. Specifically, the OC and CSM had spoken about removing Soldier A from their ORBAT due to his behaviour, despite being a qualified FHD Comd, but felt they had to select personnel based on qualifications rather than performance. Witness 001

1.4.258. Recognising all of the pressures on 2 LANCS at this time, the Panel **observes** that greater and earlier access to appropriate courses required to reach theatre entry standards would have provided the Bn with increased flexibility for the selection and training of personnel. If it is the FGen Order which unlocks these resources, 2 LANCS would have benefited from earlier receipt of it.

[93] British Defence Film Library (BDFL), Catalogue Number C1279 – no longer available from BDFL.

[94] BDFL Catalogue Number C1671 – currently available.

[95] AFC Harrogate and RMAS have confirmed that they still show the film during Ph1 training.

[96] These films were made for an Army audience, but are applicable to all Service personnel who carry small arms.

1.4.259. **Recommendation**. Director Land Warfare should improve access to courses, as appropriate and required for a unit's mission, on being warned for operational deployment (prior to receipt of a formal Force Generation Order) in order to enable units to prepare for deployment in a timely manner.

Lack of Service Police in theatre

1.4.260. Despite the fact there were c600 British Army personnel involved in Op SHADER (of c800 Service personnel), there were no RMP SIB deployed to conduct any specific policing role[97]. This meant that immediately following the death of LCpl Hetherington, no RMP were available to investigate or support UKTT(C) BG. This contrasted to Op TORAL (Afghanistan) which had one SIB WO2 and 2 General Purpose Duties Cpls specifically assigned to conduct policing for c400 British Army personnel (of c600 Service personnel). Exhibit 132

1.4.261. In 2017, one officer and 3 SIB soldiers were held at readiness (R2) to surge to either Op SHADER or Op TRENTON (South Sudan) if necessary. As these personnel were not held on the Operational Equipment Table, they did not possess the necessary visas to ensure an immediate response into theatre[98].

1.4.262. The Panel believes that despite a changing mission and an increase in numbers of UK personnel in Iraq from 2015, PJHQ planning assumptions, with respect to the requirement for Service Police, had not been revisited. The Panel **observes** that the absence of RMP on Op SHADER led to a 7-day delay in commencing policing activities.

1.4.263. Service Police have specific responsibility, under UK and Service Law, to investigate serious crime. In addition, they provide relevant evidence to HM Coroners and have a responsibility to ensure that exhibits recovered from the scene are the exact same exhibits produced or described within the Court of Law[99]. The quality of witness statements and forensic opportunities obtained from serious incidents are also linked directly to the timeliness of response. The RMP SIB was alerted to the incident on 2 Jan 17 but, [redacted] it took 7 days for the SIB to arrive at the scene. The readiness and physical location of the RMP to support Op SHADER created challenges for the SIB during Post Incident Management. Exhibit 132

1.4.264. However, the UK investigative team was fortunate in 3 regards: UKTT and ANZAC Force Protection put in place sensible and effective 'scene security measures'; rather than use the formal chain of command through PJHQ, the COMBRITFOR Ops Officer liaised directly with the RMP SIB WO1 to expedite exchange of information and ensure preservation of evidence; and US Special Agents based in Kuwait responded swiftly on the UK's behalf, despite no previous planning or formal agreement. Exhibit 132

1.4.265. Assistance was sought by the RMP SIB WO1 and provided by 5th US MP Bn based in Germany. These US criminal investigation personnel were, serendipitously, deployed in Kuwait and a composite team deployed to Taji. This ad hoc arrangement was informal and established through friends-of-friends in Exhibit 132

[97] As at Oct 17, this was still the case.

[98] Additional RMP surge capacity for Op TORAL was held at higher readiness (R1).

[99] Op KIPION SOI 043, Op Management of the Dead dated Mar 17.

the wider police network. UK personnel were fortunate to have received US assistance. The Panel **observes** [redacted].

1.4.266. **Recommendations**. CJO should:

a. Ensure that operational planning includes appropriate levels of military police capability in all operational theatres in order to ensure prompt investigation of incidents.

b. Establish formal Memoranda of Understanding with coalition partners and/or Host Nations in order to ensure appropriate military police support is available in all operational theatres.

Use of the Unit Safety and Environmental Advisor

1.4.267. The Unit Safety and Environmental Advisor (USEA) is the advisor to the CO on Safety, Health, Environment and Fire risk mitigation. The Army has 75 USEA located at high risk units[101]. The role is often rank ranged WO2 – Capt and is filled by a Reservist on a non-deployable Home Commitment. In 2016, 2 LANCS had a WO2 USEA in Weeton Barracks. Exhibit 119 Witness 003

1.4.268. USEAs have commonly been focussed on delivery of Health and Safety in barracks. The Panel believes this does not utilise USEAs to their full potential. Empowered USEAs should be able to leverage knowledge from their own experience and network, the Health and Safety Executive and Defence policy to better deliver risk management and force protection across all environments. In the Panel's opinion, it is very likely that a change in name to Force Protection Advisor would also increase engagement and understanding of their role across all ranks. Further, training USEAs as Occurrence Investigators[102] would assist commanders' capacity to conduct effective Non-Statutory Inquiries (NSI), and noting that they are already distributed throughout the Army chain of command, this would provide both greater capacity and greater responsiveness to the Army. One of the specified duties of the generic USEA role, as specified by CESO(Army), was "to promote a no-blame culture both inside and outside of barracks". The Panel determines that this should directly support the development of a Just Culture. Exhibit 119 Exhibit 084

1.4.269. The Panel **observes** that not utilising the USEA to reinforce operational safety during PDT was a lost opportunity. Witness 027

1.4.270. **Recommendations**. Chief Safety (Army) should:

a. Reinforce the remit of USEAs, as Force Protection advisors, as the lead for risk assessment, safety and force protection, in barracks and on operations, in order to support the development of an engaged Safety Culture.

[100] E.g. The open verdict in the death of LCpl David Wilson, in Iraq, Dec 08, and subsequent media coverage, demonstrates this.

[101] Army Inspector's Assurance Review, Annex G to Chapter 3 dated 23 Apr 18.

[102] Developed by the MAA, the 3-day Occurrence Investigator course provides role specific and Human Factors training for MOD personnel to undertake occurrence investigations.

b. Exploit the capacity offered by USEAs by training and empowering them to undertake Non-Statutory Inquiries in role in order to support the development of an engaged Safety Culture.

Equipment Resource Management

General Service Pistol

1.4.271. Changes in the contemporary operating environment have increased the requirement for pistols to be carried as personal protection weapons from predominantly officers and vehicle commanders to all ranks. This is considered to be the 'new normal'[103]. There are 31,545 GSPs currently in service replacing approximately 30,000 L9 Browning and SIG pistols[104]. [redacted] Exhibit 052 Exhibit 134 Exhibit 047 Exhibit 135 Exhibit 136

1.4.272. Successful marksmanship is determined by access to sufficient weapons and ammunition, under-pinned by effective training opportunities. 2 LANCS was scaled to hold [redacted] on their Equipment Table but for Op SHADER 4 held [redacted][105]. The Panel believes that access to GSP for marksmanship training during PDT was **not** a factor. Witness 003 Witness 004 Witness 010 Exhibit 137

1.4.273. The Panel recognises that the GSP Safety and Environmental Case Report (SECR) does not consider the Man-Platform Interface. This approach is considered appropriate for the scope of the SECR[106], but the Panel determines that Human Factors influence behaviour with new weapons in new operating environments. Noting the new normal of GSP carriage and its high social value, the Panel concludes that a Human Factors study into young soldiers' attraction and reactions to the GSP could better inform Defence about RtL. Exhibit 045 Exhibit 046

1.4.274. The Panel has already determined that the timing of GSP training was responsible for Soldier A's lack of familiarity with the GSP. Noting that shooting is not a skill that responds well to uneven practice[107], regular and routine shooting once qualified is necessary to sustain familiarity and improve competence. During interviews, the Panel received numerous opinions that earlier and greater exposure to the GSP would benefit soldiers. Witness 020 Witness 001 Witness 017 Witness 003

1.4.275. The Panel also concludes that introducing the GSP earlier, potentially in Basic Training, would decrease its novelty and better prepare soldiers for the increased requirement for weapon carriage on operations. The Panel **observes** that the new normal of increased GSP carriage across all ranks would benefit from a review of how and when the GSP is trained.

1.4.276. **Recommendation**. D Pers should commission a study to investigate the Human Factors implications of the wider fielding of the General Service Pistol

[103] The term implies that something which was previously abnormal has become commonplace.
[104] Confirmed by DE&S, 13 Oct 17.
[105] As at 18 Jul 2017.
[106] The Safety and Environmental Case Report for the GSP was introduced at paragraph 1.4.53.
[107] DCC, OSP Vol I, Pers Wpns, Ch1, p vi.

in order to better inform the man-machine interface section of the General Service Pistol Safety and Environmental Case Report.

1.4.277. **Recommendation**. HoC GM should review and establish best practice as to how and when Service Personnel are educated and trained to use the General Service Pistol in order to enhance confidence, competence and performance on the weapon

Dismounted Close Combat Trainer

1.4.278. The Dismounted Close Combat Trainer (DCCT) is a computer-generated indoor range simulator that is used to train skills on a variety of Small Arms weapon types. It has sensors that can provide the firer with accurate, data-based feedback to identify faults and further develop speed, accuracy and safe weapon handling. Over 150 DCCT exist for use by the Army but it is acknowledged by SASC that they are under-utilised. The Panel determines that there is opportunity within existing resources for the Army to make better use of DCCT facilities. Exhibit 138

1.4.279. The DCCT provides a safe environment where close-quarters pistol marksmanship drills can be practised and perfected. Judgemental scenarios can also be programmed in which the firer is challenged to make a spilt-second decision whether it is appropriate to fire, in a simulated CQB environment. The Panel considers the DCCT to be an excellent tool for training pistol marksmanship and judgement in barracks[108].

1.4.280. Blenheim Coy did not take full advantage of the DCCT available to them in Weeton Barracks during PDT for Op SHADER. The Panel **observes** that not using the DCCT during PDT was a lost opportunity for Blenheim Coy to improve soldiers' familiarity and exercise good judgement with the GSP. Exhibit 139

Marker Round Training System

1.4.281. The Marker Round Training System (MRTS) uses Simunition® FX marker rounds and suitable equipment to provide training which allows force-on-force training in close quarters. The Panel notes that Marker Round Ammunition is available in 9mm as are 2000 Glock 'blue' training weapons, yet this system is not utilised for Infantry deploying for FP on Op SHADER. The Panel considers this to be a lost opportunity.

Live ammunition

1.4.282. In the period from 21 Jun to 23 Sep 16, 2 LANCS demanded [redacted] rounds of 9mm live ammunition for PDT. The Panel believes that this was sufficient to resource pistol marksmanship training for the Bn prior to Op SHADER. Lack of live ammunition was **not** a factor. Exhibit 140

Blank ammunition

1.4.283. In order to fire a blank 9mm round, a blank firing adaptor would be required. However, the Glock, like all previous GSP, was not procured with a Safe Blank Firing System. Of those interviewed, 88% recognised the training benefit of blank 9mm ammunition and the potential to improve outcomes through its use. CO 2 LANCS and CO 1 RIFLES both support the carriage of GSP during Exhibit 142 Exhibit 111 Witness 020 Witness 003 Exhibit 108

[108] DCC, OSP Vol I, Pers Wpns, Ch 1, p.1-20.

PDT and the use of blank 9mm ammunition for training. These points were amplified through the 1 RIFLES Post Operational Report in Mar 17. Exhibit 040 Exhibit 143

1.4.284. The Panel notes that soldiers are currently not permitted to carry blank 9mm ammunition. Indeed, unless a specialist user, the only opportunity to have a loaded GSP is in a controlled and unrepresentative range environment or on operations. Due to the lack of blank and drill ammunition, Blenheim Coy carried GSPs but no accompanying magazines during the MRX. The Panel **observes** that conducting training without 9mm magazines or ammunition creates an unrealistic training environment and reduces the effectiveness of training with the GSP[109]. Witness 006

1.4.285. In Jun 17, MTMC requested Training Branch Field Army to grant permission for troops under training to carry blank 9mm ammunition during MST. As MTMC do not use force-on-force scenarios during the MRX, the purpose for this request was to improve confidence and an understanding of their weapon state through the opportunity to practice weapon handling with blank ammunition. However, no waiver was received. The Panel notes that the next occasion soldiers were issued their GSP, they were to be permanently live armed on operations. The Panel believes that not training with a representative weapon system, immediately prior to deployment, transferred the safety risk from the training environment to the operational theatre. This is an **Other** factor. Exhibit 144 Exhibit 145 Exhibit 146 Exhibit 144

1.4.286. **Recommendation**. HoC GM should provide a full range of equipment and ammunition for the GSP, in line with all other Infantry Small Arms, in order to provide a representative weapon system for full training progression in all environments.

1.4.287. **Recommendation**. Director Land Warfare should consider issuing a waiver to permit the carriage of blank 9mm ammunition during Mission Specific Training in order to avoid transference of risk to the operational theatre.

Knowledge Management

1.4.288. If used, knowledge is a source of lasting competitive advantage[110]. Knowledge Management (KM) is the ability to apply and share what we have learned from experience with confidence and judgement. While knowledge cannot be managed in the same way as physical resources, we can improve our overall effectiveness by developing and sharing our collective knowledge[111]. Knowledge sharing among actors with diverse and distributed interests is challenging and requires committed leadership, active participation and collaborative effort[112]. The Defence Organisational Learning Strategy (DOLS) sets the ambition that "Defence routinely learns from experience and the experience of others; seeks out what has been learnt, sharing and critiquing it before, during and after activities" [113].

[109] In other Infantry weapon systems, the availability of live, marker, blank and inert drill rounds provides a range of training opportunities for all environments. The introduction of the Glock 'Blue' as a pragmatic alternative to blank provides a safe training alternative.

[110] Argote, L (2013) 'Organisational Learning: Creating, Retaining and Transferring Knowledge'. Springer Science and Business Media.

[111] Defence Information Management Passport: Information Matters v5.0

[112] Ministry of Defence - 'Practitioner Guidance for Knowledge Management Implementation', v2.0.

[113] DSG Paper - Defence Organisational Learning Strategy, 6 Sep 13.

1.4.289. A fundamental part of the Army's commitment to DOLS is the Army Lessons Process. The purpose of this is to learn efficiently from experience and to provide validated justifications for amending the existing way of doing things in order to mitigate risk and improve performance[114]. The Panel assessed the Army Lessons Process to be mature but acknowledge that there remains scope for improvement. While the Army has created numerous processes and tools to support knowledge exchange and learning from others[115], the Panel identified examples where significant opportunites to benefit from KM were not optimised. These included: Exhibit 147 Exhibit 148 Exhibit 149 Exhibit 150 Exhibit 151

a. The poor transfer of safety-related findings into mainstream decision making processes. Exhibit 040 Exhibit 152

b. A lack of transparency across the organisation to accelerate the exploitation of information. Exhibit 020 Exhibit 153

c. The lack of an effective and universally employed database, that allowed simple retrieval of information and easy transfer of issues. Exhibit 050

Defence Lessons Identified Management System

1.4.290. Defence Lessons Identified Management System (DLIMS) is a repository of observations and lessons from stakeholders across Defence. However, it is not widely understood or well used[116] and its utility is undermined by the numerous databases that exist in isolation to record observations and lessons[117]. It is not possible for a commander to prepare for operations using DLIMS alone.

1.4.291. Without a physical recce, sub-unit OCs were reliant upon knowledge held in corporate memory, databases and the incumbent sub-unit for recent observations and lessons. The Panel notes that neither OC UKTT(Taji) nor OC UKTT(Besmaya) drew on, or were provided with, any lessons directly from DLIMS to help them understand, exploit or mitigate risks in their future locations. Exhibit 154 Exhibit 155 Exhibit 156

1.4.292. The Panel believes that in addition to DLIMS there are 4 other learning opportunities that are worthy of review to demonstrate the lack of coherent KM: Learning Accounts (LA), Initial Deployment Reports, theatre risk identification[118] and access to historic inquiries. Exhibit 152

Learning Accounts

1.4.293. Land Forces Standing Order (LFSO) 1118 defined the processes by which lessons are gathered, analysed and resolved and identified responsible organisations. The document listed at least 40 different means for data gathering and input to the lessons process, 2 of which are triggered by submission of an LA. The document also defined the format, content, internal and external Exhibit 037

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[114] Allied joint doctrine for the conduct of operations.

