1.4.157. The Human Factors report categorised the medical cover and medical guidance as a supervisory factor due to 'inadequate and absent supervision'. It stated that the staff at AC (L) had neither the knowledge, skills or experience nor the readily available emergency first aid resources to provide immediate medical assistance. The report also commented on the lack of shared situational awareness of what to do and how to respond in situations where candidates obviously required immediate medical assistance but were breathing, conscious and not bleeding. It concluded that there was a need for 'more effective oversight and supervision of both the medical cover plan and the medical guidance protocols'. Exhibit 234 Exhibit 284

1.4.158. It was the opinion of the SI Panel that a detailed medical plan or medical SOI would, more likely than not, have reduced the chances of certain events occurring. Examples of these were Candidates 1, 2, [redacted] having lowered body temperatures on arrival at hospital, the ambulance for Candidate 1 not being called until after he had been reviewed in the Spirometry Room by the Lead Assessor and the ambulance called for Candidate 2 initially going to the church rather than the Harden Centre. In addition, a detailed medical plan or medical SOI would have ensured that all AC (L) staff knew what to do and what to expect in the event of a serious medical incident. It could also have included assistance from the medical staff at AC (L) for the staff conducting the RFT (E) 2km run. Exhibit 74 Exhibit 79 Exhibit 85 Exhibit 109 Exhibit 118-123 Exhibit 237

1.4.159. Therefore, the SI Panel concluded that the lack of a medical plan or medical SOI, and the training to accompany these, likely increased the risk to candidates in the event of them becoming unwell at any point during the Soldier Selection.

1.4.160. The Service Inquiry Panel finds that the lack of a medical plan or medical Standard Operating Instruction, and the training to accompany these, was an **Aggravating Factor**.

1.4.161. **Recommendation. The Chief Executive Officer Recruiting Group should introduce a medical plan or Standard Operating Instruction for the management of candidates who suffer injury or illness at any point during the Soldier Selection process, in order to optimise the management and treatment of these candidates.**

PTI first aid training

1.4.162. JSP 375 Volume 1 Chapter 5 (JSP 375 Ch 5) established the procedures and guidance for the provision of first aid throughout Defence, in order to meet the requirements of the Health and Safety (First Aid at Work) Regulations (FAWR). Although the FAWR did not apply to Service personnel, MOD policy required the same level of provision of first aid cover to Service personnel as was required for civilians under the FAWR. While there was no legal duty to provide first Exhibit 226

aid to non-employees under the FAWR, the Health and Safety Executive (HSE) strongly recommended that they were included in any first aid provision assessment. In addition, JSP 375 Ch 5 gave responsibility to Commanding Officers (COs) and / or Heads of Establishment (HoE), as Accountable Persons, for the provision of first aid cover for visitors under their control. COs were responsible for ensuring that suitable arrangements were in place to manage the provision of first aid cover for all activities involving visitors under their control whereas the HoE was responsible for ensuring that suitable arrangements were in place for the provision of first aid cover in occupied buildings, lodger units, and visitors to sites under their control. The CO / HoE were also jointly responsible for ensuring that a written risk assessment for the activities and areas under their control identified the first aid requirements (including the number of trained First Aiders and first aid kits) and the necessary actions to be taken to provide adequate first aid cover.

1.4.163. JSP 375 Ch 5 defined first aid at work (FAW) as 'the provision of immediate care to an individual who has sustained an injury or illness in the workplace' and a First Aider as a 'civilian or Service personnel (sic) who has passed a First Aid training course from a competent training provider and holds either a valid (in date) EFAW [Emergency First Aid at Work] or FAW [First Aid at Work] Certificate and has undertaken the role voluntarily'. The MOD managed the provision of FAW through a combination of four roles: Exhibit 226

a. Appointed Person (AP) – the person who had the responsibility for taking charge in an emergency situation when an individual became ill or was injured at work, either by finding a trained First Aider (or other suitably trained medical provider) or calling for an ambulance. Although no formal training was required for this role, JSP 375 Ch 5 advised that they may benefit from attending an Emergency First Aid at Work course.

b. Emergency First Aid at Work (EFAW) – the minimum standard for the delivery of first aid in the workplace. This course involved at least 6 hours of training and was run over a minimum of 1 day.

c. First Aid at Work (FAW) – this provided additional training, covering a broader syllabus than EFAW, which included the recognition and treatment of a wider range of conditions. This course involved at least 18 hours of training and was run over a minimum of 3 days.

d. A recognised first aid qualification from a recognised body.

1.4.164. JSP 375 Ch 5 listed some of the responsibilities of First Aiders as follows: Exhibit 226

a. They had to maintain their knowledge and skills and work within the guidelines of the first aid training organisation that issued their qualification. It noted that there was significant skill fade after as little as 6 months if first aid was not practised regularly and it recommended that refresher training was undertaken annually.

b. They had to ensure that a record was maintained of all incidents that they attended and of the outcome.

c. They had to keep any first aid equipment provided to them in a serviceable condition.

1.4.165. When conducting the RFT (E) 2km run, the PTIs at AC (L) rotated between the tasks of Lead PTI (who remained on the finish point of the run) and 'Rearmarker' PTI. Paragraph 53c of RG SOI 7 stated: 'The PTI acting as a 'Rearmarker' is to be competent at administering First Aid to anyone suffering from injury or illness.' At the time of the two accidents, the HSE defined competence as 'the combination of training, skills, experience and knowledge that a person has and their ability to apply them to perform a task safely.' It stated that an employer should take account of the competence of relevant employees when conducting risk assessments in order to help decide what level of information, instruction, training and supervision employers would need to provide. Exhibit 43 Exhibit 240

1.4.166. Both civilian AC (L) PTIs (PTI1 and PTI2) completed Basic Life Support (BLS) / Automated External Defibrillation (AED) training on 9 April 2018. This BLS / AED training was a course run by the British Red Cross and was valid for 3 years. BLS / AED training only provided training on the algorithm for the initial management of casualties who were unconscious and not breathing (and who may or may not have required external defibrillation). It was a specific algorithm for a specific clinical condition and it was a small component of many first aid courses. Therefore, it was the opinion of the SI Panel that BLS / AED training, on its own, was neither sufficient training for the PTIs to be considered to be 'competent at administering first aid', as judged against the HSE definition of competence nor did it meet the minimum first aid training requirements (EFAW) for First Aiders directed in JSP 375 Ch 5. Exhibit 221 Exhibit 226 Exhibit 230 Exhibit 240 Exhibit 251

1.4.167. An external Business Assurance (BA) report in August 2018 stated that the PTIs at that time did not have in-date first aid training as a minimum level, but it noted that there were other staff members at AC (L) who held the First Aid at Work (FAW) qualification, awarded by the British Red Cross. In addition, it was noted as an observation in the BA report in 2018 that the necessary action at that time was to ensure that there were sufficient first aid trained staff to cover each intake. The internal Capita review that followed the accidents involving Candidate 1 and Candidate 2 (Project Glass), conducted in March 2020, also acknowledged the need for FAW training. In July 2020, ARITC stated Exhibit 231 Exhibit 238-239 Exhibit 251

that there was an intention to provide FAW training with a bespoke 1 day package delivered by the British Red Cross. However, this was put on hold temporarily due to national COVID-19 restrictions within the UK in 2020.

1.4.168. The SI Panel were provided with conflicting evidence regarding the first aid qualifications of the PTIs who were the Lead PTIs and 'Rearmarker' PTIs during the RFT (E) 2km runs on 17 and 27 November 2019. In written evidence provided to the SI Panel by ARITC in July 2020 it was stated that none of the PTIs nor supporting staff were specifically FAW trained on 17 or 27 November 2019. ARITC explained that the requirement at that time was that the PTIs had first aid training, but no specific qualification was stipulated. However, in further written evidence provided to the SI Panel from HQ RG in October 2020, it was stated that while there was no one present who was FAW trained on 17 November 2019, there was a FAW trained PTI present on 27 November 2019. However, HQ RG also explained that FAW training was very basic 'in the office' training, and it was not particularly applicable to PTIs in this context. Exhibit 201 Exhibit 251

1.4.169. HQ RG did acknowledge that it would be best practice to have as many AC staff FAW trained as possible. In October 2020 they again explained that they were working with the British Red Cross to put together a bespoke 1 day first aid course to combine the emergency FAW course programme with additional aspects specific to the activities carried out at the ACs. Exhibit 201

1.4.170. According to the British Red Cross website, their 3 day FAW training course provided learners with the first aid skills and confidence to help someone suffering with one of several medical emergencies, including injuries to bones, muscles or joints, as well as to assess and to monitor casualties, including those who were unresponsive, to record and report accidents and to use an AED. It was the opinion of the SI Panel that the bespoke, 1 day first aid training course planned to be delivered to AC staff by the British Red Cross was likely to cover the aspects of the 3 day FAW training course most pertinent to injuries and illnesses expected during the Soldier Selection process and it was likely to be similar to the EFAW training described in JSP 375 Ch 5. However, JSP 375 Ch 5 was clear that EFAW certification was the minimum acceptable training standard for first aid provision. Exhibit 226 Exhibit 230

1.4.171. Therefore, it was the opinion of the SI Panel that either the EFAW training course or the bespoke 1 day first aid training course that was planned by RG and the British Red Cross would provide significantly more first aid training than standard BLS / AED training, which typically lasted for less than half a day. It was highly likely that such courses would provide AC PTIs with a greater skill set and greater

confidence to administer first aid should a candidate suffer injury or illness during the RFT (E) 2km run.

1.4.172. The Human Factors report also raised concerns about the lack of first aid training and skills that AC (L) staff reported. The Human Factors report stated that 'how to respond with first aid to exertional collapse incidents was not understood, clear formal procedures and response options were not readily available and critical steps in the emergency procedures were missed' and that 'there is no shared situational awareness of what to do in situations where the candidate obviously needs immediate medical assistance but is breathing, conscious and not bleeding'. It concluded that there was a need for 'more advanced first aid training for staff'. Exhibit 234 Exhibit 236 Exhibit 284

1.4.173. It was the opinion of the SI Panel that although the civilian AC (L) PTIs were in-date for BLS / AED training, neither of the civilian PTIs present during the accidents in November 2019 were 'competent at administering First Aid to anyone suffering from injury or illness', as judged against the HSE definition of competence, nor did they possess the minimum standard of first aid training as directed in JSP 375 Ch 5. This potentially increased the risk to the candidates should they suffer injury or illness during the RFT (E) 2km run. The degree to which the risk to candidates might have been increased would have depended upon several factors, including whether or not the first aid training included the management of the injury or illness sustained by the candidates, as well as the availability of medical equipment.

1.4.174. The SI Panel concluded that the civilian PTIs at AC (L) did not receive sufficient training to ensure their competence at administering first aid to candidates suffering from injury and illness during the RFT (E) 2km run. However, the SI Panel concluded that this played no part in the specific accidents in question as first aid training at the time of the two accidents was unlikely to cover the immediate medical management of ECAST.