[115] E.g. The Army Knowledge Exchange (AKX), Mission Exploitation Symposia, the British Army Review, Kit Magazine and the Lessons Exploitation Team's 'Lessons from Operations' and' Lessons from Training'.

[116] See *Army Inspector's Review of Safety, Lessons, Organisational Learning and Assurance Mechanisms*, dated 23 Apr 18; Ch4, p150.

[117] E.g. The RMP, DSA, Army Knowledge Exchange (AKX), GEMS, the Air Safety Information Management Systems, the Navy Lessons Information Management System and Army Incident Notification Cell all use separate systems to record lessons.

[118] E.g. In the internal 1 RIFLES handover notes (Op SHADER 3 to Op SHADER 3.5), statements about risk were limited to: "BGHQ will more than likely complete [the Risk and Rigour Statement] for you".

distribution lists[119]. In addition, PJHQ SOP 0014 directs operational commanders to submit a LA for serious injuries or fatalities.

1.4.294. Effective implementation of recommendations relies on meaningful content distributed correctly in a timely manner. However, 2 highly significant LAs of smalls arms accidents did not meet these criteria, as recorded in the following vignettes.

Vignette - Afghanistan, Dec 13

1.4.295. A Senior Aircraftsman (SAC) unintentionally shot a colleague while trying to demonstrate a 'trick' with a GSP. A RAF-led Service Inquiry was convened after the SAC had been court martialled, jailed and dismissed from the Service. Exhibit 092

1.4.296. In his final comments to the internal report, the Convening Authority wrote, *"Commanders need to be informed in a timely and accurate fashion of information that is required to enable them to discharge their legal and moral duty of care responsibilities. Delay in this for any reason, or insufficient clarity or provision of information to enable them to do this, can have a detrimental impact on the safety and welfare of our people".* Although written for the RAF, this conclusion is applicable across Defence.

1.4.297. Both the RAF Regiment LA and RAF SI contain recommendations to prevent reoccurrence. The LA and SI report were not distributed to the DSA, nor readily available in the Maritime and Land domains. As a single Service SI, the report was not easily accessible to the other Services, being retained by the RAF. The Panel considers that the findings and recommendations remain relevant and yet are difficult to find. These are, therefore, reproduced in Annex A.

1.4.298. The Panel determines that where lessons identified in one domain[120] have utility in another, there is a need to develop a collaborative Learning Culture and the mechanisms to share rapidly such information with cross-domain transparency.

Vignette - Iraq, May 16

1.4.299. A Rifleman attached to 1 RIFLES in UKTT(Taji), unintentionally discharged his GSP leading to minor injuries to 3 individuals in the accommodation block. This was the same accommodation block in which, 8 months later, LCpl Hetherington was shot and fatally injured. Exhibit 040

1.4.300. The LA was written by a Royal Marine Capt attached to 1 RIFLES. As directed by LFSO 1118, he highlighted contributory factors without attributing blame. He acknowledged the dangers of complacency, a perception of novelty and a lack of access to the weapon during PDT. He made recommendations that would increase respect for, and familiarity with, the GSP. Exhibit 040

[119] Appendix 3, Annex C to LFSO 1118 '*Learning Lessons in the Land Environment*', dated May 14. This was replaced by Army Command Standing Order (ACSO) 1118 in Apr 18.

[120] The Panel uses the term 'domain' in this instance to refer to the organisations controlled by individual Top-Level Budget holders (TLB).

1.4.301. However, the LA was not issued or distributed in accordance with policy. PJHQ and CESO(Army) were not informed of this occurrence and did not receive a copy of the LA. As a consequence, personnel operating in the Land domain were never in a position to understand and learn from the circumstances or objective consideration of contributory factors. Exhibit 157 Exhibit 158

1.4.302. The Panel only became aware of these 2 NDs by chance. CO 2 LANCS was only made aware of the 1 RIFLES LA during his initial interview with the Panel, over 2 months after the death of LCpl Hetherington. In addition, neither OC UKTT(Taji) nor the FP Pl Comd received the 1 RIFLES LA at any point. Witness 003 Exhibit 040 Witness 001 Witness 007

1.4.303. The Panel notes that the 2 LANCS LA written immediately after the death of LCpl Hetherington focussed predominantly on Post Incident Management. Unlike the 1 RIFLES LA, there was no attempt at an initial assessment of why the incident may have occurred and therefore no recommendations to prevent reocurrence. It was issued as a draft, dated 2016, and, in the Panel's opinion, the distribution list was too limited. The Panel was also surprised that the FP Pl Comd stated that he had neither contributed to, nor read, the LA. On the basis of this evidence, the Panel believes this is another example of an immature Learning Culture in which the utility of LAs as mechanisms for learning from experience are not recognised. Exhibit 037 Exhibit 008 Witness 007

1.4.304. The Panel concludes that a Learning Account from which lessons are not learned, is simply an account. The Panel believes that not recognising the wider applicability of factors and lessons, and sharing them effectively, demonstrates an absence of leadership commitment to occurrence reporting and the under development of Reporting and Learning Cultures. This is an **Other** factor.

1.4.305. **Recommendation**. Director of Joint Warfare (DJW) should direct that observations and lessons from all Learning Accounts, as well as Defence and Front Line Command Service Inquiries and Non-Statutory Inquiries, are captured on a common lessons information management system in order to ensure observations and lessons are available across Defence.

Initial Deployment Report

1.4.306. The aim of the Initial Deployment Report (IDR)[121] is to draw observations and lessons from the first 30 days in theatre that will inform and shape the preparation and training of those to follow. The IDR is to include positive as well as negative aspects of the preparation, training and deployment. The Panel notes, however, that the IDR format and instructions directs units not to report those issues that can and should be resolved internally. The Panel **observes** that this introduces a level of subjective assessment that is almost certain to obscure the wider-applicability of significant but uncomfortable issues and thus does not encourage Reporting and Learning Cultures.

1.4.307. Despite the death of LCpl Hetherington, the 2 LANCS IDR, dated 13 Feb 17, only referred to the accident in reference to the processes tested on the G1 Wargame. The IDR offered no detail on the effectiveness of weapons training during PDT, the requirement to review weapons carriage policy, the complexities in post-incident management or any mention of either Risks to Life (RtL) or hazards to deployed base living. It made no related recommendations to higher Exhibit 003 Exhibit 008

[121] Appendix 5 to Annex C of LFSO 1118 provided the format for, and guidance on writing, an IDR, dated May 14. This was replaced by ACSO 1118 in Apr 18.

HQ or to follow-on Bns to shape their training. These omissions were deliberate as the LA was considered to be published and complementary to the IDR.

1.4.308. The Panel **observes** that the utility of the IDR was reduced by the omission of details, observations and lessons relating to the death of LCpl Hetherington. The Panel believes the absence of any information relating to LCpl Hetherington's death was in contrast to the significance of the accident. This was a lost opportunity to influence the preparation and training of others. Exhibit 008

Theatre risk identification

1.4.309. In 2016, 1 RIFLES had 4 NDs. Three were with pistols, occurring on 22 and 27 Jan and 5 May, in separate locations, on Op SHADER 3. Exhibit 159

1.4.310. On 24 Feb 16, 10 months prior to the deployment of 2 LANCS, 1 RIFLES presented 9 hazards, risks and mitigations for Op SHADER at the Mission Exploitation Symposium (MXS). They identified that increased training and awareness could mitigate the risk of pistol NDs, as seen on the slide in Figure 22.

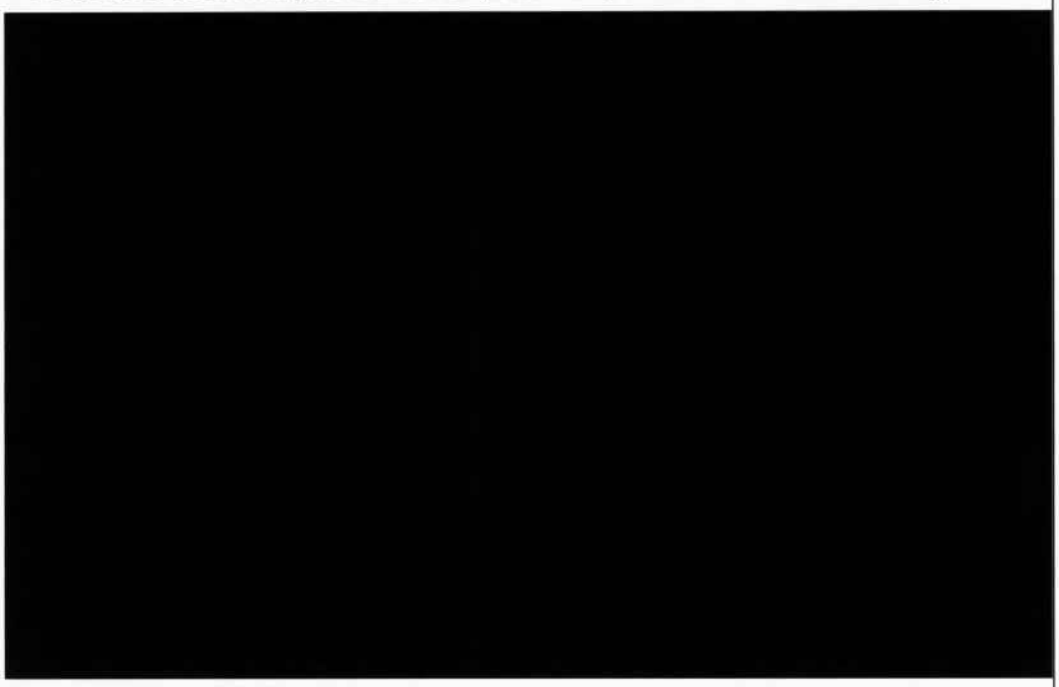

Figure 22: Risks presented at Op SHADER MXS 1

1.4.311. Noting that the unit experienced a pistol ND in UKTT(Taji) 3 months later, the Panel is surprised that the important discussions on hazards, risks and mitigations are not evident in subsequent MXS presentations. The Panel **observes** that without a consistent format, and regular reviews, it was difficult to understand the changing pattern of risks across all locations in theatre over time[122].

1.4.312. The 2 LANCS Initial Recce Report, dated 28 Sep 16, recognised 7 RtL across theatre. These were: [redacted] These 7 RtL are not identical to the 9 hazards Exhibit 017

[122] The first edition of ACSO 1109, *Army Risk Policy*, was published in Jun 18. The approach taken to expose, monitor and manage operational risks during the MXS should follow the guidance in this policy.

and risks presented by the RIFLES in MXS 1, see Figure 22, or the 13 Hazards for Deployed Base Living on the MOD Risk Assessment Form 5010 from UKTT (Taji). Exhibit 160

1.4.313. The Panel acknowledges that separate locations are likely to have different hazards and risks and that the theatre RtL should be an aggregation of those present in each sub-unit location. The Panel concludes that failure to cohere risks across deployed locations weakens safety mitigations within the conduct of operational planning. The Panel **observes** that the identification, recording and sharing of theatre hazards and risks at the time of the accident was inconsistent.

1.4.314. **Recommendation**. Director Land Warfare should direct that hazards, risks and mitigations are presented consistently and routinely in Initial Deployment and Post-Operational Reports and throughout the Army Operations Lessons Process in order to inform better the preparation and training of those warned to deploy on operations.

1.4.315. **Recommendation**. CJO should ensure that operational hazards and risks are a nested aggregation of those present in all locations in order to provide clarity and consistency in operational risk management.

Access to historic inquiries

1.4.316. In order to learn from previous occurrences, the Panel sought information about the number and cause of all pistol NDs in the last 10 years. Despite a helpful readiness across Defence to assist with this request, the Panel notes there was much uncertainty and assumption about where the information might be obtained. Unable to determine complete answers with any degree of confidence, the Panel narrowed the search to just the findings and recommendations made as a result of the 3 most recent pistol-related deaths prior to that of LCpl Hetherington. The Munitions Incident Database (MID) Cell revealed that these occurred in 2005, 2008 and 2012. Exhibit 153

1.4.317. Reports into Service fatalities and accidents are held by those organisations which conduct them. Despite requests to 10 organisations[123], and 2 weeks of effort, none were able to provide the information requested. The Panel was unable to access the full reports, findings or the recommendations made to Defence as a result of these 3 deaths. Exhibit 153

1.4.318. While it is acknowledged that some of the information relating to the accidental deaths of Service personnel is very likely to be confidential, the Panel believes that the reports, redacted as necessary, and lessons therein, should be readily available on an enduring basis. The Panel **observes** that there is currently no central repository to hold this information and therefore it is difficult to leverage its value across all levels of command.

1.4.319. **Recommendation**. Director General, Defence Safety Authority should establish a mechanism to archive and facilitate easy internal access to all safety Statutory and Non-Statutory Inquiry reports across Defence, in order to support the development of a Learning Culture.

[123] These were: [redacted]

Organisational Process

1.4.320. On convening, the Panel sought to answer the following significant question to help understand the context of this accident:

How many pistol Negligent Discharges have occurred in the Army, relative to all Small Arms NDs across Defence, in the last 10 years?

The Panel believed it should have been able to locate this information quickly and accurately. In fact, this was far from simple. Although figures do exist in the MID for the number of incidents involving Ordnance, Munitions and Explosives (OME), the exact number of NDs for any weapon system, and their impact, could not be identified or understood with any confidence. The Panel believes that analysis based on incomplete data generates inadequate and potentially ineffective interventions. There are several related reasons for this, which are explored in more detail over subsequent sections:

a. Incoherent terminology.

b. The possibility of unqualified and subjective assessments.

c. Complex and contradictory reporting policy and process.

d. Inconsistent Information Management[124].

1.4.321. This section concludes with an assessment of audit and assurance, and consideration of the creation of a Safety Management Plan.

Incoherent terminology

1.4.322. **Negligent Discharge**. The Panel discovered that a clear definition of Negligent[125] Discharge is obscured by tautology, contradiction and complexity. This continues throughout an examination of the act itself (whether actual or presumed), its causes and the numerous processes to record or prevent it.

1.4.323. Discrepancies between definitions of Negligent Discharge include:

a. "An occurrence with Small Arms ammunition up to and including 9 mm in calibre"[126] - **JSP 482**.

b. "A ND or suspected ND is deemed to have occurred when the initiation of the Small Arms ammunition is unauthorised and unintentional or inadvertent"[127] - **JSP 482**.

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[124] Information Management (IM) is the "recording and handling information so that we can readily find and use it again". *Defence Information Management Passport: Information Matters v5.0*

[125] The Oxford English Dictionary defines 'negligence' as a failure to take care over something and a breach of a duty of care which results in damage. The Manual of Service Law (JSP 830) defines 'negligence' at 1-12-11 to 1-12-12. This legal test is the same as that used in the criminal law of England and Wales and underpins any disciplinary charge arising from a 'negligent discharge', i.e. an offence under section 15(2) AFA 06.

[126] JSP 482, Ch 25, Annex D, part 1.1.1. "Above this [9mm], it should be reported as an Explosive Accident / Near Miss".

[127] Ibid.

c. "Where unauthorised and unintentional or inadvertent discharge results in death, injury or damage ... the occurrence should [not be recorded as a ND, but instead] be recorded as an Accident" - **JSP 482**.

d. "A weapon or pyrotechnic discharge, considered by the Conducting Officer or chain of command, to contravene the approved drills or procedures and contrary to the provisions in Queen's Regulations"[128] - **PAM 21**.

e. "If an individual fires without an order to do so, this is to be treated as a ND"[129] - **PAM 21**.

f. The Manual of Service Law takes care to distinguish "accidental discharge due to a defect in the weapon (not an offence) and negligent discharge which involves human error (an offence)"[130] – **JSP 830**.

1.4.324. Although the quote from CO's Guide to Sentencing (above) appears binary, JSP 830 states that if not caused by a defect in the weapon, then a Small Arms discharge must involve human error and, if found to be negligent, will be an offence. The Panel acknowledges that there may be circumstances in which a discharge not resulting from a defect in the weapon nor negligence can occur and should not lead to a charge being brought, discussed below.

1.4.325. **Dangerous Occurrence**. JSP 375 does not recognise 'Negligent Discharge', instead defining and requiring the reporting of an unintentional discharge of a weapon as a 'Dangerous Occurrence'[131].

1.4.326. **Error of Drill**. The unintentional or inadvertent actions of an individual may be considered as an Error of Drill rather than a ND[132]. An Error of Drill is defined in PAM 21 as "when the ammunition or weapon has not been operated in accordance with the user pamphlet"[133]. The pamphlet offers only "Actions on a [sic] Error of Drill" and states that "...it is the responsibility of the firer to ensure that the correct type of fire ordered is used. If they fire on automatic when ordered to fire single shots, the offence is to be treated as an error of drill. However, if an individual fires without being ordered to do so then this is to be treated as an ND". The Panel **observes** that as currently written, the ambiguity in PAM 21 between the formal definition and the 'actions on' is confusing and the use of Error of Drill to categorise unintentional discharge is open to subjective interpretation. In theory, these ambiguities could be used to mask negligence of a supervisor or a firer on a range. In addition, contradiction is created by the fact that despite being caused by human error, and therefore potentially an offence as defined by JSP 830, PAM 21 states that in the case of an Error of Drill "no disciplinary action should be taken"[134]. The Panel agrees that if no negligence is found, no disciplinary action should be taken but concludes that Error of Drill is currently a confusing categorisation of unintentional Small Arms discharge.

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[128] PAM 21, Ch 2, Section 3, p2-21.

[129] PAM 21, Ch 2, Section 3, p2.27.

[130] JSP 830, Manual of Service Law, Ch 14, CO's Guide to Sentencing at Summary Hearing, p.1-14-10.

[131] JSP 375 'Management of Health and Safety in Defence' Part 2, Vol 1, Ch 16, Annex A, "any fire, explosion or ignition involving explosive or the unintentional discharge of a weapon".

[132] If a Fire Control Order has been given, an unintentional discharge may be treated as an Error of Drill and would not be reported, PAM 21, p2-27.

[133] PAM 21, Ch 2, Section 3, p2-20.

[134] PAM 21, Ch 2, Section 3, p2-27.

1.4.327. **Other terms**. In addition to weapon and ammunition malfunction, negligence and Error of Drill, there are 2 further terms that can be used to describe causes of unintentional Small Arms discharges. These are Error in Drill and, as used by UK Police Services, the term Involuntary Discharge.

a. **Error in Drill**. This is recognised by the Army through PAM 21 and is described as when the instruction or "endorsed drills are incorrect and may require attention" [135]. The result of an Error in Drill may be an unintentional discharge. The Panel notes that the linguistic similarity between this term and Error of Drill may lead to confusion. However, the Panel believes this categorisation should remain, albeit reworded, and that if the immediate instruction received from a supervisor or the endorsed drills prove to be incorrect, the firer should not be regarded as negligent.

b. **Involuntary Discharge**. UK Police Services recognise the possibility of unintentional discharge caused by involuntary muscle contraction or Inter-Limb Interaction (ILI). This 'startle effect' may result in the contraction of hand or finger muscles due to balance disturbance, fall or use of force with the free hand. This idea is introduced into the proposed alternative model presented below. The result of ILI may be an unintentional discharge. Whilst highly likely to be an extremely rare occurrence, the Panel believes that this category should be added into the Army's lexicon. Exhibit 161

1.4.328. Although defined in JSP 375, there are no commonly agreed Defence definitions for the following terms: Accident, Incident, Near Miss, Negligent Discharge or Unintended Discharge. Without a common lexicon and mutual understanding, across all personnel and policy, the Panel **observes** that it will remain extremely difficult to achieve unity of purpose and effort in the prevention of unsafe acts.

The requirement for an alternative classification model

1.4.329. The presence of negligence arises from human error, but human error does not automatically lead to negligence. There is a broader range of culpability. The current classification model used to define the array of unintentional discharges is limiting for the following reasons:

a. If reported, and negligence is assessed, an unintentional Small Arms discharge may be recorded as a ND. However, this is currently dependent on the severity of the outcome. If of limited consequence, the occurrence will be recorded as a ND.

b. If, however, a ND results in damage, injury or death, it is not recorded as a ND, instead it is recorded as an Accident.

c. Confusingly, Error of Drill may result in severe consequences, be caused by human error or include a degree of negligence on the part of the firer but is neither regarded nor reported as a ND and does not attract disciplinary action.

The dark red segment in Figure 23 is the only occurrence that would be recorded as a ND in the current classification model.

[135] PAM 21, Ch 2, Section 3, p2-22.

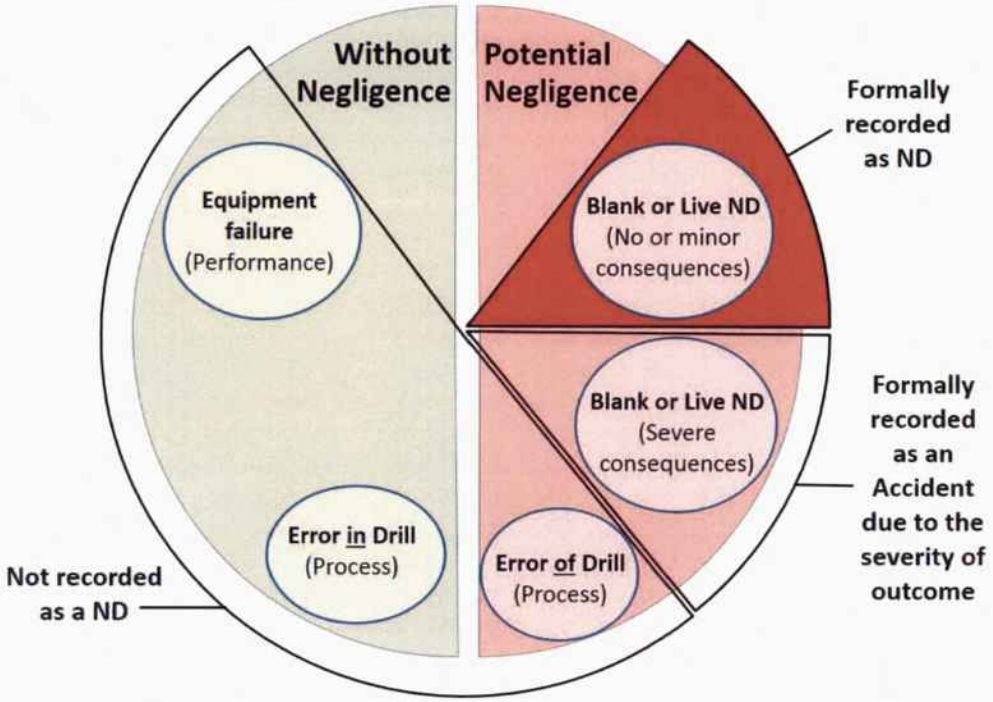

Figure 23: Current classification of Negligent Discharges

1.4.330. Such is the prevalence of the phrase 'Negligent Discharge or ND' and a general assumption of its meaning, it is used, in the Panel's experience, as a comprehensive and colloquial phrase to describe any unintentional firing of a Small Arms weapon. Indeed, PAM 21 uses the title "Actions on a Negligent Discharge" to refer to the procedure to be followed in the case of an unintentional discharge.

1.4.331. It is clear that only a proportion of unintentional discharges are caused by negligence. The Panel believes that the term ND is instinctively and immediately applied by all, regardless of the circumstances. Over-use of the term ND is due to Defence's limited classification system which does not provide a clear alternative. The Panel **observes** that use of the term is immediately prejudicial which hinders open reporting and full recording of Small Arms occurrences. As a result, Defence cannot fully comprehend the scale of unintentional versus negligent discharges across the organisation.

Unintentional Small Arms Discharge classification model

1.4.332. Rather than declare negligence from the outset, UK Police Services classify and investigate all Small Arms occurrences as 'unintentional' until proven otherwise. Their policy produces a coherent lexicon of terms, is easily understood and requires that an appropriate assessment of any occurrence is conducted before confirmation of negligence as a cause. Dependent on the environment and the consequence, differing levels of investigation allow for a wider breadth of specifically targeted interventions. This policy is seen as fair within the Police and the Panel believes that this supports directly the development of their Safety Culture. The Panel concludes that Defence would benefit from understanding and following the Police's approach to Small Arms occurrences.

Exhibit 161

1.4.333. An alternative classification model, developed by the Panel after consultation with the Police, and drawing positive feedback from HQ SASC, is shown at Figure 24. It proposes the use of the unifying term Unintentional Small Arms Discharge (USAD) to embrace all scenarios in which a Small Arms discharge may occur without intention. The Panel **observes** that the initial classification of all occurrences as unintentional prior to investigation would simplify and encourage reporting, promote a Just Culture, enable comprehensive recording and provide for better data analysis.

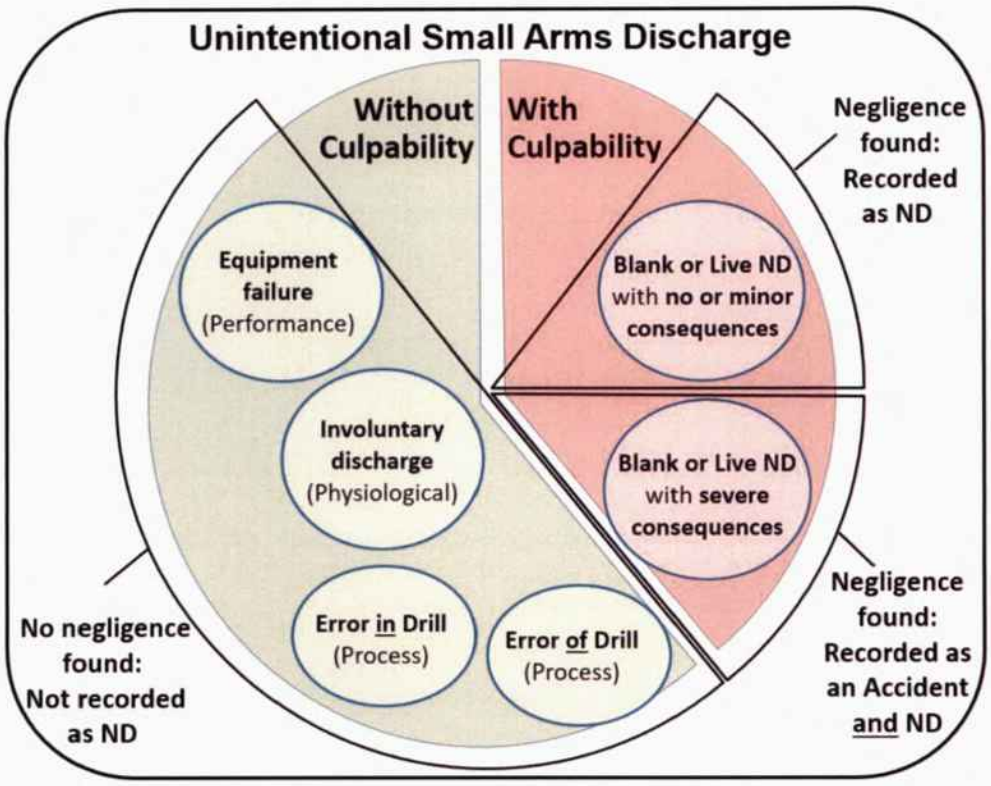

Figure 24: Unintentional Small Arms Discharge model

1.4.334. The Panel determines that the current terminology for classifying Small Arms occurrences is confusing, incoherent and poorly aligned across policy. This affects the accuracy of reporting and recording of such incidents and thus the validity of any subsequent analysis. The immediate use of the term Negligent Discharge is prejudicial and reinforces a culture of blame; in turn this undermines Just and Reporting Cultures across the Army.

1.4.335. The Panel concludes that all occurrences of unintended discharges with Small Arms should be classified, initially, as USAD before investigation determines the cause. In addition, a new category of Involuntary Discharge should be added to better enable the recording of the physiological causes of unintentional discharge. It is also proposed that Error of Drill is defined more clearly in JSP 482 and PAM 21 to remove all ambiguity and provide a classification for unintentional occurrences that does not include negligence as a factor.

1.4.336. **Recommendation**. Chief of Defence Personnel should amend CO's Guide to Sentencing, within JSP 830 'Manual of Service Law' to clarify that a

negligent discharge is an offence only following an investigation during which negligence has been proven.

1.4.337. **Recommendation**. DOSR should implement a common lexicon to clarify Defence policy and simplify Small Arms occurrence reporting.

1.4.338. **Recommendation**. DOSR should codify unintentional discharges within a new Small Arms occurrence classification model, using the unifying term Unintentional Small Arms Discharge (USAD), in order to capture all occurrences, remove immediately prejudicial language and promote a more engaged Safety Culture.

Unqualified and subjective assessments

1.4.339. Following a Small Arms discharge, the determination of cause is currently dependent on the outcome. If an unintentional discharge results in injury or death it is reported as an accident, even if its cause was negligence. An objective assessment can be made in the case of an Error in Drill or weapon and ammunition malfunction. However, in all other cases, due to insufficient taxonomy and cultural norms, the occurrence would be reported as a ND without an objective assessment or consideration of contributory factors.

Assessment of cause

1.4.340. The Panel believes that following a unintentional discharge, and as necessary, USAD occurrences should be the subject of NSI, convened at an appropriate level, to determine the causal and contributory factors.

1.4.341. In line with policy adopted by the RAF[136], NSIs must be undertaken by suitably qualified and experienced Occurrence Investigators, trained in Human Factors techniques. The investigation must be non-judgemental and offer a summary of the causes that led to the occurrence with proposed interventions. Occurrence Investigators are widespread throughout RAF units, supplemented by regional teams who can investigate more complex occurrences. The Panel notes that the Army has a pool of USEA to provide units with safety subject matter expertise. The Panel believes that USEA are well positioned to become Occurrence Investigators and this development can be linked to the recommendation placed on Chief Safety (Army) to increase the utility of USEA.

1.4.342. The Panel acknowledges that negligence can be a factor in unintentional discharges and in no way intends it to be removed from the lexicon. An occurrence review must follow the NSI, to consider the behaviour of those involved, and include assessment of culpability or the presence of negligence. However, the Panel **observes** that policy that defines an error as negligent from the outset is immediately prejudicial, may undermine impartial investigation and confidence that any outcome is just. The Panel concludes that an individual should not be declared as negligent merely as the result of an unintentional discharge, but only after all relevant factors, including Human Factors, have been assessed.

[136] Royal Air Force AP 8000, Leaflet 8005 – RAF Just Culture. The directive seeks to ensure just process is applied when making any decision or taking any action associated with accountability of individuals. Annex B is the flowchart that helps ascertain whether an action was a mistake, or cognitive rule breaking.

1.4.343. **Recommendation**. Defence Safety Authority, Director (Operations & Assurance) should mandate, through single Service Safety Centres, that unit-level Non-Statutory Inquiries are conducted for all Unintentional Discharges by suitably qualified and experienced personnel in order to provide qualified and objective assessment of causes and recommendations and thus support the development of a Just Culture.

Assessment of sanction

1.4.344. If an occurrence is reported as a ND, it will usually result in a charge[137]. When such a charge has been brought and found proven at summary hearing, a range of sanctions[138] may be applied by the CO which may, in very serious cases, result in detention and/or reduction in rank. Commonly, however, a fine is assessed to be the appropriate sanction. A CO may award a fine of up to a maximum of 28 days' pay[139] where the level of fine is determined by the seriousness of the circumstances.

1.4.345. The Panel believes that there is a large range in the scale of financial sanctions for NDs. Despite a limit of 28 days' pay and assessment made on mitigating circumstances, there is a common belief among Service personnel that if they are found guilty of a ND on operations they will be fined their operational bonus.

Exhibit 159
Exhibit 162
Exhibit 163
Witness 030
Witness 018
Witness 010

1.4.346. Although consideration must be given to the expected standard of competence an individual has shown, the Deciding Officer must have regard to the purposes of sentencing when establishing a tariff. These are[140]:

a. The punishment of an offender.

b. The maintenance of discipline.

c. The reduction of Service offences through deterrence.

d. The rehabilitation of an offender.

e. Protection of the public.

f. The making of reparations to persons affected by the offence.

g. If the offender is under 18, regard to his welfare.