1.4.175. The Service Inquiry Panel finds that the lack of sufficient first aid training amongst Assessment Centre (Lichfield) Physical Training Instructors was an **Other Factor**.

1.4.176. **Recommendation. The Chief Executive Officer Recruiting Group should ensure that all Assessment Centre Physical Training Instructors, as well as other Assessment Centre staff who are regularly involved in the Role Fitness Test (Entry), conduct regular first aid training, to an appropriate standard, in order to provide an effective response should injury or illness occur.**

1.4.177. In addition, it was the opinion of the SI Panel that using PTIs with first aid training was only one of a number of possible options to

provide medical cover for the RFT (E) 2km run. Therefore, the SI Panel made an additional recommendation, as detailed below.

1.4.178. **Recommendation. The Chief Executive Officer Recruiting Group should determine the appropriate level of medical cover for future Role Fitness Test (Entry) (RFT (E)) 2km runs and should determine the appropriate level of training for those Assessment Centre staff conducting future RFT (E) 2km runs (including training on oxygen delivery), in order to safely manage a candidate suffering exertional collapse during the RFT (E) 2km run.**

Wet Bulb Globe Temperature monitor training

1.4.179. The Wet Bulb Globe Temperature (WBGT) monitor was a measurement tool that used ambient temperature, relative humidity, wind speed and solar radiation to measure and monitor environmental conditions. Its use was mandated by JSP 539[27] (Heat Illness and Cold Injury: Prevention and Management), which detailed guidelines that dictated modifications in activity (eg the intensity of the activity, the regularity of hydration breaks, the equipment worn, and the duration of physical activity) depending upon the WBGT readings. JSP 539 also detailed climatic thresholds and gave guidance on conducting military activities. It stated: 'The upper limits should be adhered to in training, unless the implementation of additional control measures adequately reduces the risk.' WBGT monitors were provided at each AC and these, alongside the guidance in JSP 539, provided AC (L) staff with a reliable method of assessing the risks associated with climatic conditions prior to, and during, the RFT (E) 2km run.

Exhibit 6
Exhibit 73-74
Exhibit 107
Exhibit 262-263

1.4.180. JSP 539 stated that all Service personnel should have been able to recognise the symptoms of heat illness and cold injury, alongside being aware of methods of preventing these conditions and the initial first aid management of them. JSP 539 also stated that training on the use of the WBGT monitor had to be provided on the AAPTI course and that individuals were to receive education and training on the use of the WBGT during periodic mandatory training, in accordance with single Service policy, and through targeted refresher training.

Exhibit 262-264

1.4.181. PTI1 and PTI2 were Regular Army PTIs prior to being employed as civilian PTIs. PTI1 completed an older version of the AAPTI course in 1998 and PTI2 completed a newer version of the AAPTI course in 2010. Due to further changes in the course design of the AAPTI course since then, it could not be confirmed by the SI Panel if PTI1 and PTI2 had completed WBGT monitor training on their AAPTI courses. Both PTI1 and PTI2 also held civilian 'personal trainer'

Exhibit 63-65
Exhibit 218-219
Exhibit 222-224

[27] Previous guidance in JSP 539 on preventing heat illness and cold injury was superseded by JSP 375 Chapters 41 and 42, respectively, on 29 October 2020.

qualifications but the courses they had completed did not cover WBGT monitor training. However, during the SI Panel interviews, PTI1 provided an explanation on the use of the WBGT monitor on Soldier Selection. Therefore, the SI Panel concluded that it was likely that PTI1 had previously received some training on how to use the WBGT monitor. However, the SI Panel were shown no evidence that PTI1 had received formal WBGT monitor training. PTI2 had been a PTI at AC (L) since 2016, after a 3-year break from a military environment. The SI Panel were shown no evidence that PTI2 had received formal WBGT monitor training. PTI3 was a serving military PTI who had completed a newer version of the AAPTI course in 2017, which included WBGT training, and was present during the accident of Candidate 2. Due to the 10-year competency gained from completing the AAPTI course, PTI3 was in-date for WBGT monitor training.

1.4.182. The SI Panel were unable to find evidence that periodic mandatory training, in accordance with single Service policy, or targeted refresher training on heat injury prevention and WBGT monitor training had taken place for the staff at AC (L). In addition, RG acknowledged that prior to the two accidents they were not aware of the latest WBGT training introduced by the Army in July 2016, following the death of a soldier on an Annual Fitness Test. Further RG emails forwarded to the SI Panel (dated April and May 2020) stated that several of the Army core policies on heat injury prevention and training (including WBGT monitor training) that had been re-written and amended had 'missed us completely' and had 'passed us by'. RG later explained that they had been reliant on ARITC Recruiting Branch to ensure that any changes to Army policy were transmitted to RG and Capita.

Exhibit 265
Exhibit 267
Exhibit 427

1.4.183. The AC PTIs were responsible for the safe delivery of the physical assessments on Soldier Selection, including assessing and monitoring climatic conditions. The reported air temperature on the morning of 17 November 2019 was 7°C and the reported air temperature on the morning of 27 November 2019 was 9°C. However, WBGT monitor readings were not recorded immediately prior to the RFT (E) 2km runs involving Candidate 1 and Candidate 2. Evidence was later obtained by the SI Panel that the WBGT monitor had been removed from AC (L) for calibration during the period covering both accidents. Therefore, during the period covering the accidents involving Candidate 1 and Candidate 2, there was no WBGT monitor available to accurately measure the environmental conditions. In addition, AC (L) did not hold a second (spare) WBGT monitor to allow WBGT measurements to continue while the first WBGT monitor was undergoing calibration. The SI Panel concluded that the environmental conditions and the risk of climatic injury could not be accurately assessed in the absence of a WBGT monitor.

Exhibit 6
Exhibit 63-64
Exhibit 73
Exhibit 220
Exhibit 265
Exhibit 267

1.4.184. The Human Factors report also raised concerns about the lack of WBGT training. The report stated that it had appeared that there

Exhibit 268

was 'a lack of professional responsibility and diligence on the part of [AC (L)] staff to understand the WBGT policy, administer it correctly, and recognise the potential impact of cold weather on physical performance.' It also noted that there had been no training evident to address this. In addition, the Human Factors report discussed the impact of cold weather conditions on CW candidates and the limited understanding of the AC (L) staff of this factor. The weather was noted in the Human Factors report as an 'uncontrollable variable' and the report discussed the impact of colder temperatures on CW candidates from warmer climates. The report suggested that the contrast in weather experience for CW candidates (coming from their home country to the UK) may have affected them, as it may have been the first time that they had experienced such cold temperatures, they may never have done any physical exercise in such cold weather and they may not have been aware of the impact of the cold weather on their capability and their performance. Therefore, accurate WBGT measurements should have been taken prior to each RFT (E) 2km run to reduce the risk to all candidates of injury in colder temperatures.

Exhibit 262-264
Exhibit 284

1.4.185. It was the opinion of the SI Panel that no WBGT monitor training had been provided to AC (L) staff prior to the accidents involving Candidate 1 and Candidate 2. The SI Panel concluded that the absence of WBGT monitor training was likely to increase the risk of climatic injuries.

1.4.186. The Service Inquiry Panel finds that the absence of a Wet Bulb Globe Temperature monitor on the days of the accidents involving Candidate 1 and Candidate 2 was an **Other Factor**. The Service Inquiry Panel also finds that the absence of Wet Bulb Globe Temperature monitor training for Assessment Centre (Lichfield) Physical Training Instructors was an **Other Factor**.

1.4.187. **Recommendation. The Chief Executive Officer Recruiting Group should ensure that Wet Bulb Globe Temperature monitor readings are taken and recorded as detailed in Joint Service Publication 375, in order to reduce the risk of climatic injury during Soldier Selection events.**

1.4.188. **Recommendation. The Chief Executive Officer Recruiting Group should instigate Wet Bulb Globe Temperature monitor training for all appropriate Assessment Centre staff, in order to reduce the risk of climatic injuries to as low as reasonably practicable.**

PTI Career and Personal Development

1.4.189. RG SOI 7 stated: 'The AC Manager (ACM) is to ensure that enough Physical Training Instructors (PTIs) are trained and available for

Exhibit 43

the safe and efficient conduct of RFT (E) for all CS[28] events.' Paragraph 6 stated: 'AC PTIs are to conduct one day of Career and Personal Development (CPD[29]) per annum. This will take the form of a workshop with assistance requested from the SO2 Physical Development (PD), Head Quarters Army Recruiting & Initial Training Command (HQ ARITC). This is to be arranged by the Business Planning Manager (BPM).'

1.4.190. All the PTIs involved in the accidents on 17 November and 27 November 2019 held the appropriate PT qualifications to enable them to deliver the RFT (E). However, the SI Panel identified that the PTIs had only completed 1 day of CPD training since the start of their employment at AC (L). This CPD, delivered by Staff Officer Grade 2 Physical Development (SO2 PD) ARITC, in March 2019, was a day of training on the delivery of the RFT (E). Prior to March 2019, the PTIs had not completed any PT-related CPD. Exhibit 218 Exhibit 270 Exhibit 253

1.4.191. AGAI Vol 1 stated that PTIs had to remain technically current and competent to deliver training. In the Army this was achieved by regional training and study days and by completing mandated Annual Deficit Training (ADT). ABN 58/17 stated that a record of all PT activity, Continuous Professional Development and In-Service Training (IST) had to be recorded in the individual's PTI logbook. Continuous Professional Development within the Army was an ongoing process of developing, maintaining and documenting professional skills via formal courses and training. CPD and ADT for Army PTIs provided a mechanism to ensure that they were updated on current training methods and equipment. The endorsement of PTI logbooks in the Army provided a further layer of assurance which recorded PTI currency. The SI Panel found no evidence of the use of logbooks, CPD or an ADT programme for AC PTIs. Exhibit 274

1.4.192. The Human Factors report discussed the limited time that AC (L) staff were provided for training and personal and professional development, which included specific PTI training. The report also noted the lack of formal recognition of knowledge and skills. It suggested that the focus was on getting numbers through Soldier Selection rather than staff development, and it suggested that this was likely as a result of commercial pressures. Exhibit 266 Exhibit 284

1.4.193. It was the opinion of the SI Panel that it was very likely that the AC PTIs received limited CPD and no ADT. As a result, this was very likely to have limited the currency and competency of the staff conducting the RFT (E) within the ACs.

---

[28] The term Common Selection (CS) was used in SOI 7, however it was referred to as 'Soldier Selection' throughout this SI report.

[29] The term CPD was also used in the Army, however it was known as Continuous Professional Development.

1.4.194. The Service Inquiry Panel finds that the limited Career and Personal Development, and the lack of Annual Deficit Training and logbooks for the Assessment Centre Physical Training Instructors was an **Other Factor**.