1.4.347. Interview testimonies revealed that fines do not deter unintentional discharges. Despite the imposition of fines as a deterrent, soldiers consider the professional indignity of having a ND a far more powerful disincentive than any financial penalty. While acknowledging that current sentencing may have some preventative effect, the Panel **observes** that as unintentional discharges continue to occur, imposing fines as the principal punishment to deter does not achieve the effect sought.

Witness 010
Witness 005
Witness 032
Exhibit 164
Exhibit 165

[137] Under section 15(2) of the Armed Forces Act 2006, "negligently performing a duty".
[138] JSP 830 - Manual of Service Law, Volume 1 - CO's Guide, Chapter 14, pages 10-11.
[139] JSP 830 - Manual of Service Law, Volume 1 - CO's Guide, Chapter 13, paragraph 105.
[140] JSP 830 - Manual of Service Law, Volume 1 - CO's Guide, Chapter 13, paragraph 4.

1.4.348. **Recommendation**. D Pers should determine whether administering substantial financial penalties deters NDs in order to understand better the utility of current disciplinary practice and support the development of a Just Culture.

Complex and contradictory reporting policy

1.4.349. The Army Inspector acknowledged that high volumes of over-lapping policy constrains activity. Across Defence, rather than provide unequivocal direction and maximum utility, the incoherence of policy merely provides a "comfort blanket of complexity"[141]. In order for Defence to benefit, simplicity in reporting policy should be sought. Exhibit 090

1.4.350. In the case of LCpl Hetherington's death, UKTT(Taji) formally reported the accident through the operational chain of command and Bn networks immediately, in accordance with PJHQ SOP. However, the Army Form 510 was not sent to PJHQ until 9 weeks after the accident. In addition, the MID Cell was not formally notified of LCpl Hetherington's death in accordance with JSP 482 until a different report was hastened in Nov 17. In the Panel's opinion, this is an example of complex and contradictory reporting policies impacting on the effective understanding and sharing of information. Exhibit 008 Exhibit 166 Exhibit 167 Exhibit 168

Small Arms occurrence reporting policy

1.4.351. There is a great deal of Joint and single Service policy that determines OME reporting. Depending on which policy document is considered predominant, an occurrence may be reported differently. Although routes for data capture appear simple, the Panel believes that they are too complex. This adversely influences the successful collation of an accurate data set and thus trend analysis is ineffective and interventions inefficient. All the policies in Figure 25 determine the recording and reporting of Small Arms occurrences at the time of the accident.

[141] The Hon. Sir Charles Haddon-Cave, "Lessons from the Nimrod Review", 19 June 2013.

Joint Service Publications	
JSP 375 - Management of Health & Safety in Defence	
JSP 482 - MOD Explosives Regulations	
PJHQ SOP 3004 - Incident Reporting	
MOD Forms	
MOD FORM 510* - Accident Incident Report	**This form has been replaced by separate TLB forms, of different names, "in order to reduce confusion". JSP 375*
MOD FORM 1664 - Negligent Discharge Monthly Report	
MOD FORM 1668 - Initial Munitions Incident Report	
MOD FORM 1670 - Munitions Accident / Near Miss Full Report	
Land Forces Standing Orders	
LFSO 1118 - Learning Lessons in the Land Environment	
LFSO 3202 - Reporting of Incidents & Matters of Public Interest during Training	
LFSO 3203 - Discipline – Reporting to the Police & Investigation of Offences and Serious Incidents	
LFSO 3207 - Conduct and Management of Service Inquiries and Non-Statutory Inquiries	
LFSO 3216 - Organisation and Arrangements for the Management of Safety and Environment Protection in Land Forces *(Refers to JSP 375 to define Accident, Incident & Near Miss)*	
Field Army Pamphlet	
PAM 21 - Training Regulations for Armd Fighting Vehicles, Infantry Weapons Systems & Pyrotechnics	

Figure 25: Occurrence reporting policy documentation at Jan 17

1.4.352. **JSP 482**. The top level policy for reporting munitions incidents can be considered to be JSP 482. JSP 482[142] provides a practical table of initial reporting methodology, calling for a MOD Form 510 to be completed following any accident or incident involving death, injury or damage. However, both JSP 482[143] and JSP 375[144] offer different reporting formats and distribution lists. Whereas JSP 482 is intended for immediate use in the event of any occurrence involving OME, and the format in JSP 375 can be used in such circumstances, the predominant purpose of JSP 375 is to record personal injuries. In neither case is it clear which policy document has primacy, complicated by further out-of-date references.

1.4.353. **PJHQ**. PJHQ provide a range of SOPs as guidance for operational commanders in the event of death or injury of personnel[145]. This guidance applies to all British forces and assets deployed on operations and explains the protocol to be followed. In these SOPs there are no references to JSPs, with the exception of the Manual of Service Law, or clarity on precedence of policy.

1.4.354. **MOD Form 1600 series**. JSP 482 requires that the MOD Form 1600 series are used for reporting occurrences involving OME. Three principal reporting forms are:

[142] JSP 482 (Ed 4) Ch 25, Annex H.
[143] JSP 482 (Ed 4) Ch 25, Annex B, Appendix 1.
[144] JSP375 Part 2 Vol I Ch 16 Annex B.
[145] PJHQ SOP 3004 – Incident Reporting and PJHQ SOP 0012, para 51.

a. **MOD Form 1664**. The 'Negligent Discharge Monthly Report' can be used by units, when a ND or a number of NDs occur, to inform their local Explosives Technical Support of the incidents. The Form can be used either when the ND occurs, the preferred method of reporting, or on a monthly basis.

b. **MOD Form 1668**. The 'Initial Munitions Incident Report' contains the initial information required by Ammunition Technical Officers in the event of an ammunition fault or other OME occurrence.

c. **MOD Form 1670**. The 'Munitions Accident/Near Miss Report' is to be completed by the Unit Responsible Officer in the event of any incident involving OME[146].

The guidance provided on usage of each form can be confusing to interpret. The MOD Form 1664 is used when no injury or damage has resulted from the ND, otherwise the incident would be reported on a MOD Form 1668 then followed up with a MOD Form 1670. The Panel believes that as no formal occurrence evaluation training is afforded to chains of command, errors in usage and reporting are highly likely to occur. Exhibit 169

1.4.355. **Land Forces Standing Orders**. Land Forces Standing Orders (LFSO) of the time, now replaced with Army Command Standing Orders (ACSO), provided additional layers of guidance and complexity[147]. For example:

a. **LFSO 3216** directed that all accidents and incidents are reported to Army LF CESO-AINC-MULTIUSER without delay by means of a Form 510[148]. This is additional guidance that repeats requirements from JSP 482, JSP 375 and PAM 21.

b. **LFSO 3216 and LFSO 1118** provided conflicting guidance on the generation of Learning Accounts[149].

c. **LFSO 3202 and LFSO 3216** both contained guidance to submit different reports to the Land Accident Investigation Team (LAIT), an organisation that was subsumed into the DSA in 2015[150].

1.4.356. **MOD Form 510 – Accident Reporting Form**. Before its replacement in Jun 14, MOD Form 510 was the initial reporting format mandated for all dangerous occurrences. Each TLB now has their own version of MOD Form 510 adapted for their own reporting needs[151]. However, the Panel notes that continued use of the MOD Form 510 template causes confusion and leads to the unnecessary rejection of accident reporting through submission on incorrect versions.

1.4.357. **Army Form 510**. Although LFSO 3216 and PAM 21 both state that "all accidents and Near Miss reporting should use Army Form 510", this is contrary to JSP 482 Chapter 25 (Annexes A and H). Army Form 510 requires the reporting Exhibit 170

[146] As defined in JSP 482 (Ed 4) Ch 25 Annex H.

[147] LFSOs are being replaced with Army Command Standing Orders (ACSOs); this provides opportunity for re-writing where inadequate.

[148] An equivalent form is now controlled by each TLB. The RAF Form 7454 is broadly equivalent but used to provide notification of health and safety incidents only.

[149] LFSO 1118 was replaced with Army Command Standing Order (ACSO) 1118, in Apr 18.

[150] On 1 Oct 2015, LAIT was merged with SEFIT and MIL AAIB to form DAIB, an element of the Defence Safety Authority.

[151] Joint Forces Command/HOCS IN Form 510, RN Form NSIR Series, Army Form 510 and RAF Form 7454.

officer to identify the type of occurrence, offering "dangerous occurrence" as an option. However, the term is not defined in the Form 510, JSP 482 or PAM 21. The term is defined in JSP 375[152], but as observed, the definition of ND differs from that in both JSP 482[153] and PAM 21[154].

1.4.358. **Pamphlet No 21**. Despite the quantity of policy already highlighted, the principal source of direction on initial reporting following an occurrence involving OME is widely held, throughout the Land domain, to be PAM 21. However, PAM 21 makes no reference to the higher-level policy and there is little correlation of reporting formats, processes, distribution and timelines[155]. The Panel notes that significant discrepancies include:

a. Para 2-61 does not state with clarity who is responsible for completing accident/incident reporting, but does quote essential actions regarding agencies to inform.

b. Para 2-62 provides guidance for 'Explosive accidents and Near Miss reporting', including what must be reported to Defence Equipment & Support (DE&S), yet does not reference JSP 482 Chapter 25 Annex B.

c. Figure 2-2 is untitled and unreferenced but contains the fields of an unregistered Accident/Incident Reporting Format that broadly replicates MOD Form 1668. Its purpose is to assist with the Unit's responsibility to 'inform', however, it fails to offer clear direction on how or to whom to report.

d. Para 2-70 provides scant detail on the actions to be taken in the event of a Near Miss. The Range Conducting Officer (RCO) is to record the details of the occurrence and those involved, but there is no direction on how or to whom this is reported. The RCO is authorised to decide if training can continue, if remedial training is required or disciplinary action necessary.

1.4.359. **Near Miss reporting**. There is as much to be learned from a Near Miss as there is from an occurrence with consequence. Although Near Misses cause no immediate harm, they are leading indicators of potential accidents. If reported and scrutinised, suitable interventions can prevent accidents. Although Near Misses can be reported on Form 510s, there is no clear direction to do so in JSP 482. Thus the complexity of reporting and recording of incidents is equally applicable to Near Misses. Yet the Panel has little evidence to indicate Near Miss reporting in the Land domain occurs routinely or adds to Defence knowledge. How the confusion in policy and complexities in process impacts on reporting different occurrences is illustrated at Figure 26.

[152] JSP 375 Ch 16, p. 10.

[153] JSP 482 (Ed 4), Ch 25, Annex D, p. 1.

[154] DCC Trg, PAM 21, Ch 2, Section 3, p2-21.

[155] The only mention of JSP 482 within PAM 21 is at paragraph 2-41 which states that the rules governing the storage and movement of ammunition and explosives are 'in either JSP 482 - MOD Explosives Regulations (U) and JSP 800 – Defence Movements and Transport Regulations Vol 4b'.

Small Arms OME Reporting							
Outcome	**Reported as**	**Defining Policy**	**Explicit Reporting**	**Implicit Reporting**	**Recipients**		
Death Major Injury Minor Injury Damage	**Accident** (cause)	JSP 482, Ch 25	510, 1668 & 1670		ATO, AINC, IE & MID		
		PJHQ SOP 3004	SINCREP [1]		PJHQ J3 Ops		
		LFSO 3202 [2]	INCREP		JCCC, Army HQ, CESO & CoC		
		LFSO 3207	510		AINC		
		LFSO 3216 [3]	510		AINC		
		PAM 21 [4]	510	1668	ATO, AINC & DAIB (Land)		
Not significant (Not Accident)	**Near Miss** [5] (outcome)	JSP 482, Ch 25, Annex B	1668		ATO, AINC, IE & MID		
		JSP 482, Ch 25, Annex H	Not specific [6]				
		LFSO 3216	510		AINC		
		PAM 21 [7]	Not specific				
Not significant (Not Accident)	**ND** (cause)	JSP 482 [8]	1664, 1668				MID
		PAM 21	Basic details [9]			Unit	
		PAM 21	AFC 351A		ATO	→	MID

Footnotes:
1. Those deployed on operations under CJO's OPCOM are to adopt this common protocol for incident reporting.
2. No reference to JSP 482 and refers to organisations since subsumed into DSA.
3. Refers to organisations since subsumed into DSA.
4. Direction states that process "must comply with LFSO 3216" while listed recipients should be informed "as appropriate".
5. Definition of near miss restricts reporting to specific outcomes.
6. Report depending on the severity of the near miss
7. Details recorded are to be based on Conducting Officer's interpretation of a near miss.
8. If not reported to Explosives Technical Sp immediately, monthly reporting action is possible on 1664.
9. Details recorded are to be based on Conducting Officer's interpretation of ND.

Figure 26: Occurrence reporting complexity

1.4.360. **Conclusion**. Contradiction and ambiguity undermines coherence. The Panel concludes that the introduction of multiple forms, of different designs, to report the same event, leads to confusion and undermines reporting. Duplicated policy, subordinate to JSP 482, which does not nest with the higher level policy, generates complexity and incoherence. This undermines the development of a Reporting Culture, trend analysis and the implementation of potential interventions. This is an **Other** factor.

1.4.361. **Recommendation**. DOSR should establish a coherent hierarchy of OME occurrence reporting policy and process in order to increase the effectiveness of Small Arms incident reporting across Defence.

1.4.362. **Recommendation**. DSA, Director (Operations and Assurance) should implement a single, easily-accessible mechanism for reporting any safety occurrence, replacing MOD Forms 1664, 1668, 1670 and Army Form 510 (and single Service equivalents) in order to enable more effective analysis and exploitation of safety occurrence information.

1.4.363. **Recommendation**. HoC GM should ensure that all Small Arms policy documentation subordinate to JSP 482 is updated to include references to this publication and replace out-of-date references to old documents and organisations in order to clarify occurrence reporting policy.

Inconsistent Information Management

Munitions Incident Database Cell

1.4.364. The MID Cell is an element of the Weapons Operating Centre, Weapons Engineering Team within DE&S. It receives and collates details of accidents and incidents involving OME across Defence[156]. The MID Cell offers safety advice and trend monitoring of all reported OME occurrences to industry partners and customers across Defence. Although the MID Cell is the principle source and central repository of OME data, its information output can only be as accurate as the quantity and quality of the data input[157]. Exhibit 171

1.4.365. There is a clear disparity between the total number of Defence NDs reported to, and recorded by, MID and the number of Army personnel being disciplined for having SA80 rifle and pistol NDs. MID records, accessed in Jul 17, show that in 2016, 50 NDs occurred across the whole of Defence. Evidence from just 1 (UK) Div, 3 (UK) Div and the RMP REDCAP database gathered at the same time showed that summary dealings or criminal charges for 112 NDs were recorded in 2016. In May 18, MID records 92 Small Arms NDs for the same period, demonstrating a lag from delayed reporting. The Panel concludes that despite being the authoritative source for OME occurrences, the number of small-arms NDs recorded in MID for 2016 is incorrect. Without an accurate baseline and confidence in the data, useful trend analysis of the number, location, unit, frequency, cause and effect of unauthorised and unintentional discharges of small-arms is impossible. The inability to gather and interpret raw data into useable knowledge hinders the ability to learn from experience and demonstrates an immature Reporting Culture. Significantly, if Defence is unable to understand the causes of Small Arms occurrences, they are highly likely to reoccur. Exhibit 172 Exhibit 173 Exhibit 174 Exhibit 175 Exhibit 176

MID input standards

1.4.366. Figures 27 and 28 show the various ways that the SA80 rifle and the GSP can be recorded on MID. The variation in styles is due to free-text options[158]. As a consequence, accurate interrogation of the system requires understanding of all possible options or an incomplete dataset will be obtained.

[156] http://defenceintranet.diif.r.mil.uk/Organisations/Orgs/DES/Organisations/Orgs/COMLand/Weapons/Pages/Weapons.aspx.

[157] "Entering information accurately is vital and is referred to as data quality. Poor quality data can have a huge impact to the department in terms of its efficiency and even reputation". *Defence Information Management Passport: Information Matters v5.0*

[158] MID currently has 18 different descriptions for the GSP, 12 further entries for other pistol variants and 85 separate descriptions for rifles.

53 ways to reference SA80 L85A2		30 other rifle descriptors
L85A2 RIFLE	Rifle 5.56mm L86A2 LSW	BSA Marini Action .22 Match Rifle
L85A2 RIFLE 5.56	Rifle 5.56mm L98 (Cadet)	C8 Assault Rifle L119A1
L85A2 Rifle with BFA and LDS fitted	Rifle 5.56mm L98A2	C8 Carbine, Rifle 5.56mm Assault L119A2
L85A2 Rifle with conversion kit L41A2	Rifle 5.56mm L98A2 (SA80)	Drahunov SVD 7.62mm self loading sniper rifle
L98A1 Gp Cadet Rifle	Rifle 5.56mm Modified L85A2	L115A1 SNIPER RIFLE
L98A2 Cadet GP Rifle	Rifle 5.56mm SA80	L115A3 Sniper Rifle.
Rifle	Rifle 5.56mmL85A2 (SA80)	L119A1 - Assult Rifle (C8)
RIFLE 5.56 L85A2	RIFLE 5.56MML85A2 (SA80)	L119A1 Rifle
Rifle 5.56mm	Rifle A2 SUSAT	L129A1 7.62mm Sharp Shooter Rifle
Rifle 5.56mm L85A2	Rifle L85 (SA 80)+ Conv Kit .22	L129A1 Sharpshooter Rifle 7.62mm
Rifle 5.56mm (Endeavour) IAW L85A2	Rifle L85 A2	L81A2 Cadet Tgt Rifle
Rifle 5.56mm (SA80)	Rifle L85A2	Lee Enfield Rifle No 8
Rifle 5.56mm Assault Rifle L119A1	Rifle L85A2 5.56mm	Rifle .22 inch No 8
Rifle 5.56mm Cadet GP L98A2	Rifle L85N A NO.722	Rifle .22 inch No 8 Mk 1
Rifle 5.56mm L110A2	Rifle SA 80 A2	Rifle .22in
Rifle 5.56mm L85A1 (SA80)	RIFLE SA80 A2	Rifle .338 (8.59mm) L115A3 (Sniper Rifle)
RIFLE 5.56MM L85A2	Rifle SA80 L85 A2	Rifle .338 L 115A2
RIFLE 5.56mm L85A2	Rifle SA80A2	Rifle .338 L115A3
Rifle 5.56mm L85A2	SA80 A2 Rifle	Rifle 0.338 (8.59mm) L115A3
RIFLE 5.56mm L85A2 (SA 80) Iron Sight	SA80 Rifle	Rifle 4.6mm H&K MP7
RIFLE 5.56mm L85A2 (SA 80) IRON SIGHT	SA80 Rifle 5.56mm L85A2	Rifle 7.62mm L129A1 Sharpshooter
RIFLE 5.56MM L85A2 (SA80)	SA80 RIFLE L85A2	Rifle 7.62mm L96 (Sniper)
RIFLE 5.56mm L85A2 (SA80)	SA80A Rifle	Rifle 7.62mm L96A1 (Sniper)
Rifle 5.56mm L85A2 (SA80)		Rifle 7.62mm MpiK (AKM)
RIFLE 5.56mm L85A2 (SA80) Iron Sight		Rifle Diemarco L119A1
RIFLE 5.56MM L85A2 (SA80) IRON SIGHT		Rifle L115A3 (Sniper)
Rifle 5.56mm L85A2 (SA80A2)		Rifle L115A3 (Sniper)
RIFLE 5.56MM L85A2 with .22 con kit		Rifle sharpshooter L129A1
Rifle 5.56mm L85A3		SNIPER RIFLE .338 L115A3
Rifle 5.56mm L85A4		Sniper Rifle L115A3

Figure 27: Complications in recording rifle type in MID

18 ways to reference GSP L131A1		12 other pistol descriptors
L131A1 General service Pistol	General Service L131A1 Glock	Pistol 9mm Sig Sauer L105A1
General Service Pistol L131A1	L131A1 (Glock 19, Gen 4)	Pistol 9mm Automatic L105A1 SIG
GS Pistol Semi-Automatic 9mm L131A1	GENERAL SERVICE PISTOL L131A1	Pistol 9mm Automatic L18A1
Glock 17	GLOCK L131A1	Pistol 9mm Automatic L9A1
Glock Pistol	L131A1 (GLOCK)	Pistol 9mm Glock 19
L131A1 GSP	L131A1 9MM Pistol Glock	Pistol 9mm L105A2 SIG
Glock L131A1 (G17)		Pistol 9mm L117A1 P229
9mm Glock		Pistol 9mm L9A1
GLOCK PISTOL		Pistol 9mm SIG
GLOCK		Pistol 9mm SIG L105A2
L131A1 GLOCK 17		Pistol 9mm Sig Sauer P226
PISTOL GLOCK 17 GEN 3		SIG Sauer Pistol 9mm

Figure 28: Complications in recording pistol type in MID

1.4.367. The Panel notes that there are inherent weaknesses in the database and its design that reduce confidence in the accuracy of the data relating to Small Arms NDs across Defence.

a. MID relies on occurrences being reported. There is a clear disparity between the numbers of NDs reported to MID and the number of Army personnel being disciplined for reportable occurrences. The prioritisation of disciplinary action over safety reporting leads to an absence of formal reporting that masks the true scale of Small Arms occurrences across the Land domain. The lack of meaningful data undermines the ability to discover causation and provide relevant safety interventions. Exhibit 049 Exhibit 177

b. The MID Cell believes that the quality of data input is undermined by incomplete, inconsistent and delayed reporting. The Panel believes that the complexity of occurrence reporting policy and poor Reporting Culture reduces the likelihood of accurate and timely reporting of occurrences. Exhibit 177

c. The poor design of MID complicates both the overall dataset and the ability to perform analytics and extract accurate information that would provide meaningful lessons. The Panel believes that reporting via free text forms, and relying on third-party population of the MID introduces errors that makes trend analysis difficult. In addition, the Panel believes that the design of MID is a micro-reflection of design[159] error that is prevalent across Defence. It is not clear for which 'customer' or 'customers' the MID was designed at all. Although functional, the MID does not have a user-friendly interface, does not have easily accessible instructions or training, does not reward interaction with it and it does not automatically cross-check data from other sources. In addition to their inherent inaccuracy, any data analytics achieved are not readily accessible by all stakeholders, for their own purposes. The current design of MID does not support the development of a Reporting or Recording Culture and thus the strategic importance of data analytics to inform decisions and improve productivity, and gains that could be made as a result, are lost. Exhibit 177

1.4.368. As noted in Nicholas Blake's 2006 Deepcut Review, the recording of information is a first step to responding to it and understanding what it reveals[160]. The Panel **observes** that, incoherent terminology, unqualified assessment of occurrences, complex and contradictory reporting policy and the poor standard of Small Arms ND data, mean that decisions or interventions based on an analysis of MID, although comforting, are sub-optimal.

1.4.369. **Recommendation**. DOSR should replace Munitions Incidents Database with an accessible, single web-based repository with a consistent data model for the recording of all Small Arms OME occurrences, that can be monitored and assessed for safety trend analysis, in order to improve OME safety across Defence.

1.4.370. **Recommendation**. DOSR should ensure a unified, user-focussed and data-driven approach to OME reporting and recording in order to align with broader Defence and single Service data and information sub-strategies.

Audit and Assurance

1.4.371. **Safety Management**. An Operational Safety Management System was developed in line with the PJHQ template by UKTT(C) and is dated 18 Dec 16, reflecting the principal elements of a Safety Management System (Risk Management, Promotion, Assurance and Policy). The following structure was established for UKTT(C) BG: Exhibit 019

a. **Risk Assessment**. A MOD Risk Assessment Form 5010 existed in the UKTT(C) BG. This listed 13 'Hazards associated with Deployed Base Living' and their control measures. The risk determined for each of these ranged from Very Low to Medium. The 2 LANCS CQMS completed a review of all risk assessments following his arrival in theatre. He visited each location and ensured the amended versions were re-signed Witness 014

[159] Design thinking seeks empathy, understanding other perspectives, and realising that with complex systems, simple solutions do not necessarily become the ideal solutions.

[160] The Deepcut Review, March 2006, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228930/0795.pdf p.287.

appropriately. Blenheim Coy did not have a risk assessment relating to weapon handling and carriage; they considered the weapon drills defined in Standard Operating Instructions as sufficient to preclude a separate risk assessment, and believed the control measures to manage the risk were in place. However, after replacing 2 LANCS in theatre, and following their ToA, 2 MERCIAN added an additional Hazard entitled "Carriage of Loaded Weapons (Not Made Ready)" to the Risk Assessment Form. Witness 014 Exhibit 023 Exhibit 160

b. **Risk Register**. The hierarchy of policy documentation directed the establishment of a Risk Register[161] to facilitate the management and transfer of risks[162]. In addition to a BG Risk Register, HQ BRITFOR(L) confirmed that all sub-unit locations in UKTT(C) had their own local risk register. The CSMs acted as the Op Safety Focal Points and were responsible for managing the local risk assessments and keeping their Company Commanders informed. The RSM managed this across the BG and ensured that the CO was aware of these risks, who would elevate them to COMBRITFOR as necessary. The RSM reviewed the sub-unit risk assessments routinely and when new risks were added. Although the Panel has reviewed the COMBRITFOR Risk Register for Op SHADER, a request to see the UKTT(Taji) Risk Register has not been met. Exhibit 178 Exhibit 179 Exhibit 180 Exhibit 181

c. **Operational Safety Meetings**. Monthly Safety Working Groups were held in accordance with PJHQ SOP 0012. The agenda indicated the meetings covered important safety issues. The minutes dated 31 Jan 17 did not reiterate the top 5 risks or record any discussion or actions relating to the death of LCpl Hetherington. The minutes dated 27 Mar 17 noted that the number of reported safety occurrences dropped dramatically, indicating "one of 2 things. Firstly that the Op Safety measures are working well, minimising injury, or more likely that Near Miss and accidents are not being reported". The Panel notes that the figures do not appear to have been challenged and there was no record of follow-on actions to determine the reason. Exhibit 037 Exhibit 182 Exhibit 160

d. **Assurance**. As defined in PJHQ Sop 0014, 3 levels of assurance checks are demanded by PJHQ, from quarterly self-assessments to occasional external PJHQ Operational Safety Visits. The Panel note that PJHQ rarely have the resource or capacity to undertake external audits of all deployed locations. Consequently, assurance activity is commonly limited to subjective self-assessments and limited by the experience of the in-theatre force. Exhibit 037

1.4.372. The Panel is surprised that the minutes from the UKTT(C) Operational Safety Meetings held after the fatal shooting did not acknowledge the death of LCpl Hetherington or record any discussion of consequences. The Panel found no evidence that processes were changed significantly in the aftermath but acknowledge that the Standard Operating Instructions (SOIs) were **not** a factor. However, consideration of risks and their mitigations must drive priorities and have a material effect on activity and decision making. While the risk architecture was sound, the Panel believe that UKTT(C) were not using the outputs of their Safety Management System to the maximum potential. By not using the Safety Management Meeting as a mechanism to consider the Human Factors and latent safety weaknesses associated with the death of LCpl Hetherington, the UKTT(C) Exhibit 091 Witness 014 Witness 007

[161] Op SHADER LAND OPORD 01-016, dated 27 Jun 16, and PJHQ SOP 0012 'Operational Safety Management System'.
[162] PJHQ, SOP 0100.

lost an opportunity to enhance operational safety management. This was an **Other** factor.

1.4.373. **Recommendation**. CJO should ensure Safety Management System education and training, to include Human Factors, for deploying personnel with safety management responsibilities is achieved in order to enhance the understanding and application of safety management in operational theatres.

Safety Management Policy

1.4.374. Reflecting the requirements of higher Defence Policy and DSA01.1, the Panel notes that the RAF Safety Management Policy (AP 8000) describes the organisation, processes and procedures by which the RAF manages all aspects of safety. This clear policy coheres Safety Management Plans at both ODH and DDH levels. The Panel **observes** that without a similarly unifying approach, the British Army does not have a coherent mechanism to define safety policy, organisation, safety management processes or the promotion of safety.

1.4.375. **Recommendation**. Deputy Chief of the General Staff (DCGS) should enhance the direction provided in ACSO 3216[163] to include all aspects of an effective Safety Management System in order to provide a primary source document that coheres the application of safety management in the Army.

Organisational Safety Culture

Just Culture

1.4.376. In Defence aviation, a Just Culture is defined as, "the shared attitudes, values, beliefs, behaviour and practices of personnel in which individuals are encouraged and able to communicate openly and honestly because there is an absence of unjustifiable blame"[164]. It is a pre-requisite for a transparent Reporting Culture and is fundamental to a strong Safety Culture[165]. A Just Culture is founded on 2 principles[166], which apply to everyone in an organisation:

a. Human error is inevitable and an organisation's policies, processes and interfaces must be continually monitored and improved to accommodate these errors.

b. Individuals should be accountable for their actions if they knowingly violate safety procedures or policies.

1.4.377. In 2009, the Chief of the Defence Staff stated that establishing a Just Culture was one of the greatest challenges for senior leaders with command

Exhibit 090

[163] Army Command Standing Order 3216, *The Organization and Arrangements for the Management of Safety and Environmental Protection in the Army* 1st ed. May 18.

[164] MAA02, Military Aviation Authority Master Glossary.

[165] AP 8000, Oct 16, Issue 2.1, Leaflet 8005.

[166] "The Human Element - a guide to human behaviour in the shipping industry", MCA, 2010.

responsibility[167]. An Army Inspector's report of May 2017, found "a widely-held belief that the British Army has an embedded blame culture". The following vignette illustrates a recourse to discipline and blame, rather than appreciation of error in circumstances without consequence, which reinforced a reticence to report and demonstrated the immaturity of an engaged Safety Culture[168].

Vignette – Iraq, Dec 16

1.4.378. In the Army it is unacceptable for weapons to be left unattended at any time. This was reinforced by theatre SOs.

1.4.379. In the first few weeks of deployment on Op SHADER, an officer left his pistol hanging on the cubicle door following a dash to the lavatory immediately prior to his evening brief. The meeting occurred approximately 50m away from the wash-rooms. Found by a soldier and handed to a SNCO, the pistol and holster were returned to the officer within a few minutes. Although the weapon was left unattended, there were no adverse consequences. Witness 023

1.4.380. Despite advice to the contrary, the officer reported his momentary lapse of concentration to his CO, demonstrating openness and integrity. In addition, the officer was content that the story was shared as an important reminder, for those new to theatre, to check for the presence of their weapon system. Witness 023

1.4.381. As a result of precedence from Afghanistan and legal advice, rather than taking administrative action, his chain of command delivered formal disciplinary action and the officer was charged. He was found guilty of negligence, fined £750 and had a disciplinary flag placed against his military record in perpetuity. Exhibit 008

1.4.382. The recommendation to prosecute the officer had unintended consequences. He lost faith in the objectivity and purpose of the disciplinary system. He stated that the punishment he received was a disincentive for further occurrence reporting. Witness 023

1.4.383. In a Just Culture, safety, discipline and individual responsibility are balanced fairly. To embed the principle of Just Culture throughout the Defence Aviation Environment, a standardised system is used to ensure impartial and consistent judgement. The Defence Aviation Flowchart Analysis of Investigation Results (DA FAIR) model[169] is a management tool to determine the nature of errors and assess levels of culpability. It is not to be used in isolation and relies upon an independent, no-blame, safety investigation being conducted by trained personnel to establish the facts prior to its use. The output is used to enable commanders to hold individuals accountable, apply just discipline and develop appropriate interventions to prevent reoccurrence. Application of the internationally recognised model ensures an impartial and consistent judgement as to what are deemed acceptable and unacceptable actions.

1.4.384. A notional 'line in the sand' is employed to distinguish between behaviour which is undesirable, but to some extent understandable, and that which in principle is deemed unacceptable to the organisation. Use of the flowchart would

[167] Sir Jock Stirrup, *Desider Magazine*, January 2009.

[168] The Army Leadership Code recognises that mistakes can be used by leaders as learning opportunities to prevent reoccurrence.

[169] Detailed in the Manual of Air Safety, Chapter 3, Annex C. The DA FAIR model provides top-level policy across the Defence Air environment as part of the Military Aviation Authority's Regulatory Publications.

help identify if occurrences were caused by errors, mistakes or rule-breaking. The Panel found no equivalent model for the assessment of occurrences within established British Army processes.