1.4.195. **Recommendation. The Chief Executive Officer Recruiting Group should assure the completion of Career and Personal Development and Annual Deficit Training, and the use of logbooks for Physical Training Instructors in Assessment Centres, in order to ensure their technical currency and competency to deliver the Role Fitness Test (Entry).**

Staff Disclosure and Barring Service clearance

1.4.196. JSP 893 (Policy on Safeguarding Vulnerable Groups) contained the Defence policy on safeguarding vulnerable groups. This included direction on obtaining Criminal Records Bureau (CRB) employment checks to aid the safeguarding of children and vulnerable adults who were part of or associated with the MOD community. The Disclosure and Barring Service (DBS), previously known as the CRB, was used to fulfil part of the safeguarding process for regulated activity involving both vulnerable groups. The DBS was an organisation that assisted employers to make safer recruitment decisions and prevented unsuitable people from working with vulnerable groups, including children. Exhibit 243

1.4.197. The Children Act 1989 defined a child as 'anyone who has not yet reached their 18th birthday'. The fact that a child had reached 16 years of age, was living independently or was in further education, or was a member of the Armed Forces did not change their status or entitlements to services or protection. Exhibit 242-243

1.4.198. There were three levels of DBS checks which could have been completed. These were as follows: Exhibit 243-244

a. Basic. This was a basic criminal record check.

b. Standard. This was a background check used by employers on behalf of applicants.

c. Enhanced. This was a more detailed check that detailed any cautions, warnings, reprimands, or convictions on an applicant's criminal history, and if relevant, could also check against the children or young adults barred list.

1.4.199. Soldier Selection involved a combination of civilian and military staff from AC (L) monitoring and supervising individuals aged 15 years and 9 months old up to 37 years old. As a result, all AC (L) staff Exhibit 245 Exhibit 243

were required to hold Enhanced DBS clearance for safeguarding purposes when working with children, in accordance with JSP 893.

1.4.200. The absence of Enhanced DBS checks was identified in the Business Assurance (BA) report in August 2018, prior to the accidents involving Candidate 1 and Candidate 2. Following these accidents, in March 2020, the Project Glass report also identified the lack of Enhanced DBS clearance amongst AC (L) staff. In July 2020, RG stated that when the Enhanced DBS clearances for AC staff had been due in May 2019, they encountered technical issues that hindered the process, and it was confirmed by RG that during the period covering both accidents (17 November to 27 November 2019) not all the assessors and interviewers at AC (L) had Enhanced DBS clearance. By July 2020 this matter had been resolved by RG and all AC (L) staff had completed the appropriate Enhanced DBS checks. Exhibit 203 Exhibit 238-239 Exhibit 275

1.4.201. The RG safeguarding policy, dated November 2017, stated that civilian staff undertook DBS checks during their recruitment process. When members of AC (L) staff had completed their chaperoning duties and their probationary period, the Enhanced DBS checks were completed. As such, it was the responsibility of RG to oversee the implementation of DBS checks for all AC (L) staff. Consequently, it was the opinion of the SI Panel that the lack of Enhanced DBS clearance was contrary to the RG safeguarding policy and this had the potential to raise safeguarding issues in the recruitment process. Exhibit 245 Exhibit 252

1.4.202. The Service Inquiry Panel finds that the lack of Enhanced Disclosure and Barring Service clearance amongst the Candidate Assessors and Candidate Interviewers at Assessment Centre (Lichfield) was an **Observation**. Exhibit 252

The Conduct of the RFT (E) 2km run

Roles and responsibilities

1.4.203. All the Capita (civilian) staff at AC (L) had defined roles and responsibilities in their job specifications. All the military staff who worked at AC (L) were either Non-Commissioned Officers (NCOs) or commissioned officers with defined roles and responsibilities in their Terms of Reference (TORs). The NCOs were part of the AC (L) Candidate Assessors' team, except for the Assessment Centre Sergeant Major (ACSgtM) who was the Facilities Manager. The commissioned officers were employed primarily as Candidate Interviewers. Exhibit 50

1.4.204. From the interviews conducted by the SI Panel at AC (L), it was evident that there was a lack of clarity surrounding the roles and responsibilities of the staff conducting the RFT (E) 2km run. The SI Panel questioned several members of the AC (L) staff regarding who had overall responsibility for the conduct of the RFT (E) 2km run. One Exhibit 50 Exhibit 280-283

member of the AC (L) staff stated that it would have been a PTI, however that PTI could have had several additional roles, depending on AC (L) staff availability. Other members of AC (L) staff were unsure who had the overall responsibility for the conduct of the RFT (E) 2km run. Another member of AC (L) staff commented that there was an expectation that a decision regarding the roles and responsibilities was made the day before the RFT (E) 2km run. Despite the roles and responsibilities that were detailed within the job specifications, a degree of assumption and uncertainty regarding individuals' roles and responsibilities relating to the conduct of the RFT (E) 2km run appeared to exist. The SI Panel concluded that this uncertainty may have impacted on the risk management procedures relating to the conduct of the RFT (E) 2km run at AC (L).

1.4.205. The Service Inquiry Panel finds that the lack of clarity regarding individuals' roles and responsibilities relating to the conduct of the Role Fitness Test (Entry) 2km run was an **Other Factor**.

1.4.206. **Recommendation. The Chief Executive Officer Recruiting Group should ensure that Assessment Centre staff are aware of their roles and responsibilities relating to the conduct of the Role Fitness Test (Entry) 2km run, in order to ensure the safe and efficient conduct of the run.**

RFT (E) equipment

1.4.207. The MTP test, used during Soldier Selection, assessed the muscular strength of the lower limbs. The equipment used to conduct this test is shown at Figure 1.4-11. The minimum score to be achieved by each candidate was matched against their preferred Army role.

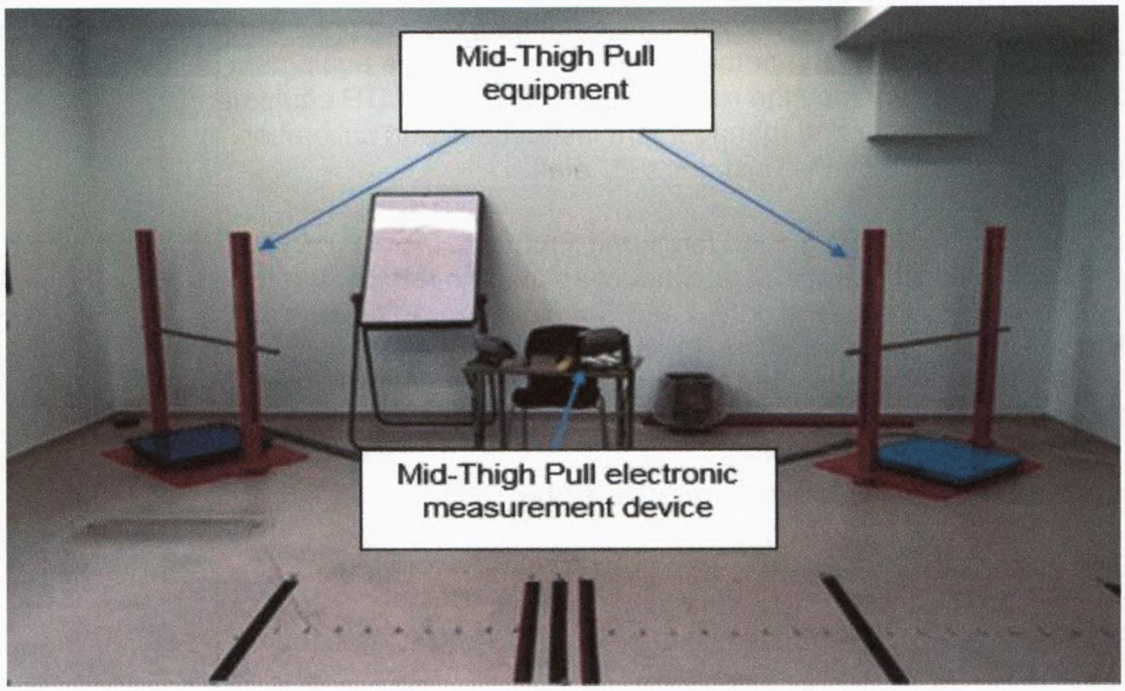


Figure 1.4-11 – The MTP platforms in the PD suite. Exhibit 246

1.4.208. The MBT test, used during Soldier Selection, assessed the explosive power of the upper body. The MBT was delivered within the area of the PD suite shown at Figure 1.4-12. The minimum score to be achieved by each candidate was matched against their preferred Army role.

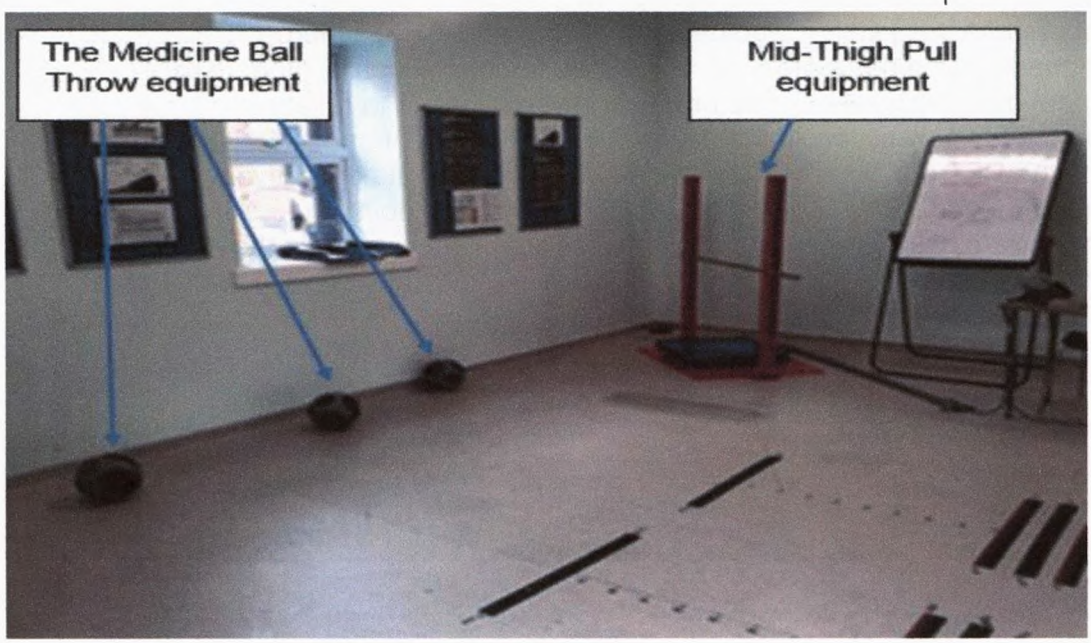


Figure 1.4-12 – The MBT area in the PD suite. Exhibit 383

1.4.209. The MTP equipment had only been held at ACs since April 2019 and held an initial 3-year maintenance contract. The equipment at each site was managed by the respective AC staff. The MTP equipment had daily maintenance and management instructions and calibration was to be conducted by the host unit's PT staff. Exhibit 253