1.4.385. Errors, mistakes and rule breaking all have differing psychological and motivational precursors. Unit commanders are not trained or resourced to consider or evaluate the causal and contributory factors that influence human error. Without this consideration, similar occurrences may attract disproportionate punishment which overlook the potential for performance management through alternative interventions.

1.4.386. In the Panel's opinion, the officer's actions in the vignette demonstrated no conscious disregard for risk, no plan to leave the weapon unattended and no intention to contravene SOs. This was an unintended action with no consequence and as such the Panel believes this was an example of human error. In reporting his lapse of concentration, the officer acted in support of a Learning Culture. The Panel **observes** that the decision to pursue disciplinary action in this case was highly unlikely to change behaviours and improve performance. In addition, charging the officer for negligence perpetuated a reticence to report and undermined the development of an engaged Safety Culture. Witness 023

1.4.387. The Panel concludes that this vignette demonstrates a culture of behaviour within the British Army based on punitive discipline that does not focus on minimising the likelihood of reoccurrence. Perceptions that outcomes are unjust, undermines a Reporting Culture. Combined, these weaken the development of an engaged Safety Culture.

1.4.388. **Recommendations**. D Pers should:

a. Introduce a model for assessing the behaviour of individuals and a relative level of culpability for their actions, after investigation, exploiting the Defence Aviation Flowchart Analysis of Investigation Results model, for utilisation within the Army in order to engender an engaged Safety Culture[170].

b. Include the influences of Human Factors in accident causation and the importance of occurrence reporting at key stages of officer and NCO command education and training in order to transform the Army's approach to safety management and develop an engaged Safety Culture.

The importance of an engaged Safety Culture

1.4.389. Haddon-Cave noted that *"a broad consensus has developed across the safety community, academia, and informed opinion in Industry, that fostering a strong and effective 'Safety Culture' is vital to help reduce the number of accidents that occur in complex systems and organisations"*[171]. To generate recommendations throughout this report, the Panel has referred to the 5 critical elements of an engaged Safety Culture: Reporting Culture, Just Culture, Flexible Culture, Learning Culture and Questioning Culture, see Figure 29.

[170] This links to the recommendation for CESO(Army) that calls for reinforcement of the remits of USEAs.

[171] The Nimrod Review, p.571; 27.2.

1.4.390. A key challenge for any organisation is to build a culture which enables and motivates people, of their own accord, to share learning in a critical and productive way to continuously improve the organisation. Although there is a great deal of policy and much activity to protect our people, this has not been designed within a systems approach and fails to achieve the unifying purpose of the Haddon-Cave model.

Figure 29: The 5 sub-cultures of an engaged Safety Culture

1.4.391. The Panel believes that this accident demonstrates an immaturity of each element of an engaged Safety Culture. This can only be matured if all ranks feel confident to challenge and report any event, error, hazard, Near Miss or concern. In part, this is reliant on a simple, easy-to-use and effective means of reporting and recording. This must be supported by the willingness of the chain of command to consider all reports justly, share and learn actively from experience and implement best practice and lessons with agility of mind and process.

1.4.392. The Panel **observes** that cultural maturity is difficult to quantify and is unaware of any coherent attempt to do so for Safety in the Army. However, within an organisation it is possible to survey and measure the attitudes and perceptions of personnel to safety related issues and generate interventions to resolve concerns. As part of the paradigm shift in safety management in the Air domain following the Haddon-Cave Report, the RAF utilise widely a Safety Environment Enhancement Tool (SEET) to assess the degree to which each sub-element of Safety Culture is embedded within units. The RAF SEET was developed from a model used by the US Air Force Safety Centre. It is an anonymous online survey that identifies shortcomings in, and makes recommendations to improve, an engaged Safety Culture. It was designed such that questions can be tailored for individual groups or units by an OC and should be used annually to assess trends. For the tool to be beneficial, personnel must understand that the survey is owned by the commander, that results will allow local action to be taken and that concerns raised will be addressed directly. All responses are confidential, although aggregated data can be utilised by the organisation for trend analysis above the unit level. Use of this attitudinal survey is a fundamental aspect of assurance activity within the RAF Safety Management System.

1.4.393. **Recommendation**. DCGS should develop and implement a Safety Environment Enhancement Tool in order to help commanders understand and exploit the maturity of Safety Culture within their units.

Linking organisational safety culture and tactical actions

1.4.394. Culture sets the conditions for individual actions. At its simplest, organisational culture can be described as 'what happens when the boss isn't in there'[172]. It is evident from this Inquiry that the professional military behaviours expected of all soldiers, and crucial to the Army's Safety Culture, were not powerful enough to counter the magnetism of the Glock GSP in this case.

1.4.395. LCpl Hetherington was shot and died on operations; he was the first fatality on Op SHADER. His needless death was not the result of enemy action but instead the inappropriate and dangerous actions of his best friend. Soldier A was trained, qualified and current in his use of the GSP, but despite orders to the contrary, he succumbed to the temptation to play with his pistol with tragic consequences.

1.4.396. Six months prior to the death of LCpl Hetherington, another Infantry Coy experienced a similar incident with the unintended firing of a GSP on Op SHADER, in the same accommodation block; by fortune alone the result was only minor wounding. Two years prior to that, a RAF Regiment gunner was very seriously wounded in Afghanistan by a 9mm shot fired recklessly by his peer. The observations and lessons from both former accidents were not shared or implemented sufficiently to prevent reoccurrence. The Panel believes that, in part, this is due to an organisational tendency to believe that the firer alone is responsible rather than an accumulation of factors.

1.4.397. Safety should not be treated as something which is separate from the conduct of the business itself[173]. By approaching this inquiry through the HFACS model of accident causation, the Panel concludes that an appropriate level of respect for the weapon system, in the new normal of GSP carriage, was lacking at various levels of authority, throughout the Army. This is compounded by historic approaches to punishment and extant policies and processes that, without change, will continue to undermine the development of safer behaviours and the safe psychological space required of an engaged Safety Culture. As such, problems were unseen, interventions sub-optimal and risk was transferred to theatre. If Defence wishes to prevent another LCpl Hetherington from dying because of unsafe practice with a GSP by an apparently competent person, and similar accidents, it must do more than punish the individual; it must acknowledge the latent weaknesses identified in this report and address the full spectrum of accident causation throughout the organisation.

[172] As described in Frei F & Morriss A, *Culture Takes Over When the CEO Leaves the Room*, Harvard Business Review, May 10 2012.
[173] Lord Cullen , Piper Alpha Disaster Public Inquiry, 1990.

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Chapter 6 – Summary of Findings

1.4.398. The Panel identified a significant number of accident factors during the course of the Service Inquiry:

1.4.399. **Causal Factors**. The Panel identified 4 Causal Factors which led directly to the outcome of the accident, the death of LCpl Hetherington:

a. The fatal gunshot wound to LCpl Hetherington. 1.4.23

b. The weapon state. Soldier A lost awareness of his weapon state, probably due to the mis-application of weapon handling drills. 1.4.32

c. Directional safety. The weapon was pointed in an unsafe direction. 1.4.33

d. A lack of trigger discipline. 1.4.34

1.4.400. **Contributory Factors**. The Panel identified 9 Contributory Factors which made the accident more likely on the balance of probability:

a. Although trained and qualified, the timing of GSP training for Soldier A limited his familiarity with the GSP relative to other Infantry weapon systems. 1.4.81

b. A light tempo of training and operations did not fully stimulate all FP PI soldiers in what was perceived as a benign threat environment. This could have set the conditions for immature individuals with high impulsivity and a lack of controlled aggression to mess around with their pistols. 1.4.90

c. Lack of respect for the GSP. Rather than being seen as a functional tool, the GSP was perceived by some individuals in the FP PI as an attractive novelty, in contrast to the SA 80 Rifle. 1.4.94

d. Soldier A did not uphold the safety and professional standards required of a JNCO. 1.4.101

e. The close friendship between LCpl Hetherington and Soldier A could lead to an unprofessional social dynamic in which they negatively influenced each other. This relationship was exacerbated by their confinement to Camp Taji and sharing a room which reduced the opportunity of relief from each other's company. 1.4.105

f. There was no recognition that the empty holsters represented incomplete weapon systems or the significance of the behaviours that had led to the holsters being left behind. A lack of decisive action to address unsafe standards of weapon handling or use them as an opportunity for learning. 1.4.123

g. Not applying the formal process of Minor Administrative Action to correct professional and personal failings made the accident more likely. This is associated with low confidence in the effectiveness of AGAI action and the reluctance of FP PI JNCOs to use it. 1.4.157

h. The Company Sergeant Major was a significant presence within Blenheim Coy and exerted robust leadership over his soldiers. The impact of his absence was underestimated and is very likely to have weakened the chain of command and the ability to maintain values and standards in FP Pl.	1.4.161
i. Insufficient Command Leadership and Management training for the Pl Sgt limited his competence and potential.	1.4.245

1.4.401. **Aggravating Factors**. Noting the result of the accident was the death of LCpl Heatherington from a single shot fired by his best friend, the Panel found no factors which would have made the outcome any worse.

1.4.402. **Other Factors**. The Panel identified 15 Other Factors which may cause or contribute to a future accident:

a. Inappropriate signage at the weapon loading and unloading facility.	1.4.45
b. Disregard for the standard of the weapon loading and unloading facility itself did not reinforce in the minds of the FP Pl the professionalism necessary for safe weapon handling.	1.4.47
c. Poor record keeping. Gaps in training records for small arms training and qualification were insufficient to provide the Army with accurate information about when, and to what standard, soldiers acquired competency and qualification.	1.4.76
d. Problem recognition. A Safety Culture will only exist if all individuals, regardless of rank, actively pursue error detection and prevention. E.g. Consistently overlooking an unsecured file containing sensitive information indicates that the FP Pl did not have a mature culture of problem-seeking and resolution.	1.4.127 and see also 1.4.45 1.4.171
e. A lack of imagination and innovation with the Coy chain of command led to a reliance on the repetition of routine lessons and military skills training which dulled enthusiasm and did not provide a stimulating learning environment. A lack of progressive training in theatre and not establishing an engaging programme for individual development and collective training was a lost opportunity.	1.4.176
f. Not promoting or utilising the Safety on Deployment Pocket Guide effectively was a lost opportunity.	1.4.181
g. Inadequate pre-deployment reconnaissance of Company locations in theatre meant that 2 LANCS did not fully understand the infrastructure or challenge potential limitations to range activity.	1.4.203
h. A lack of collaborative estimate planning prior to departure meant that decreased diversity of thought, the opportunity for learning through shared experience and the development of a common operational picture. In addition, conducting the BG estimate and issuing UKTT(C) operational orders prior to departure would have decreased the burden on BG staff and OCs in the early stages of deployment in theatre.	1.4.217

i. Programming the Mission Rehearsal Exercise without sufficient time for remedial training, if required, forces a course of action to deploy the unit whether appropriate or not. 1.4.228

j. There is currently a mechanical rather than consequential understanding of the instruction to 'make ready' a weapon. The addition of the consequence of any action is important to understanding and will increase comprehension of the risks posed by a made ready GSP. When asked to define 'Made Ready', all weapon users should respond unprompted with both a mechanical and a consequential description. This would reinforce respect for the lethal nature of the weapon. 1.4.250

k. The continued use of an obsolete training film to convey the risk and consequence of unintentional discharges does not inculcate respect for the GSP and is detrimental to the development of an engaged Safety Culture. 1.4.254

l. Not training with a representative weapon system, immediately prior to deployment, transferred the GSP safety risk from the training environment to the operational theatre. 1.4.285

m. A Learning Account from which lessons are not learned is merely an account. Not recognising the wider applicability of factors and lessons, and sharing them effectively, demonstrates an absence of leadership commitment to occurrence reporting and the under development of Reporting and Learning Cultures. 1.4.304

n. The complexity of small arms occurrence reporting leads to confusion and undermines the development of a Reporting Culture, trend analysis and the implementation of potentially effective interventions. 1.4.360

o. UKTT(C) were not using the outputs of their Safety Management System to the maximum potential. By not using the Safety Management Meeting as a mechanism to consider the Human Factors and latent safety weaknesses associated with the death of LCpl Hetherington, the UKTT(C) lost an opportunity to enhance operational safety management. 1.4.372

1.4.403. **Observations**. The Panel made 32 Observations which should be considered to promote better working practice:

a. Within the Rules of Safe Handling there is no direction as to when a soldier may Make Ready their weapon. A more explicit reference would reinforce the significance of the action. 1.4.35

b. Sub-units conducting their own GSP training and WHT do not benefit from external assurance and this introduces additional risk and the opportunities for an internal 'paper pass'. 1.4.64

c. The Army does not record with purpose the progress towards the achievement of GSP competence. Without a means to record and demonstrate successful completion of lessons and practice periods, the chain of command is only able to refer to a soldier's WHT as the first evidence of GSP competence. This fails to incentivise completion of all basic lessons and practice and, as such, introduces unnecessary risk to all stakeholders. 1.4.65

d. Incentivising GSP marksmanship. A badge to recognise and reward GSP marksmanship would both assist the development of a culture of Skill at Arms excellence and increase respect for the pistol. 1.4.69

e. The recording of Weapon Handling Tests during initial training. Soldier A's Competency Profile recorded by the Army Personnel Centre aggregates all WHT passes for each weapon system and records them as one date. Although convenient, it is not a true representation of when a soldier passes his WHT for each weapon type during CIC and thus initial currency is based on his arrival at his Bn, not the time since passing the WHT. 1.4.74

f. [redacted]. Although very likely unintentional, unchecked over-familiarity negatively influenced supervision. 1.4.120

g. The self-directed, integrated 2LANCS and RE sub-unit pre-deployment exercise, UNITED LION, proved to be an excellent opportunity for interoperability training and was essential for successful re-grouping and integration in theatre. 1.4.134

h. The Assurance Note written at the end of the Mission Rehearsal Exercise did not include useful commentary on command culture, the degree of progress made during the MRX or any recommendations for interventions to ensure the highest standards of Coy level supervision. 1.4.147

i. Despite the complex environment in which new Commanding Officers can operate, the Army does not routinely provide formal mentoring or coaching during the first critical months of their command. 1.4.188

j. A lack of visas denied officers who would assume command of UKTT(Taji) and UKTT(Besmaya) the ability to physically assess their future locations prior to deployment. PJHQ could more effectively assist units with the provision of Iraqi visas to facilitate the conduct of timely reconnaissance abroad. 1.4.199

k. The conduct of a G1 estimate to better understand the administrative policy and processes to be used in Post Incident Management promotes mutual understanding and best practice, but is dependent on appropriate representation from all stakeholders. To be more effective, a 'death on operations' scenario should also be exercised. 1.4.223

l. The Bde that commanded the 2LANCS BG and oversaw their pre-deployment training would neither accompany them to theatre nor continue to command them once deployed. The focus of Bde supervision was Force Generation not the mission itself and did not engage in the estimate process or require a back-brief from the CO on his mission-specific BG orders. 1.4.226

m. COMBRITFOR did not receive a copy of the MTMC Assurance Note. The distribution of the note was too narrow and should also include the force generating Bde and PJHQ in order that commanders are made aware of the strengths and weaknesses of units prior to deployment. 1.4.233

n. Greater and earlier access to appropriate vehicle commander courses required to reach in-theatre entry standards would have provided the Bn with increased flexibility for the selection and training of personnel. 1.4.258

o. The absence of Service Police in Iraq at the time of the operation and a lack of visas for the 3 RMP held at readiness to deploy, led to a 7-day delay in commencing policing activities and a reliance of US Special Agents. 1.4.262

[redacted] there exists reputational risk to the UK of failing to investigate serious accidents in theatre appropriately. 1.4.265

p. The use and title of the Unit Safety and Environmental Advisor (USEA) were questioned. Not utilising the USEA to their full capacity to promote a no-blame culture inside and outside of barracks and a failure to reinforce operational safety during PDT were lost opportunities. It is very likely that a change in name to Force Protection Advisor would increase engagement and understanding of their role across all ranks. The Panel believes that their capacity to conduct Non-Statutory Investigations in role would also support the development of an engaged Safety Culture. 1.4.269

q. The GSP Safety and Environmental Case Report (SECR) does not consider the Man-Platform interface. The Panel determines that Human Factors influence behaviour with new weapons in new operating environments. Consideration of the 'new normal' of increased GSP carriage across all ranks would benefit from a review of how and when the GSP is trained. 1.4.275

r. Not taking full advantage of the Dismounted Close Combat Trainer (DCCT) during PDT was a lost opportunity to improve soldiers' familiarity and exercise good judgement with the GSP. 1.4.280

s. The GSP, unlike other weapon systems in the Army, does not have a safe blank firing system. Soldiers are not permitted to carry blank 9mm ammunition. Blenheim Coy carried GSP but no accompanying magazines during the MRX. Conducting training without 9mm magazines or ammunition creates an unrealistic and less effective training environment. 1.4.284

t. The Initial Deployment Report (IDR) format and instructions directs units not to report those issues that can and should be resolved internally. This introduces a level of subjective assessment that is almost certain to obscure the wider-applicability of significant but uncomfortable issues and thus does not encourage Reporting and Learning Cultures. The utility of the IDR was further reduced by the omission of details, observations and lessons relating to the death of LCpl Hetherington and a lost opportunity to influence the preparation and training of others. 1.4.306 1.4.308

u. A year prior to the 2LANCS deployment on Op SHADER, 1 RIFLES presented 9 hazards, risks and mitigations at the Mission Exploitation Symposium. These included live firing and pistol NDs. 1 RIFLES had a GSP ND in Taji 3 months later yet there was no discussion of these hazards, risks and mitigation evident in subsequent MXS presentations. Without a consistent format, and regular reviews, it was difficult to understand the pattern of risk across all locations in theatre over time. 1.4.311

v. The theatre Risks to Life should be an aggregation of those identified in each sub-unit location. Recording and sharing of theatre hazards and risks was inconsistent. The failure to cohere risks across deployed locations weakens safety mitigations within the conduct of operational planning.	1.4.313
w. Access to lessons from historic small-arms related inquiries is difficult to find and retrieve from across the Defence organisations who conducted the investigations. There is currently no central repository to hold reports, redacted as necessary, and the lessons therein. It is therefore difficult to leverage their value across all levels of command.	1.4.318
x. Error of Drill. As currently written, the ambiguity in PAM 21 between the formal definition and the 'actions on' is confusing and the use of the term Error of Drill to categorise unintentional discharge is open to subjective interpretation. These ambiguities could be used to mask negligence of a supervisor or a firer on a range. In addition, contradiction is created by the fact that despite being caused by human error, and therefore potentially an offence, PAM 21 states that in the case of an Error of Drill "no disciplinary action should be taken". The Panel agrees that if no negligence is found, no disciplinary action should be taken but concludes that Error of Drill is currently a confusing categorisation of unintentional Small Arms discharge.	1.4.326
y. Incoherent and confusing small arms occurrence terminology. Although defined in JSP 375, there are no commonly agreed Defence definitions for the following terms: Accident, Incident, Near Miss, Negligent Discharge or Unintended Discharge. Without a common lexicon and mutual understanding, across all personnel and policy, it will remain extremely difficult to achieve unity of purpose and effort in the prevention of unsafe acts.	1.4.328
z. Prejudicial use of 'Negligent Discharge' terminology. Only a proportion of unintentional discharges are caused by negligence. However, such is the prevalence of the phrase 'Negligent Discharge or ND' and a general assumption of its meaning, it is used very often as a colloquial phrase to describe any unintentional firing of a Small Arms weapon. This instinctive and immediate application, regardless of the circumstances, is immediately prejudicial. It reinforces a culture of blame which hinders open reporting and full recording of Small Arms occurrences. As a result, Defence cannot fully comprehend the scale of unintentional versus negligent discharges across the organisation.	1.4.331 and see 1.4.342
aa. Over-use of the term ND is due to Defence's limited classification system which does not provide a clear alternative and therefore an alternative model is required. The initial classification of all occurrences as unintentional prior to investigation would simplify and encourage reporting, promote a Just Culture, enable comprehensive recording and provide for better data analysis. The Panel propose the use of the unifying term Unintentional Small Arms Discharge (USAD) to embrace all scenarios in which a Small Arms discharge may occur without intention.	1.4.333
bb. Self-evidently, monetary fines do not deter unintentional discharges. While fines may have some preventative effect, unintentional discharges continue to occure. The use of fines as a principal punishment to deter does not achieve the effect sought. Soldiers consider the professional indignity a far more powerful disincentive than a financial penalty.	1.4.347

cc. Incoherent terminology, unqualified assessment of occurrences, complex and contradictory reporting policy and the poor standard of small arms ND data, mean that decisions of interventions based on analysis of the Munitions Incident Database are sub-optimal. 1.4.368

dd. Without a similarly unifying approach to the RAF's Safety Management Policy (AP8000), at the time of the accident, the Army did not have a coherent mechanism to define safety policy, organisation, safety management processes or the promotion of safety. 1.4.375

ee. The Panel provided a vignette from Op SHADER in which a recourse to discipline and blame, rather than appreciation of error in circumstances without consequence, reinforced a reticence to report. The punitive approach did not focus on minimising the risk of reoccurrence and instead undermined the development of an engaged Safety Culture. 1.4.386

ff. This accident demonstrates an immaturity of each of the 5 sub-cultures of an engaged Safety Culture. This can only be matured if all ranks feel confident to challenge and report any event, error, hazard, Near Miss or concern. In part, this is reliant on a simple, easy-to-use and effective means of reporting and recording. This must be supported by the willingness of the chain of command to consider all reports justly, share and learn actively from experience and implement best practice and lessons with agility of mind and process. 1.4.392

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Annex A to
Taji_SI_Part_1.4

Summary of Findings from a RAF Regiment Service Inquiry - 2013

INCIDENT FACTOR IDENTIFICATION

1.4.43 **Causal Factors.** The Panel concluded that the cause of the incident was that Gunner A, of his own volition, withdrew his loaded Glock pistol from its holster, pulled back the top slide and, pointed the pistol in the direction of Gunner B, and fired a round that hit Gunner B in the abdomen.

1.4.44 **Contributory Factors.** The Panel identified the following factors that were contributory to the incident:

a. Gunner A's interpretation of weapon handling orders.	1.4.14
b. The inclusion of the unauthorised brass check drill in Close Quarter Battle training syllabus.	1.4.15b
c. The ability to cock a loaded Glock 17 without chambering a round.	1.4.18
d. Further disciplinary or administrative action was not taken following Gunner A's second verbal warning by Witness H.	1.4.21
e. Members of the Sqn did not report Gunner A's actions to the chain of command prior to the shooting.	1.4.22
f. The absence of a Reporting Culture.	1.4.24
g. Insufficient command and leadership training during FT1.	1.4.25
h. High proportion of acting NCOs with insufficient training and experience.	1.4.32

1.4.45 **Aggravating Factors.** The Panel did not identify any aggravating factors.

1.4.46 **Observations.** The Panel made the following observations.

a. The DSAT process was not followed when a new operational need demanded a change in training.	1.4.30b
b. There were opportunities to identify unauthorized drills before they were included into formal training documentation.	1.4.30c
c. Delivering weapon training that did not conform to the GSP pamphlet could indicate wider non-compliance to weapon training policy.	1.4.31
d. Members of Sqn C felt they were being treated as the poor relation to Sqn D.	1.4.33a

e. The departure of the [redacted] removed a significant level of supervision. 1.4.33b

f. When Gunner A had performed his unauthorized drill prior to the incident it was with different multiples. 1.4.34

g. A Service Inquiry could have run in parallel with the Service Police inquiry which would have delivered findings and recommendations in a more timely manner. 1.4.39

h. There is no Joint co-ordinating authority or guidance on how to manage inquiries that span Services. Although this may now be addressed by the formation of the Defence Safety Authority (DSA). 1.4.42

INCIDENT FACTOR CLASSIFICATION

1.4.47 **Organisational Influences.** The Panel identified the following factors over which an organisation, at higher level, could be expected to exercise some measure of control:

a. Adequate preparation of LCpls for command and leadership responsibilities. 1.4.25

b. Gunner A not obeying 2 verbal warnings. 1.4.30c

c. Adequate response to the high proportion of acting NCOs on Sqn C. 1.4.32

1.4.48 **Breached Defences.** The Panel identified the following breached defences:

a. Gunner A's non-compliance with the weapon handling rules and regulations. 1.4.14

b. The inclusion of unauthorised weapon drills into formal training documentation. 1.4.21

c. Opportunities to identify unauthorised drills before they became included into formal training documentation. 1.4.30c

d. Loss of supervision due to the removal of a dedicated Sqn C HQ. 1.4.33a

e. Removal of the [redacted]. 1.4.33b

f. Enhanced levels of supervision could have mitigated some of the risk associated with having inexperienced SNCOs and Flt Cdrs. 1.4.33c

PART 1.5

Recommendations

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PART 1.5 – RECOMMENDATIONS

Recommendations	Analysis
1.5.1. The following recommendations are made in order to enhance Defence safety and prevent reoccurrence.	
1.5.2. **Director General, Defence Safety Authority** should:	
a. Establish a mechanism to archive and facilitate easy internal access to all safety Statutory and Non-Statutory Inquiry reports across Defence, in order to support the development of a Learning Culture.	1.4.319
1.5.3. **Defence Safety Authority, Director (Operations and Assurance)** should:	
a. Mandate, through single Service Safety Centres, that unit-level Non-Statutory Inquiries are conducted for all Unintentional Discharges by suitably qualified and experienced personnel in order to provide qualified and objective assessment of causes and recommendations and thus support the development of a Just Culture.	1.4.343
b. Implement a single, easily-accessible mechanism for reporting any safety occurrence, replacing Ministry of Defence Forms 1664, 1668, 1670 and Army Form 510 (and single Service equivalents) in order to enable more effective analysis and exploitation of safety occurrence information.	1.4.362
1.5.4. **Defence Ordnance Munitions and Explosives Safety Regulator** should:	
a. Update Joint Service Publication 403, Volume 2, Chapter 32, Weapon Unloading Facilities, to clarify if and where instructions for safe weapon handling should be positioned in order to reinforce the importance of safe weapon handling and effective supervision	1.4.46
b. Implement a common Ordnance Munitions Explosives lexicon in order to clarify Defence policy and simplify Small Arms occurrence reporting.	1.4.337
c. Codify unintentional discharges within a new Small Arms occurrence classification model, using the unifying term Unintentional Small Arms Discharge (USAD), in order to capture all occurrences, remove immediately prejudicial language and promote a more engaged Safety Culture.	1.4.338
d. Establish a coherent hierarchy of Ordnance Munitions and Explosives occurrence reporting policy and process in order to increase the effectiveness of Small Arms reporting across Defence.	1.4.361
e. Replace the Munitions Incident Database with an accessible, single web-based repository with a consistent data model for the recording of all Small Arms Ordnance Munitions and Explosives occurrences, that can be monitored and assessed for safety trend analysis, in order to improve Ordnance Munitions and Explosives safety across Defence.	1.4.369

f. Ensure a unified, user-focussed and data-driven approach to Ordnance Munitions and Explosives reporting and recording in order to align with broader Defence and single Service data and information sub-strategies.	1.4.370

1.5.5. **Chief of Defence Personnel** should:

a. Chief of Defence Personnel should amend the CO's Guide to Sentencing, within JSP 830 'Manual of Service Law' to clarify that a negligent discharge is an offence only following an investigation during which negligence has been proven.	1.4.336

1.5.6. **Chief of Joint Operations** should:

a. Include 'boredom through a lack of stimulus' in the Permanent Joint Headquarters Operational Risk Register in order to expose this as a significant risk on operations and enable appropriate mitigation activity and proactive management.	1.4.91
b. Improve the promotion and usage of the Safety on Deployment Pocket Guide in order to enhance the effective dissemination and understanding of information relating to operational safety.	1.4.182
c. Direct that physical reconnaissance to independent locations is mandated whenever possible in order to minimise risk and maximise opportunities prior to deployment.	1.4.204
d. Direct that whenever a physical reconnaissance cannot be achieved, other means must be provided to give units the character of their future location in order to minimise risk and maximise opportunities prior to deployment.	1.4.209
e. Direct that units conduct collaborative planning and produce mission specific orders prior to deployment in order to better mitigate threats and maximise opportunities.	1.4.218
f. Direct force generating headquarters to commission J1 wargames, as appropriate, aligned to the theatre risk register, in order to improve operational Post Incident Management.	1.4.224
g. Ensure that operational planning includes appropriate levels of military police capability in all operational theatres in order to ensure prompt investigation of incidents.	1.4.266
h. Establish formal Memoranda of Understanding with coalition partners and/or Host Nations in order to ensure appropriate military police support is available in all operational theatres.	1.4.266
i. Ensure that operational hazards and risks are a nested aggregation of those present in all locations in order to provide clarity and consistency in operational risk management.	1.4.315
j. Ensure Safety Management System education and training, to include Human Factors, for deploying personnel with safety management	1.4.373

responsibilities is achieved in order to enhance the understanding and application of safety management in operational theatres.

1.5.7. **Director of Joint Warfare** should:

a. Direct that observations and lessons from all Learning Accounts, as well as Defence and Front Line Command Service Inquiries and Non-Statutory Inquiries, are captured on a common lessons information management system in order to ensure observations and lessons are available across Defence. 1.4.305

1.5.8. **Deputy Chief of the General Staff** should:

a. Enhance the direction provided in Army Command Standing Order 3216 to include all aspects of an effective Safety Management System in order to provide a primary source document that coheres the application of safety management in the Army. 1.4.375

b. Develop and implement a Safety Environment Enhancement Tool in order to help commanders understand and exploit the maturity of Safety Culture within their units. 1.4.393

1.5.9. **Director of Personnel** should:

a. Determine and implement a method of more consistent application of Minor Administrative Action in order to deliver greater trust in the Minor Administrative Action process and drive higher standards of behaviour. 1.4.158

b. Enhance how junior officers and Senior Non-Commissioned Officers are taught the practice of creative training design in order to deliver interesting and innovative training that motivates soldiers. 1.4.177

c. Consider implementing a mentoring scheme, or similar, outwith the chain of command, to new Commanding Officers, in order to help maximise talent and optimise efficiency and effectiveness. 1.4.189

d. Use Project 'Command Leadership and Management 2019' to mandate that all 3 parts of Command, Leadership and Management training are completed within one year of promotion, and hold chains of command accountable, in order to ensure that all soldiers are trained appropriately for their rank. 1.4.246

e. Commission a study to investigate the Human Factors implications of the wider fielding of the General Service Pistol in order to better inform the man-machine interface section of the General Service Pistol Safety and Environmental Case Report. 1.4.276

f. Determine whether administering substantial financial penalties deters Negligent Discharges in order to understand better the utility of current disciplinary practice and support the development of a Just Culture. 1.4.348

g. Introduce a model for assessing the behaviour of individuals and a relative level of culpability for their actions, after investigation, exploiting the 1.4.388

Defence Aviation Flowchart Analysis of Investigation Results model, for utilisation within the Army in order to engender an engaged Safety Culture.

h. Include the influences of Human Factors in accident causation and the importance of occurrence reporting at key stages of officer and Non-Commissioned Officer command education and training in order to transform the Army's approach to safety management and develop an engaged Safety Culture. 1.4.388

1.5.10. **The Army Inspector** should:

a. Audit how the Army records completion of General Service Pistol instructional training and achievement of General Service Pistol Annual Combat Marksmanship Test and Live Fire Tactical Training in order to assure General Service Pistol competence. 1.4.67

1.5.11. **Head of Capability, Ground Manoeuvre** should:

a. Amend weapon handling procedures, within Skill at Arms training, to specify the circumstances when a pistol is to be Made Ready, in order to clarify and augment the Rules for Safe Handling. 1.4.36

b. Enable Small Arms School Corps to promote, reward and recognise General Service Pistol marksmanship excellence, across all ranks, in order to elevate the importance of General Service Pistol marksmanship as a core skill. 1.4.70

c. Ensure accurate record keeping of all weapons training and qualifications is achieved at the start of a Service Person's career and maintained accurately throughout, in order to improve accountability and assurance. 1.4.77

d. Reinforce the importance of the holster as a critical element of the General Service Pistol safety system within Operational Shooting Policy in order to increase safe behaviours and elicit corrective action when unsafe practices are identified. 1.4.124

e. Amend DCC Trg Vol II, Personal Weapons – Pistol, to include a training objective that describes the consequences of making the General Service Pistol ready to fire, in order to increase comprehension of risks and General Service Pistol lethality. 1.4.251

f. Replace 'An Unthinking Moment', for a tri-Service audience to reflect the nature of contemporary operations using this Service Inquiry as a vignette in order to reinforce the lethal nature of the General Service Pistol and help develop an engaged Safety Culture. 1.4.255

g. Review and establish best practice as to how and when Service Personnel are educated and trained to use the General Service Pistol in order to enhance confidence, competence and performance on the weapon 1.4.277

h. Provide a full range of equipment and ammunition for the General Service Pistol in order to provide a representative weapon system for full training progression in all environments. 1.4.286

i. Ensure that all Small Arms policy documentation subordinate to Joint Service Publication 482 is updated to include references to this publication and replace out-of-date references to old documents and organisations in order to clarify occurrence reporting policy. 1.4.363