1.4.210. ARITC SOI PES Standards and Protocols (April 2019) stated that a stop watch was required to conduct an aerobic run. During the RFT (E) 2km runs that Candidate 1 and Candidate 2 participated in, the PTIs used their personal watches to record candidates' finishing times. The SI Panel were not able to ascertain how accurate their personal watches were. The SI Panel noted this as an **Observation**. Exhibit 43 Exhibit 254

The RFT (E) 2km run communication plan

1.4.211. RG SOI 7 stated that the Lead PTI must monitor the performance of the candidates during the RFT (E) 2km run. In addition, they were directed to give advice to the other AC (L) staff that supported the RFT (E) 2km run, where necessary. Exhibit 43

1.4.212. The Lead PTI was usually positioned at the finish point, which is shown at Figure 1.4-13 and at Figure 1.4-14. As the position of the Lead PTI was static, it would have been impossible to monitor all the candidates from this position, as stated in SOI 7. Therefore, to resolve this issue, three AC (L) Candidate Assessors positioned themselves around the 1km running route loop to act as route-markers for the RFT (E) 2km run and to monitor candidates as they conducted the assessment. It was established during the SI Panel interviews that members of AC (L) staff (Candidate Assessors and PTIs), when positioned around the route, had no method to communicate, other than personal mobile phones. Therefore, they had no means to reliably communicate collectively in the event of a major incident or accident during the RFT (E) 2km run. The inability to communicate collectively denied the Lead PTI, who was positioned at the finish point, the opportunity to give advice to multiple AC (L) staff concurrently in the event of a medical emergency. Exhibit 43 Exhibit 78 Exhibit 81 Exhibit 108 Exhibit 271

Figure 1.4-13 – The RFT (E) run finish point. | Exhibit 247

Figure 1.4-14 – The RFT (E) route at AC (L). | Exhibit 248

1.4.213. During the accidents involving Candidate 1 and Candidate 2, due to the location of each accident, the staff could respond without the need for immediate communication via radios. Figure 1.4-14 shows the point that Candidate 1 stopped and the point that Candidate 2 collapsed. Exhibit 81 Exhibit 85 Exhibit 118 Exhibit 271

1.4.214. After the accident involving Candidate 2, it was recognised by RG that AC (L) lacked an effective communication plan for the RFT (E) 2km run. Consequently, following the two accidents, six radios were issued to AC (L). During the RFT (E) 2km run these radios were distributed to the Lead PTI on the finish line, the 'Rearmarker' PTI running at the rear of the RFT (E) 2km run, the three route-markers and the Candidate Assessor manning the phone in the AC (L) reception. While the SI Panel acknowledged that these radios improved communications on the RFT (E) 2km run, it was established in January 2020 that the safety vehicle still had no method to communicate collectively with the AC (L) staff monitoring the RFT (E) 2km run. AC (L) staff stated that the PTI running at the back of the RFT (E) 2km run, in front of the safety vehicle, had a radio and therefore the safety vehicle did not require a radio. However, it was the opinion of the SI Panel that the lack of a radio in the safety vehicle may have delayed an immediate response. In addition, AC (L) were provided with six radios for the RFT (E) and all radios were required to be used during the RFT (E) 2km run. This allowed for no spare radio in the event that a radio was unavailable. Exhibit 271-273

1.4.215. No radios were used during the accidents involving Candidate 1 and Candidate 2. It was the opinion of the SI Panel that, if the accidents had occurred out of sight of the AC (L) staff or the safety vehicle, then the lack of radios may have exacerbated the situation and potentially could have been an Aggravating Factor. However, this was not the case in the accidents involving Candidate 1 and Candidate 2.

1.4.216. The Service Inquiry Panel finds that the lack of radios during the Role Fitness Test (Entry) 2km run was an **Other Factor**.

1.4.217. **Recommendation. The Chief Executive Officer Recruiting Group should ensure that there is a robust and effective communication plan for the staff conducting the Role Fitness Test (Entry) 2km run at all Assessment Centres, in order to ensure effective communication between all staff members in the event of an incident or accident.**

The safety vehicle on the RFT (E) 2km run route

1.4.218. Paragraph 51 of RG SOI 7 discussed the requirements for the RFT (E) 2km run. It stated: 'A safety vehicle driver will be required if a safety vehicle is used.' Paragraph 52g stated: 'When a safety vehicle is used, the driver is responsible for following the last participant around the route and picking up any participant (or member of the Conducting Exhibit 43

Staff) that requires transporting to the finish of the test.' During the RFT (E) 2km runs at AC (L) on 17 and 27 November 2019, one safety vehicle was used and pictures of this safety vehicle can be found at Figure 1.4-15.

Figure 1.4-15 – The safety vehicle. Exhibit 49

1.4.219. During the accidents involving Candidate 1 and Candidate 2, both individuals were nearing the end of RFT (E) 2km run. Candidate 1 stopped approximately 400m from the finish of the RFT (E) 2km run and Candidate 2 collapsed approximately 200m from the finish. However, if these accidents had occurred on the first lap of the route, the safety vehicle would have been busy dealing with the accident, and not supporting the RFT (E) 2km run. SOI 7 provided no guidance on whether or not the RFT (E) 2km run should have continued or have been stopped in these circumstances and this situation could potentially have

Exhibit 6
Exhibit 43
Exhibit 73
Exhibit 78
Exhibit 81
Exhibit 108
Exhibit 271-273

been exacerbated by the lack of a robust communication plan, as previously discussed.

1.4.220. Paragraph 5d of SOI 7 stated: 'the defibrillator can be carried by the PTI at the rear of the group or on the Safety Vehicle.' The safety vehicle on 17 and 27 November 2019 contained bottles of water and blankets, and the only medical equipment carried was the basic vehicle first aid kit and an AED, as previously discussed. Exhibit 43

1.4.221. After the accident involving Candidate 2, the lack of standardised safety vehicle equipment that would have assisted AC staff in dealing with an incident or accident was recognised by RG. The safety vehicle equipment that was required to be carried in the safety vehicle during the RFT (E) 2km run was expanded and it was detailed in the updated version of the SOI 7 dated 1 June 2020. Exhibit 255

1.4.222. There was no prescribed safety vehicle equipment list at the time of the accidents involving Candidate 1 and Candidate 2. In addition, SOI 7 provided no guidance on whether or not the RFT (E) 2km run should have continued or should have been stopped, if a candidate required medical attention. SOI 7 also provided no guidance on further actions for the safety vehicle and the remainder of the AC staff in the event of an incident or accident during the RFT (E) 2km run. The SI Panel concluded that the lack of information regarding the RFT (E) 2km run safety procedures was likely to have added uncertainty and unnecessary risk, should a further incident or accident have occurred. Exhibit 43 Exhibit 255

1.4.223. The Service Inquiry Panel finds that the lack of a safety vehicle equipment list and the lack of information regarding the use of the safety vehicle during the Role Fitness Test (Entry) 2km run within Standard Operating Instruction 7 was an **Other Factor**.

1.4.224. **Recommendation. The Chief Executive Officer Recruiting Group should provide policy regarding the minimum safety equipment to be carried and the use of a safety vehicle during the Role Fitness Test (Entry) 2km run, in order to provide an appropriate safety capability to deal with safety incidents.**

The RFT (E) 2km running route

1.4.225. RG SOI 7 stated: 'The Aerobic Test (Run) is to be conducted on a 2km (800m warm-up and 2km best effort) course on level ground affording a good running surface (a 400m running track may be used).' SOI 7 also stated: 'Where a 400m running tack (sic) is used for the test, the Lead PTI may wish to appoint a Counter to record the number of laps covered by each participant.' AC (L) did not have a 400m running track and only AC (Pirbright), of the three AC locations visited by the SI Panel, had one. Exhibit 43

1.4.226. The annual audit report produced by a civilian contractor in 2018 for RG assessed the running route of the PSS (R), which is pictured at Figure 1.4-16. The PSS (R) route was very similar to the RFT (E) route shown at Figure 1.4-14. The PSS (R) covered the same areas of the course where the accidents involving Candidate 1 and Candidate 2 occurred. Exhibit 249

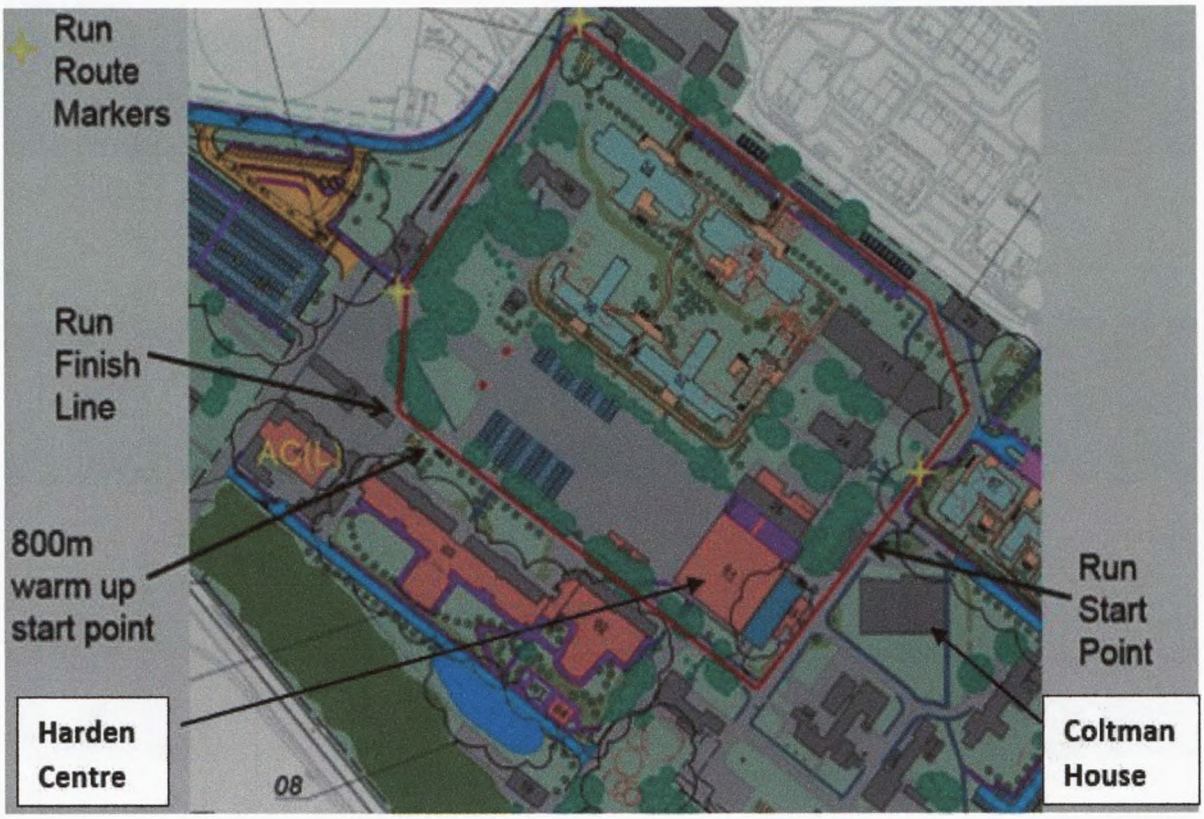


Figure 1.4-16 – The PSS (R) route used at AC (L) prior to April 2019. Exhibit 276

1.4.227. The annual audit report identified a need to 'Investigate better running courses that fulfil the stipulated criteria of 'level ground affording a good running surface'. Where existing 2.4km run courses (shortened to 2km if the proposed pre-employment run test is confirmed) are found to be the best available option, efforts should be made again to get the road surfaces repaired and the start and finish lines clearly marked. Care should be taken when measuring the new course distances and principles agreed on where the running line is measured (eg running 1 metre from curbs on the corners, running the best line through the S-bends etc).' The comment about level ground was in reference to two significant slopes (one downhill and one uphill) on the circular PSS (R) route at AC (L). Exhibit 249

1.4.228. The old PSS (R) route had been reduced by 400 metres due to the implementation of the RFT (E) in April 2019, which resulted in a change from a 2.4km route to a 2km route. Despite the change in PT Exhibit 249

assessment, the new RFT (E) 2km run route still included the slopes which ran downhill from the start point down to the first bend and uphill from the second bend up to Coltman House. This was contrary to the direction in SOI 7. Pictures of the uphill slope can be found at Figure 1.4-17 and at Figure 1.4-18.

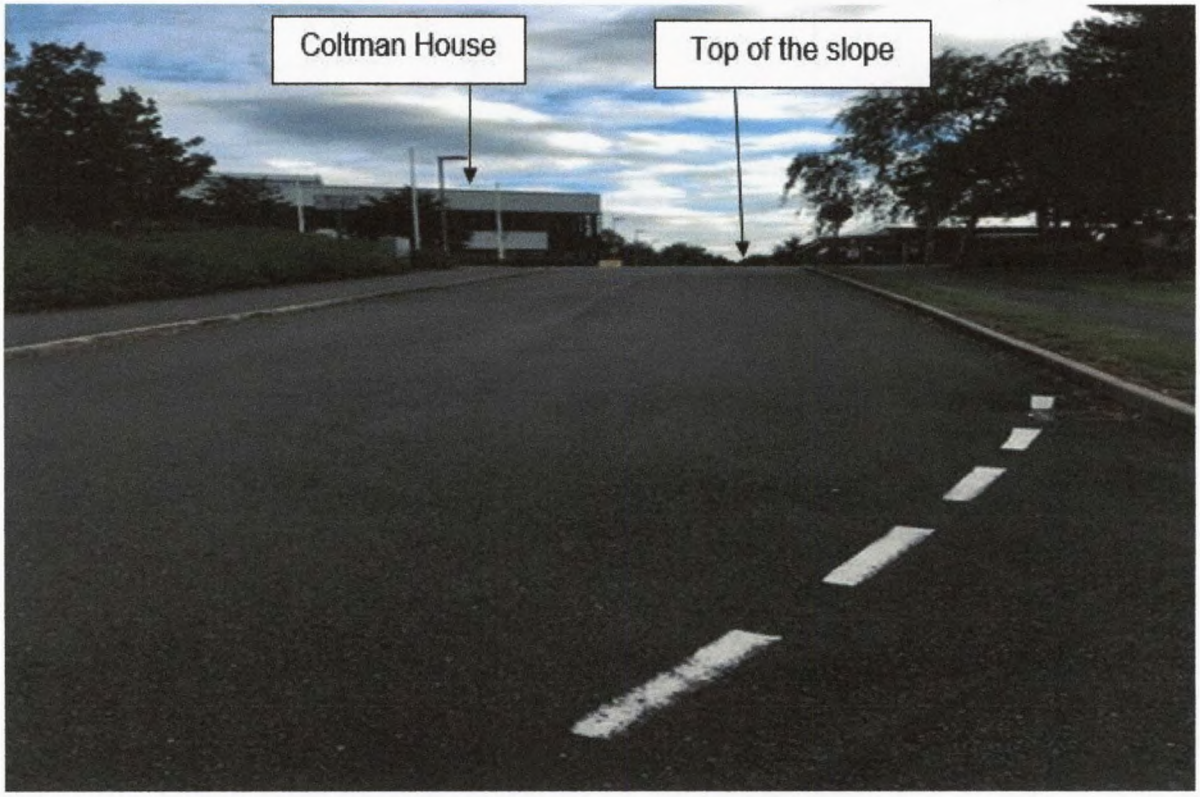


Figure 1.4-17 – The uphill slope on the RFT (E) 2km run route up to Coltman House.

Exhibit 277

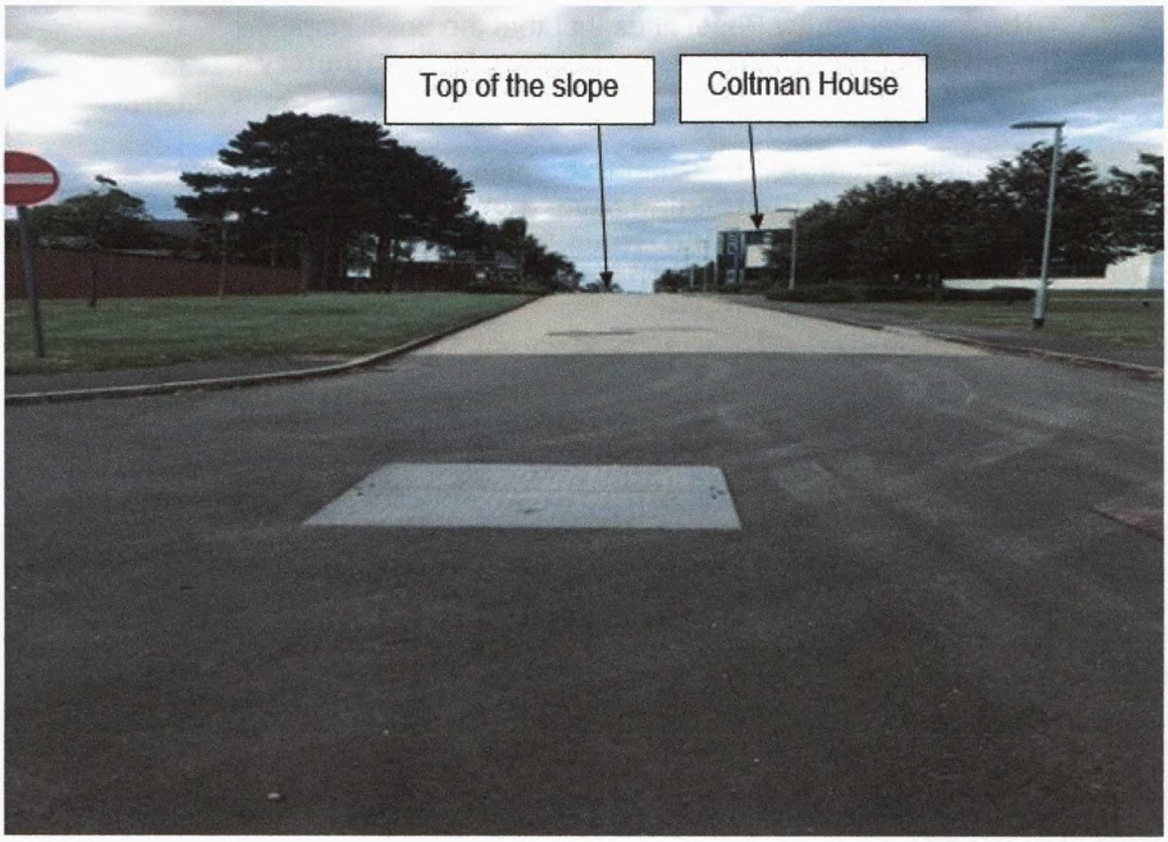


Figure 1.4-18 – The top of the uphill slope on the RFT (E) 2km run route alongside Coltman House.

Exhibit 278

1.4.229. While there was no definitive evidence that the uphill slope on the RFT (E) 2km running route directly contributed to the accidents involving Candidate 1 or Candidate 2, the SI Panel noted that Candidate 1 stopped on the middle of the slope just before Coltman House and Candidate 2 collapsed just after the top of the slope opposite the Harden Centre. In both cases this was on their second lap of the route, as they approached the end of the 2km run.

1.4.230. Both Candidate 1 and Candidate 2 collapsed on or just after the slope, on their second lap, as they approached the end of their 2km run. It was the opinion of the SI Panel that the candidates would likely have been approaching their maximal level of exertion on the approach to the finish line and the additional exertion of running up the slope would likely have increased the level of exertion required at this point. Therefore, the slope made it more likely that additional exertion would be required towards the end of each lap. Exertional sickling can begin following 2 - 5 minutes of 'all-out exertion' and it is an intensity syndrome. Therefore, it was the opinion of the SI Panel that it was likely that the slope on the RFT (E) running route made an ECAST event more likely to happen.

Exhibit 6
Exhibit 73-74
Exhibit 107
Exhibit 279

1.4.231. The Service Inquiry Panel finds that that the uphill slope on the Role Fitness Test (Entry) 2km running route was a **Contributory Factor.**

1.4.232. **Recommendation. The Chief Executive Officer Recruiting Group should ensure that the running route at Assessment Centre (Lichfield) complies with Recruiting Group Standard Operating Instruction 7, in order to ensure that the route is safe.**

RFT (E) risk assessments

1.4.233. JSP 375, which will be discussed further in the reporting factors section of this SI report, gave direction to ensure that Defence policy was compliant with health and safety regulations. JSP 375 stated: 'All activities undertaken on the defence estate or undertaken elsewhere by defence personnel should be risk assessed. Risk assessment is not a substitute for making things safe. Where practical the hazard should always be eliminated rather than managed.' JSP 375 stated that all risks should be reduced to a level that was As Low As Reasonably Practicable (ALARP). 'Reasonably practicable' involved weighing a risk against the trouble, time and money needed to control it. The concept of ALARP led to the principle that 'the risk of injury or fatality within a workforce or wider society can be tolerated providing that the risk is both mitigated to ALARP and also justified when considering the benefits that would be achieved from undertaking the activity.' Exhibit 240 Exhibit 285

1.4.234. JSP 375 stated: 'MOD Form 5010 is the recommended means of recording the risk assessment although its use is not mandated.' MOD Form 5010 was the recognised Risk Assessment (RA) form in the Army that was used to assess the risks associated with Defence activities. It was used to evaluate the risks for one specific activity, and it was intended to be used by a competent person who had knowledge of the activity. Managers with oversight of the activities were responsible for ensuring that RAs were effective and ensuring that they were reviewed, where necessary, on a regular basis. Exhibit 285 Exhibit 377

1.4.235. In contrast, RG used their Safety, Health, Environmental and Fire (SHEF) 005 form as the RA form to assess the risks associated with all the activities conducted during the Soldier Selection process, at all four ACs. The RG SHEF005 form was a RA form which was provided to the ACs from HQ RG. This was a single document that included RAs for all three elements of the RFT (E). Exhibit 250

1.4.236. JSP 375 stated that managers were charged with the planning of activities, the assessment of all the hazards and the completion of a RA by a competent person (the risk assessor) who operated in the environment where the activity took place. The Assessment Centre Manager (ACM) job specification stated that one of Exhibit 285-28 Exhibit 307

the key responsibilities of an ACM was to have the 'responsibility for the safety of everyone at the site.'