1.5.12. **Chief Safety (Army)** should:

a. Make reference to Joint Services Publication 403 for Weapon Unloading Facilities in Operational Safety presentations and the Safety on Deployment Pocket Guide in order to reinforce the importance of safe weapon handling and effective supervision. 1.4.48

b. Direct a review of the policy and implementation of 'peer-supervision' as currently authorised, in order to determine if it is an appropriate mechanism for checking safety critical activity. 1.4.102

c. Reinforce the remit of Unit Safety and Environmental Advisors as the lead for risk assessment, safety and force protection, in barracks and on operations, in order to support the development of an engaged Safety Culture. 1.4.270

d. Exploit the capacity offered by Unit Safety and Environmental Advisors by training and empowering them to undertake Non-Statutory Inquiries in role in order to support the development of an engaged Safety Culture. 1.4.270

1.5.13. **Director Land Warfare** should:

a. Improve access to courses, as appropriate and required for a unit's mission, on being warned for operational deployment (prior to receipt of a formal Force Generation Order) in order to enable units to prepare for deployment in a timely manner. 1.4.259

b. Consider issuing a waiver to permit the carriage of blank 9mm ammunition during Mission Specific Training in order to avoid transference of risk to the operational theatre. 1.4.287

c. Direct that hazards, risks and mitigations are presented consistently and routinely in Initial Deployment and Post-Operational Reports and throughout the Army Operations Lessons Process in order to inform better the preparation and training of those warned to deploy on operations. 1.4.314

1.5.14. **Head of Warfare Development** should:

a. Ensure that the Mission Training and Mobilisation Centre Assurance Note is specific, transparent and written in straightforward language, to include an assessment of attitude, effort and progress made, in order to ensure that the chain of command understands a unit's strengths and weaknesses. 1.4.148

b. Ensure that the Mission Training and Mobilisation Centre Assurance Note is issued to the Brigade Commander and Commanding Officer in sufficient time for them to act meaningfully on its content. 1.4.234

c. Ensure that the Mission Training and Mobilisation Centre Assurance Note is issued to Commander British Forces in order to improve his understanding of incoming Force Elements and thus management of risk. 1.4.234

1.5.15. **Mission Training and Mobilisation Centre** should: 1.4.162

a. Assess how Company Groups manage the absence or loss of critical command personnel in order to test succession planning within deploying units.

PART 1.6

Convening Authority Comments

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PART 1.6 – CONVENING AUTHORITY COMMENTS

1.6.1. During the late afternoon of 2 Jan 17, while deployed on Operation SHADER[1], Lance Corporal (LCpl) Scott Hetherington received a fatal gunshot wound to his abdomen. He was with Soldier A in the two-man accommodation room they shared in Camp Taji, Iraq. Despite receiving immediate first aid and surgery rapidly afterwards, he was pronounced dead 45 minutes later.

1.6.2. At the time of this tragic accident, LCpl Hetherington was 22 years old. Since joining the Army on 19 Feb 12, he had seen operational service in Afghanistan and conducted overseas training in Kenya. He had been promoted to LCpl in Dec 15. He was described as a superb soldier and a first-class leader. His death is a dreadful loss to his young family and to the 2nd Battalion, The Duke of Lancaster's (King's, Lancashire and Border) Regiment (2 LANCS).

1.6.3. Having convened on 20 Jan 17, this Service Inquiry (SI) has taken longer than normal to report. This was due to associated legal proceedings, primarily the Court Martial (CM) of Soldier A[2]. It was requested the report be withheld and access to Soldier A limited until CM proceedings had been completed in Mar 19. The Director of Service Prosecutions (DSP) did agree to non-prejudicial recommendations being released and this was done in Jul 18[3].

1.6.4. I am grateful to the SI President and his Panel for their comprehensive Report. It is thorough in its consideration and analysis of the evidence gathered and has met fully the Terms of Reference (TOR) set. I agree with its findings and recommendations, which if implemented fully, will help prevent a recurrence of a similar accident. This Report will be applicable beyond just those users of the General Service Pistol (GSP) and other Infantry weapon systems. Its examination of cultural and behavioural issues makes it a valuable leadership study, especially for those training for and deploying on operations.

1.6.5. LCpl Hetherington died from a gunshot wound to the abdomen. The gunshot was the result of an unintended discharge from Soldier A's GSP. A lack of individual discipline, notably unsafe and inappropriate weapon handling led directly to this unintended discharge.

1.6.6. These comments will focus on those factors that made the accident more likely – the 9 Contributory Factors. Whilst there were no Aggravating Factors – factors that made the final outcome of the accident worse, the SI identified a large number of Other Factors and Observations[4]. A number of these concern Command Climate, Culture and professional development and are covered prior to my Concluding Comments.

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[1] Operation SHADER is the name given to the UK's military contribution to the 68-member global Coalition committed to defeating Daesh in Iraq within the US-led Operation INHERENT RESOLVE. LCpl Hetherington was in the Force Protection Platoon within the UK Training Team (Taji) subunit group, itself formed around a core from Blenheim Company, 2 LANCS.

[2] Soldier A unintentionally fired the round from his GSP, which caused the death of LCpl Hetherington.

[3] Non-prejudicial recommendations aimed at preventing a similar occurrence were issued by DG DSA to DCGS and members of the Defence Safety Committee on 19 Jul 18 (DSA/DG/COMMS/DCGS dated 19 Jul 18)

[4] An Other Factor may cause or contribute to a future accident, and an Observation is made for subsequent consideration to improve working practices.

Unsafe Acts – Causal Factors

1.6.7. Extensive policy is in place concerning the use and handling of weapon systems, including the GSP[5]. All soldiers are taught that they are, at all times, responsible for the safe handling of their weapons. This training starts from initial Skill at Arms lessons and is repeatedly reinforced throughout a career. Despite this, Soldier A's GSP was Made Ready to fire, pointed in an unsafe direction and the trigger operated. These 3 Unsafe Acts were identified as Causal Factors, which led directly to the accident[6].

Preconditions for Unsafe Acts – Contributory Factors

1.6.8. In examining the preconditions which led to these Unsafe Acts taking place, 5 of the overall 9 Contributory Factors were identified[7] in this group. These made the accident more likely to happen.

1.6.9. The first concerned Soldier A's limited familiarity with the GSP. Whilst trained and qualified, his familiarity with the weapon was considered limited relative to the other Infantry weapon systems on which he was trained. He was only introduced to the GSP some 3 and a half months prior to arriving in theatre. This short time period suggests a need to consider the timing of GSP training, which should reflect its more routine carriage and use. Despite the challenges of incorporating GSP training into busy unit programmes, its earlier and more frequent exposure would improve familiarity, expertise and respect for the weapon. This echoes the findings of a recent Non-Statutory Investigation into the Glock GSP, following a number of unintended discharges across Defence[8].

1.6.10. The operational and training tempo facing the Force Protection Platoon (FP Pl) was identified by the MOD Human Factors (HF) Psychologist as not stimulating the soldiers fully. This ran counter to expectations, which arguably were rooted more in the high intensity operations of recent UK involvement in Afghanistan and Iraq. Deployment to Camp Taji was considered relatively benign and, by a number of FP Pl soldiers interviewed, boring. The FP Pl's task was to provide security to the UK Training Teams. However, at the time of the accident, they had conducted this task only 3 times per week, with no tasks at night and each day task lasting for no more than 6 hours[9]. In early Jan 17, the light tempo of training and operations, which did not stimulate FP Pl members, in conjunction with a desire for a more kinetic tour, could have set the conditions for less mature individuals with high impulsivity to 'mess around' with their pistols. This made the accident more likely.

1.6.11. Opinions gathered in evidence from members of the FP Pl indicated the GSP was regarded as an attractive novelty in contrast to the SA80 rifle. This 'novelty factor' was reinforced through: its recent introduction, a lack of familiarity on its use, its high perceived 'social value' and with its construction being perceived as 'plastic' and it being like a 'new toy', owing to its significant polymer composition. All these contributed to the GSP being

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[5] JSP 398 Part 2 (V2.0 Mar 17) Annex D (known as Card Alpha) for guidance on when to open fire for the protection of human life. Directorate Land Warfare, Doctrine Note 15/11. Op CARDEL, [redacted], and UKTT(Taji) Standing Orders, which defined rules for the safe carriage and control of weapons for UK personnel in Camp Taji.

[6] 3 x Causal Factors were identified that led directly to the accident. **The Weapon State** – Soldier A lost awareness of his weapon's state. In the absence of a compelling hypothesis, it was highly likely that Soldier A unwittingly Made Ready his GSP in his accommodation while playing with it. **Directional Safety** – Soldier A pointed his weapon in an unsafe direction, and **Trigger Discipline** – the trigger mechanism of Soldier A's weapon was operated.

[7] These particular 5 (of the total 9) Contributory Factors (which made the accident more likely) were: the timing of GSP training, low operational and/or training stimulus, a lack of respect for the GSP, Soldier A not upholding standards as required for a JNCO, and Soldier A's relationship with LCpl Hetherington.

[8] DAIB/18/012 – Glock Pistol Safety Issues, dated 20 November 2018.

[9] This is despite the Battle Group Headquarters (BG HQ) having directed that 'Continuation Training' be undertaken.

regarded with a lack of respect, especially when compared to the SA80, which was regarded as more of a functional tool.

1.6.12. Evidence from Soldier A's peers regarding his behaviour and professionalism predominantly referred to him as failing to display the standards expected of a JNCO. He was considered good in the field, but poor in barracks and at times lazy, ill-mannered and immature. Regardless, as a JNCO, he was trusted and given responsibility. This included being authorised to supervise and be supervised for the loading and unloading of weapons. On 2 Jan 17, Soldier A and LCpl Hetherington would have supervised each other to complete weapon loading drills at the Weapon Unloading Facility (WUF). The SI believed that this formal process either didn't take place or their 'peer supervision' was too relaxed and ineffective. Furthermore, the fact that LCpl Hetherington and Soldier A were very close friends would have removed any supervisory 'authority gradient'. Their friendship led, at times, to disruptive behaviour which had affected others. As a consequence, they were posted to different rifle companies in Oct 15, but brought back together again in Blenheim Company (and allowed to share a room) as an expedience during the Battalion's pre-deployment reorganisation. Not upholding the safety and professional standards required of JNCOs and the behaviours displayed in their relationship made the accident more likely.

Command and Organisational Influences – Contributory Factors

1.6.13. Both Soldier A and LCpl Hetherington were members of the FP Pl. The FP Pl was commanded by a young and inexperienced junior officer on his first operational tour. The Platoon Commander (Pl Comd) was supported by a widely respected, robust, yet relatively inexperienced platoon sergeant (Pl Sgt) and a number of other JNCOs. Despite this leadership construct, the SI found supervision and management insufficient to prevent the sequence of events that ultimately led to the accident. The prevalence of 5 core issues supported this[10].

1.6.14. [redacted] negatively influencing supervision. The SI identified 2 examples that took place on 2 Jan 17, where poor supervision and poor military judgement resulted in action not being taken to address unsafe standards of weapon handling. These set the conditions which made the accident more likely. The Company Sergeant Major (CSM) had 16 years service and numerous operational tours under his belt. He was highly regarded throughout 2 LANCS and known for exerting robust leadership over his soldiers. He would have been a significant presence in Taji, but at the time of the accident was conducting in-theatre processing and training, his deployment having been delayed [redacted]. The absence of the CSM was assessed to have weakened the chain of command and the ability to maintain appropriate standards and made the accident more likely.

1.6.15. There is a formal process for Minor Administrative Action (MAA). This exists to rehabilitate, censure or initiate sanctions to correct professional or personal failings. It is used by the chain of command to safeguard or restore operational effectiveness and efficiency. In 2 LANCS the authority to administer MAA was delegated to JNCO level. There was a belief in Blenheim Company that MAA was being used appropriately, but evidence suggests this was not the case, especially regarding Soldier A. Numerous instances were uncovered where, in the SI Panel's opinion, Soldier A should have been

[10] The 5 issues were – Leadership Dynamic, Over Familiarity, Poor Military Judgement, Problem Recognition and the Management of Soldier A.

subjected to MAA. One of these took place in Nov 16 and involved Soldier A and LCpl Hetherington engaging in a 'quick-draw' competition with unloaded GSPs. Not applying the formal process of MAA to record and correct professional failings made the accident more likely.

1.6.16. UKTT (Taji) Company Group (Coy Gp) comprised numerous cap-badges formed around a core from Blenheim Company, 2 LANCS. The Company had earned a strong professional reputation following good performances during prior non-operational training events. This was not the case during their Mission Rehearsal Exercise (MRX), where clues regarding weaknesses in the Coy Gp's command climate became apparent. Mission Training and Mobilisation Centre (MTMC) staff evidence portrayed a perception of a Coy Gp with an over-inflated self-belief, an unimpressive approach to training and a command climate and leadership dynamic that had become a concern to MTMC staff. Evidence cited 'an arrogance to training' displayed by some key individuals, the Coy Gp demonstrating ineffective control of information, events and personnel, and FP PI soldiers, including Soldier A, messing around with their (unloaded) GSPs.

1.6.17. These concerns were recorded formally in the Assurance Note that followed the MRX, but not effectively. The 'anonymous style' adopted by subsequent editing (including by Comd MTMC) of the Assurance Note undermined these concerns and served instead to shield individuals and the specifics of any shortfalls. Furthermore, none of the concerns relating to command culture and approach to training were briefed to Comd 42 Inf Bde or CO 2 LANCS at the After Action Review (AAR). This resulted in missed opportunities for the chain of command to understand shortfalls and intervene to ensure appropriate standards of company level supervision, leadership and culture.

Broader Aspects – Other Factors and Observations

1.6.18. A number of Other Factors and Observations were made. Of these, I highlight the importance of information and knowledge management. The SI is littered with examples of information inaccuracy, poor record keeping, an immature approach to the sharing of information and failures of knowledge exchange[11]. To learn lessons from our experiences, particularly those involving small arms, Defence relies on the accurate reporting of occurrences, near misses and hazards. Yet this investigation has highlighted that the number of negligent discharges across Defence is not accurately quantifiable. As a consequence, precisely targeted interventions to adjust policy, rules or guidance and deliver safer behaviours are difficult to achieve. A longer-term ambition across the Army and Defence must be to improve the timely collection of accurate information and its use.

Concluding Comments

1.6.19. This SI has focused sharply on Command Dynamics and Human Factors. A lack of discipline led to a climate within which violation and a Failure to Follow Procedures prevailed. The chain of command's responsibility to understand its personnel and act and apply timely interventions to address root causes, including the application of the MAA process, to change behaviours, should become routine and accepted as a vehicle for personal development.

1.6.20. Many of the accident factors in this SI mirror those I identified as Defence Prevalent Accident Factors in my Annual Assurance Report to the Secretary of State[12]. These were a

[11] This tragic death was not the first accident caused by the unintentional discharge of a firearm. Indeed, just 6 months prior to LCpl Hetherington's death, another infantry soldier negligently fired his pistol in the same accommodation block in Taji on Operation SHADER, slightly injuring 2 soldiers.

[12] Defence Safety Authority Annual Assurance Report Apr 17 – Mar 18, Section 6.3, dated 26 October 2018.

Failure to Follow Procedures, a lack of appropriate Supervision and ineffective or inadequate Leadership. The latter also requires a Moral Courage from leaders to take positive action to address transgressions and an honest and transparent reporting culture.

1.6.21. In writing my comments as the Convening Authority, my thoughts have been with those bereaved or close to LCpl Scott Hetherington. On behalf of all members of the DSA, I offer my sincere condolences.

Lieutenant General R F P Felton CBE
Director General
Defence Safety Authority