1.4.237. Throughout the period during which the accidents involving Candidate 1 and Candidate 2 occurred, the RG SHEF005 form (dated August 2019) was in operation across RG and at AC (L). The SI Panel were provided with evidence of an in-date SHEF005 form that provided RA and risk mitigations to reduce the risks of the RFT (E) to ALARP during this period. The SHEF005 form covered all the risks identified throughout the Soldier Selection process and detailed how each risk was mitigated and controlled. Exhibit 250

1.4.238. Despite JSP 375 recommending that MOD Form 5010 was the preferred means of recording the risk assessment, it was the opinion of the SI Panel that the SHEF005 form used by Recruiting Group provided a similar level of risk assessment and mitigation as the MOD Form 5010. This ensured that the Soldier Selection process, including the Role Fitness Test (Entry), was appropriately risk assessed to the standard specified in Joint Service Publication 375. The SI Panel concluded that the use of the SHEF005 form, in place of the MOD Form 5010, was **not a factor** in the accidents involving Candidate 1 and Candidate 2. Exhibit 250

Internal PT Assurance Audits

1.4.239. All ACs underwent an annual audit during the period 2013 to 2018 by a civilian contractor, in order to provide support to the physical assessments at the ACs. The objective of the annual audit was to make recommendations to improve the conduct of the physical assessment processes and several recommendations were made. However, ACs were not audited by a civilian contractor in 2019. Exhibit 249

1.4.240. The 2018 audit provided recommendations for correcting issues at AC (L). It identified several issues, including the route of the RFT (E) 2km run and uncertainty regarding the WBGT criteria for the RFT (E) 2km run. This audit noted the lack of action from 2013 to 2017 by RG regarding equipment, documentation and process and this was subsequently compounded by the fact that an audit was not conducted 2019. Exhibit 249

1.4.241. The Service Inquiry Panel finds that the limited action in relation to audit recommendations during the period 2013 to 2018 and the lack of an audit being conducted in 2019 was an **Other Factor.**

1.4.242. **Recommendation. The General Officer Commanding Army Recruiting and Initial Training Command should ensure that an annual audit of Assessment Centres is conducted and all audit**

recommendations are tracked to closure, in order to provide assurance of the Soldier Selection process.

Suitability of the RFT (E) 2km run in Soldier Selection

1.4.243. The RFT (E) 2km run was a best-effort test. It was designed to assess the aerobic capacity of candidates on Soldier Selection. The SI Panel identified four accidents related to ECAST in candidates with SCT since the introduction of the RFT (E) in April 2019. Two of these accidents resulted in the deaths of Candidate 1 and Candidate 2 and two of these accidents resulted in the prolonged hospitalisations of Candidate 3 and Candidate 4. Exhibit 43 Exhibit 74 Exhibit 107 Exhibit 205 Exhibit 208-210

1.4.244. During the SI Panel's visit to Washington DC, the SI Panel was informed of nine deaths that were suspected to be due to ECAST in the US Military in 2019. Two of these deaths occurred following a 1.5 mile (2.4 km) best-effort run during week 5 of initial training for the US Navy. The two Servicewomen involved died following timed runs in a purpose-built, indoor training facility, which significantly mitigated many of the risk factors associated with ECAST. They died despite having completed 4 weeks of graduated physical training and wearing red sashes to identify them as having SCT. This demonstrated that even with SCT screening and the level of awareness of SCT and ECAST within the US Navy in 2019, and with several risk mitigations in place, the use of best-effort, timed runs as fitness assessments still led to fatalities from ECAST in individuals with SCT. Exhibit 382

1.4.245. During the interviews at AC (L), the SI Panel heard several anecdotal reports that CW candidates were typically, highly motivated individuals, often due to their personal circumstances. However, some AC (L) staff reported concerns over the apparent lack of physical preparation of some of the candidates and suggested that there had been more incidents and accidents during the run element of the physical assessment since the introduction of the RFT (E) in April 2019. As discussed earlier, it was the opinion of the SI Panel that excessive motivation (as a **Contributory Factor**) had the potential to increase the risk of ECAST during a maximal effort, aerobic assessment such as the RFT (E) 2km run. Exhibit 280 Exhibit 283

1.4.246. The Human Factors report raised concerns regarding cold acclimatisation for CW candidates attending Soldier Selection. It posed the question of whether it was a comparable and fair experience for CW candidates to participate in the RFT (E) 2km run during cold weather as part of the Soldier Selection assessment process. In addition, it noted that the acclimatisation period was an 'uncontrolled period' with little structure provided and little consistent advice given on exactly what adaptation and acclimatisation needed to take place. It suggested that 'not having a clear and well-defined protocol runs the risk of the individual not being able to measure whether or when they have been Exhibit 269 Exhibit 284

acclimatised enough for the necessary physiological or behavioural changes to take place to allow their best performance without detrimental effects.' Although, the SI Panel did not find any definitive evidence that the acclimatisation period was a factor in either accident, it was the opinion of the SI Panel that conducting physical assessments indoors would provide a controllable, repeatable environment for all candidates, which would allow the assessments to be consistent, reproduceable and thus fair.

1.4.247. The SI Panel identified that there were alternative, validated methods available for assessing the aerobic capacity of candidates on Soldier Selection, such as the Multi-Stage Fitness Test (MSFT). The MSFT was a running test, already widely used by the UK Military, to assess a candidate's aerobic capacity. During the test, candidates were required to run between two lines which were 20m apart, in time with a bleep. Candidates had to run back and forth between the two lines and had to reach the line before the next bleep sounded. As the MSFT continued, the time between each bleep got shorter and the test became progressively more difficult. Once a candidate failed to reach the line before the bleep, they had to stop and the level that the candidate had achieved was recorded by the PTI. Exhibit 384

1.4.248. The MSFT was used during the Army Officer Selection Board (AOSB) at Westbury as the method of assessing the aerobic capacity of potential Officer candidates. The MSFT was also used on Soldier Selection when inclement weather meant the RFT (E) 2km run could not be held outdoors and, in 2020, during periods when the national COVID-19 restrictions meant the RFT (E) 2km run could not be used due to social distancing requirements. Exhibit 255 Exhibit 385

1.4.249. It was the opinion of the SI Panel that the MSFT could be a safer and fairer test to use during Soldier Selection as it might be easier to mitigate some of the risk factors for ECAST within an environmentally controlled facility indoors. In addition, when conducting the MSFT, all candidates could be observed easily as the test progressed and, because the test started slowly and got faster, there would likely be a gradual increase in exertion and heart rate. Exertional sickling can begin following 2 - 5 minutes of 'all-out exertion' and it is an intensity syndrome. It was the opinion of the SI Panel that during the RFT (E) 2km run there was greater risk of a prolonged period of 'all-out exertion' compared to the MSFT as the level of exertion in the MSFT built gradually. During the MSFT, candidates were required to stop once they had failed to reach the line before the bleep, which theoretically reduced the time spent at maximal, 'all-out exertion'. As discussed earlier in this report, another factor that might theoretically make the RFT (E) 2km run more likely to precipitate ECAST in candidates with SCT compared to the MSFT is the slope on the RFT (E) 2km running route. Conducting the MSFT indoors would eliminate the issue of the slope. Exhibit 279 Exhibit 384

1.4.250. The SI Panel discussed the use of the RFT (E) 2km timed run and the potential use of the MSFT with several ECAST experts from the US. One ECAST expert suggested that stopping when maximal exertion had been reached, or once the participant had failed to reach the line before the bleep, could mean that the MSFT might be lower risk for precipitating ECAST as a result of decreasing the length of time at maximal exertion. However, they suggested that more research was required, as they felt it could create some paradoxical motivational patterns during the attempt to reach a specific level. Another ECAST expert questioned the need to assess the maximal aerobic capacity of candidates on Soldier Selection at this stage of their recruitment and initial training journey. However, they stated that the SI Panel's analysis in paragraph 1.4.249 was 'perceptive and logical and in theory may hold up in practice' and agreed that the MSFT might be safer than the RFT (E) 2km timed run. They noted that timed fitness runs have proved fatal over and over again in individuals with SCT in the US military, in all climates and settings. However, they did raise concerns regarding the final stages of the MSFT, especially in light of human nature and the potential issue of excessive motivation. Exhibit 430

1.4.251. Therefore, it was the opinion of the SI Panel that the use of the RFT (E) 2km run during the Soldier Selection process had the potential to increase the risk of ECAST in candidates with SCT compared to using an alternative, validated assessment of aerobic capacity such as the MSFT. The SI Panel concluded that it was more likely than not that the use of an alternative validated assessment of aerobic capacity, such as the MSFT, in place of the RFT (E) 2km run during Soldier Selection would have reduced the risk of ECAST amongst the population of untrained, civilian candidates.

1.4.252. The Service Inquiry Panel finds that using the Role Fitness Test (Entry) 2km run, as the physical fitness assessment during Soldier Selection, was a **Contributory Factor**.

1.4.253. **Recommendation. The Director Personnel (Army) should assess the safety and suitability of the Role Fitness Test (Entry) 2km run against alternative methods of assessing aerobic fitness during Soldier Selection which can be conducted in a controlled, repeatable environment and which minimise the time spent at maximal exertion, in order to reduce the risk of exertional collapse during or following these physical fitness assessments.**

Reporting Factors

Introduction

1.4.254. This section of the report discusses incident and accident reporting. It discusses the hierarchy of documentation that applied to incident and accident reporting, moving from the requirements in UK Legislation and working down to relevant local policy documents. Reporting actions taken following the accidents involving Candidates 1, 2, 3 and 4, and the reporting chain from the local accident reports to their conclusion will then be discussed and analysed.

Definitions

1.4.255. This section contains key definitions and explanations of terminology that can be used for clarifying the meanings of terms used in the analysis sections below. Table 1.4-3 gives the definitions provided in JSP 375, Part 2, Volume 1 (Accident Reporting). It was the opinion of the SI Panel that the events involving Candidates 1, 2, 3 and 4 were, by these definitions, accidents. Table 1.4-4 gives the JSP definitions for injury severity. These additional categories were intended to be used alongside the terminology of incident and accident, in order to convey the severity of an occurrence.

Accident	a. Any injury or occupational disease to a person or which caused / had the potential to cause a RIDDOR[30] dangerous occurrence.
Incident	a. An event which causes loss or damage to property, plant or equipment due to a shortfall in safety measures. b. An intervention or enforcement notice from an internal or external regulatory body. c. Contamination of an individual or workplace by an article contaminated with Chemical, Biological or Radioactive (CBR) material. d. A CBR contaminated article being lost from institutional control.
Near miss	a. An event that, while not causing harm, has the potential to cause injury, damage or ill health but which was avoided by circumstance or through timely intervention.

Table 1.4-3 – JSP 375 Accident / Incident definitions. Exhibit 287

[30] Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) will be discussed in the UK Legislation section below.

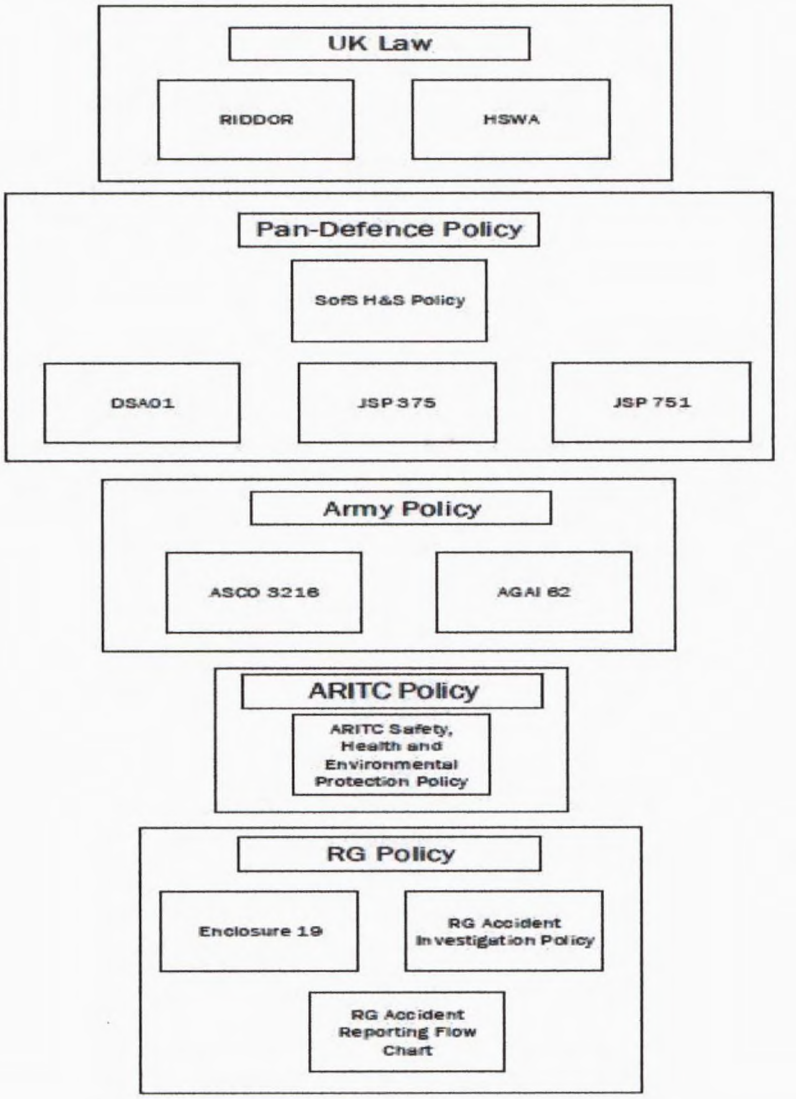
Minor injury accident / incident	Any injury, accident or incident that results in up to 7 days lost time and is not reportable under RIDDOR or causes minor damage.
Serious injury, accident / incident	Any injury, accident or incident that results in: a. More than 7 days lost time (or unable to perform full range of duties) requiring medical treatment but not admission to hospital. b. Requiring a formal report to the HSE under RIDDOR and is not a specified injury, accident or incident or dangerous occurrence. c. Failure or corruption of safety measure or procedure (eg broken or damaged device). d. Localised spillage or leak of pollutant (eg short-term damage to flora and fauna).
Specified Injuries	Any injury, accident or incident that results in: a. A fracture, other than to fingers, thumbs and toes. b. Amputation of an arm, hand, finger, thumb, leg, foot or toe. c. Permanent loss of sight or reduction of sight. d. Crush injuries leading to internal organ damage. e. Serious burns (covering more than 10% of the body, or damaging the eyes, respiratory system or other vital organs). f. Scalpings (separation of the skin from the head) which requires hospital treatment. g. Unconsciousness caused by head injury or asphyxia. h. Any other injury arising from work in an enclosed space, which leads to hypothermia, heat-induced illness or requires resuscitation or admittance to hospital for more than 24 hours.

Table 1.4-4 – JSP 375 injury severity definitions. Exhibit 287

Reporting Policy

1.4.256. The Ministry of Defence (MOD), like other organisations operating in the UK, was bound by UK Health and Safety (H&S) and Environmental Protection (EP) laws and regulations. The relationships between UK law and Defence policy was a hierarchical one, with the requirements set by law at the highest tier and with the lower tiers serving to expand and provide guidance with increasingly specific and local detail. Figure 1.4-19 shows the key documents discussed in this section, located in their policy tier, in order to demonstrate how Exhibit 288

requirements, set in UK law, became the guidance and policy provided to local workplaces.



Key

- RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013)
- HSWA (Health and Safety at Work etc. Act 1974)
- SofS (Secretary of State)
- DSA (Defence Safety Authority)
- JSP (Joint Service Publication)
- AGAI (Army General and Administrative Instructions)
- ACSO (Army Command Standing Order)
- ARITC (Army Recruiting and Initial Training Command)
- RG (Recruiting Group)

Figure 1.4-19 – Hierarchy of documentation.

UK legislation

1.4.257. All responsibilities for health, safety and reporting of an accident to an employee or member of the public in the workplace, originated in the Health and Safety at Work etc. Act 1974 (HSWA). A fundamental provision of this Act was: 'It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.' Exhibit 289

1.4.258. Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) all employers were required to record incident or accident information and submit reports for incidents and accidents that occurred due to work-related health and safety failings within a set timeframe. Although the MOD was legally exempt from these requirements where a service person suffered an injury or died whilst on-duty, the MOD's General Agreement with the HSE stated that reports would be made where the death or serious injury was as a result of HS management failings. The MOD did not have an exemption in respect of civilians or off-duty personnel. Exhibit 290-291

1.4.259. The point at which civilians undertaking the recruitment process officially became Service personnel was upon signing enlistment papers in the presence of a recruiting officer. The signing of enlistment papers took place following successful completion of the recruitment process on the candidate's first day at basic training. Therefore, all candidates attending Soldier Selection were to be considered as civilians (eg members of the public). Consequently, Capita and the MOD, as partners in the RPP, were obligated under the HSWA and RIDDOR to ensure their safety as far as was reasonably practicable and record and report accidents within set time frames. Exhibit 292-293

Pan-Defence policy

1.4.260. The Secretary of State for Defence (SofS) was regarded as the employer for the purposes of complying with the requirements of UK H&S and EP legislation and was answerable to Parliament for ensuring Defence complied with this duty through a Policy Statement that identified the key requirements and high-level responsibilities for H&S and EP management. This Policy Statement applied to all organisations and personnel within Defence and everyone who conducted activities on behalf of Defence, including contractors and MOD's partner organisations. Therefore, the Policy Statement was the document that expressed the MOD's obligation to comply with UK H&S requirements. The fundamental objective of the Policy Statement was that those who delivered or conducted Defence activities minimised work-related Exhibit 294

fatalities, ill-health and reduced health and safety risks so that they were as low as reasonably practicable.

1.4.261. The Defence Safety Authority (DSA) was an organisation established by the authority of the SofS to act as the regulator and investigator for H&S and EP within Defence. The DSA was the sponsor of DSA01 and JSP 375, which were the primary pan-Defence documents for setting out and enacting the SofS's H&S and EP Policy Statement. Exhibit 295

1.4.262. JSPs provided direction and guidance on a variety of issues for all those working in the Defence environment. JSP 375 (Management of Health and Safety in Defence) provided the MOD with direction on how the HSWA should have been implemented throughout Defence. Exhibit 288

1.4.263. The Joint Casualty and Compassionate Cell (JCCC) was an organisation that provided a focal point for casualty administration and notification and managed requests for compassionate travel (for those personnel serving overseas) for Service personnel. The JCCC sponsored JSP 751 (Joint Casualty and Compassionate Policy Procedures) as a primary source of policy and guidance, particularly for those working in management positions who might need to access JCCC's services. Exhibit 296

Army policy

1.4.264. Subordinate to Defence policy was the tier of Army policy. The purpose of this tier was to give Army specific guidance for adherence to Defence policy.

1.4.265. Army Command Standing Orders (ACSOs) were documents, produced with the authority of the Deputy Chief of the General Staff, to provide routine and enduring non-operational orders to the Army. ACSO 3216 (The Army's Safety and Environmental Management System) was produced to provide the guidance, methodology and procedures to implement established pan-Defence policy and UK Law relating to H&S and EP within the Army. Exhibit 297-298

1.4.266. Army General and Administrative Instructions (AGAIs) provided details on the procedures and the directions for implementation on a range of topics for the general administration of Army life and behaviour. AGAI 62 (Discipline Policy) provided guidance and policy regarding disciplinary action and Service criminal justice.[31] Exhibit 299

[31] AGAI 62 was an outlier from the other policy documents mentioned as it had a different focus and followed a different hierarchy than the H&S publications. AGAI 62 has been included in this section as it was the source of the Army Incident Report (INCREP) form which will be discussed later in the section.

Army Recruiting and Initial Training Command policy

1.4.267. Subordinate to Army policy was the tier of ARITC policy. The purpose of this tier was to address specific areas of Army policy relevant to ARITC.

1.4.268. The ARITC Handbook was a document produced to provide a single source of policy, processes and guidance, specifically for use by ARITC personnel. Two chapters relevant to this section were the chapter on Safety, Health and Environmental Protection and the chapter on Incident Reports (INCREPs), as these detailed the expansion of higher tier H&S policy relevant to ARITC. Exhibit 300-301

Recruiting Group policy

1.4.269. Subordinate to ARITC policy was the tier of Recruiting Group (RG) policy. The purpose of this tier was to provide specific and local instruction for individuals working within RG, in order to fulfil the requirements that had been set by the higher tier policies. As RG was a partnership between Capita and the MOD, charged with delivering the RPP, this tier of policy provided guidance for the fulfilment of the requirements of Capita as well as the requirements of the Army.

1.4.270. The Capita Accident, Safety, Property and Environmental Reporting (CASPER) compliance tool was a multifunctional tool used throughout Capita's organisations to manage a broad range of compliance requirements. CASPER was the primary system used by RG to submit and monitor all incidents, accidents and near misses in accordance with UK legislation. Exhibit 302

1.4.271. RG published a range of policies and instructional documents to support their personnel. Of these, the following three were pertinent to this section of the report: Exhibit 303-306

a. Enclosure 19 - RG Incident, Accident and Casualty Reporting was an enclosure to Commanding Officer Recruiting Group Directive 2016/17, produced by RG, to provide specific policy and direction in the event of incidents or accidents.

b. RG Accident Investigation Policy was a supplementary publication intended to support Enclosure 19 with specific guidance regarding the actions required following an accident within RG.

c. The RG Accident Reporting Flow Chart was produced by RG to provide a visual explanation of the CASPER reporting system for RG personnel.

1.4.272. The relationship between these documents was hierarchical. Policy and general requirements were contained at the top and these were refined into guidance increasingly targeted at specific readers as the levels progressed downwards. Therefore, each tier of policy should have facilitated the objectives and requirements of the tier above. Exhibit 297

Reporting Actions Required by Policy

1.4.273. The policies discussed above contained many reporting actions and requirements that had to be fulfilled following an accident. Within each policy tier was the requirement to submit some version of a report form for the accident. In this section those requirements relevant to the accidents involving Candidates 1, 2, 3 and 4 will be discussed. The four actions listed below are those which were required by policy at the time of, and in relation to, the four accidents: Exhibit 304 Exhibit 307

a. Notification of the Army Incident Notification Cell (AINC) through the submission of an Army Form 510 (AF510).

b. Notification of the Defence Accident Investigation Branch (DAIB) by telephone.

c. Notification of the SofS through the Deputy Chief of the Defence Staff's Duty Officer (DCDSDO).

d. Notification of the RG H&S Manager.

However, there were other reporting actions, some of which were used in these cases, and these are discussed later in this report.

Report forms

1.4.274. Part of the SofS's H&S requirements was that 'the circumstances of a H&S and EP event are recorded fully and reported to their nominated incident notification cell, and where appropriate, investigated'. Integral to this requirement was the submission of an incident or accident report form. This subsection deals with the different report formats that were directed for use at different policy levels, as shown in Figure 1.4-20. Exhibit 308

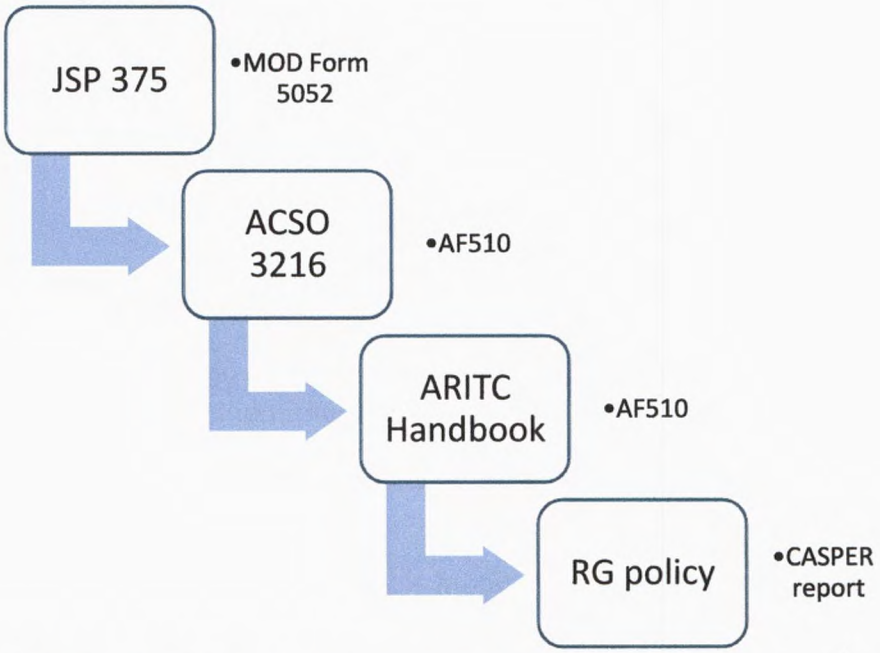


Figure 1.4-20 – Accident reporting forms directed by policy.

Exhibit 287
Exhibit 305
Exhibit 309-310

1.4.275. JSP 375 was the tri-Service single point of reference for H&S policy. Within JSP 375 the following guidance was given regarding accident or incident reporting: Exhibit 287

> 'All specified accidents/incidents which may have been the result of health and safety failures must be reported to the TLB/TFA CESO organisation and fatalities reported as soon as possible on MOD Form 5052 containing as much information as is readily available.'

1.4.276. ACSO 3216 provided non-operational guidance for the implementation of pan-Defence H&S policy across the Army. Within ACSO 3216 the following guidance was given regarding accident reporting: Exhibit 311

> 'All accidents, incidents, near misses, dangerous occurrences and equipment failures across the Army TLB must be reported to the Army Incident Notification Cell (AINC) using the Army Form 510 (AF510).'

1.4.277. The AINC was an organisation that maintained the Army database of accident and incidents; it also recorded the results of investigations and subsequent actions. The AF510 was specifically designed to allow information recorded on the form to be automatically transferred to the AINC database. Exhibit 314

1.4.278. The ARITC Handbook provided a single point of policy and guidance, specifically for use by ARITC personnel. Within the ARITC Handbook the following guidance was given regarding incident and accident reporting: Exhibit 310

> 'Units must capture and immediately report all accidents and incidents to the Army Incident Notification Cell (AINC) using Army Form 510.'

1.4.279. The purpose of RG policy was to provide direction and guidance for the Capita and Army personnel working within RG. Within Enclosure 19 - RG Incident, Accident and Casualty Reporting it was stated that the following should be submitted: Exhibit 305

> a. 'An RG Incident Report (INCREP) in the event of a notifiable incident.'[32]
>
> b. 'An RG Accident Report on the Capita CASPER system through DII [Defence Information Infrastructure] for all Capita and military personnel who have sustained any injury in and out of work.'

1.4.280. The hierarchical nature of policy documents meant that the reporting method directed in JSP 375, a pan-Defence policy document, should have been followed in single Service policy. Therefore, from a policy perspective, when faced with conflicting reporting methods for reporting in the form of the MOD Form 5052 in JSP 375 and the AF510 in ACSO 3216, the direction in JSP 375 should have been taken as the authority. However, at the time of the accidents, the MOD Form 5052 was not used as a reporting tool by any of the single Services and it lacked the specific format required for the automatic inclusion of data into the AINC database. Furthermore, reference to the MOD Form 5052 was removed from JSP 375 in updates to the document that took effect in August 2020. Exhibit 311-312

1.4.281. It was the opinion of the SI Panel that, while the MOD Form 5052 was the correct reporting method by virtue of policy authority, it was a less effective reporting tool than the submission of an AF510 (and use of both would have been a duplication of effort), and nothing would have been lost by only submitting the AF510.

1.4.282. Following a meeting in November 2017 between RG and AINC, an agreement was made that, due to the mixed working environment of civilian Capita employees and Army personnel within RG, the CASPER system would be the single reporting method used by Exhibit 313

[32] This included but was not limited to: serious accidents or illnesses; serious breaches of discipline; serious incidents involving the general public; serious incidents occurring during Work Experience Events or involving minors; and other incidents likely to attract media (whether local or national) or ministerial interest.

RG personnel. This agreement resulted in a change from the previous direction to use an AF510 to the new direction to use a CASPER form, resulting in a difference between the ARITC and RG policy tiers.

Notification of the Army Incident Notification Cell

1.4.283. The AINC was responsible for the Army's incident and accident database and it was the designated recipient for reports submitted using the AF510. DSA01 stated the requirement for all accident reports to be submitted to the nominated accident reporting cell, and for the Army this was the AINC. Exhibit 315

1.4.284. Direction was given in ACSO 3216 and in the ARITC Handbook to submit an AF510 to the AINC. This direction changed at the RG level where the direction became to submit reports using the Capita CASPER system. However, while the reporting method changed, the requirement for reports to be submitted to the AINC was not removed. The method agreed between RG and AINC in the November 2017 meeting was that the RG H&S Manager would forward all CASPER reports to the AINC, thereby fulfilling this reporting requirement. Exhibit 313

Notification of the Defence Accident Investigation Branch (DAIB)

1.4.285. The DAIB was the part of the DSA that provided Defence with an accident investigation capability independent of the single Services. The role of the DAIB was to conduct impartial and expert no-blame safety investigations across all domains focussed on the identification and understanding of all accident factors. To facilitate this role, the DAIB was staffed by teams of trained investigators who responded to incidents or accidents. If it was determined that an event required further investigation, the Director General of the Defence Safety Authority (DG DSA) could have convened a Service Inquiry, which would have been supported by the DAIB, or directed a Non-Statutory Inquiry (NSI), which would have been conducted by the DAIB. Exhibit 316

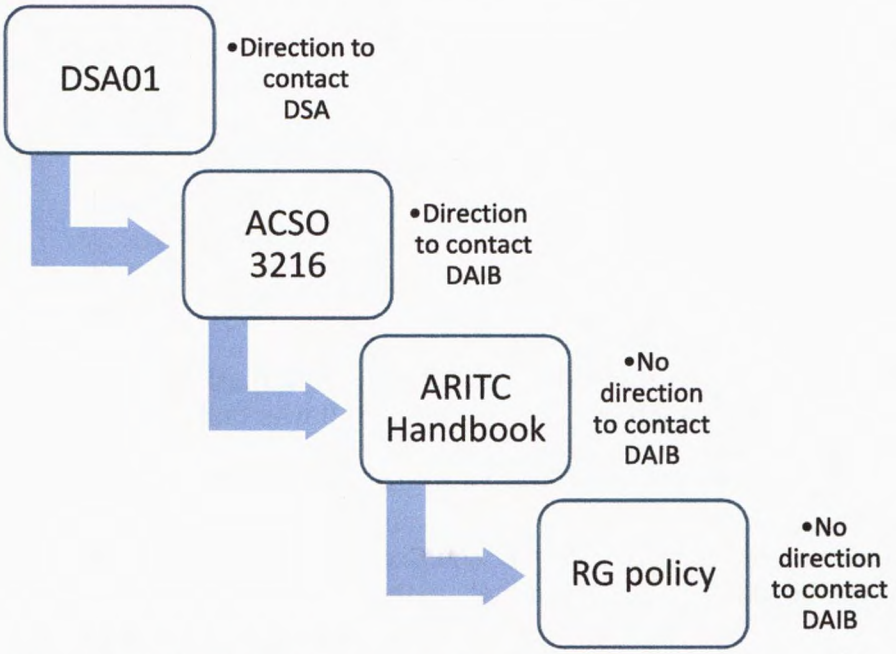


Figure 1.4-21 – Direction to contact the DAIB in levels of policy.

1.4.286. Guidance to contact the DSA following a serious accident first appeared in the DSA01 publication. This guidance was amplified in the primary Army H&S document ACSO 3216 which gave direction and details for contacting the DAIB, as shown in Figure 1.4-21. However, the subsequent lower tiers of ARITC and RG policy did not contain any direction to contact the DSA or DAIB; instead it directed that HQ ARITC and HQ RG be contacted respectively. Exhibit 307 Exhibit 309

Notification of the Secretary of State for Defence (SofS)

1.4.287. The requirement to inform the SofS's office was established in JSP 375 and repeated in DSA01. These documents directed that serious or fatal H&S events were to be reported to the Deputy Chief of the Defence Staff's Duty Officer (DCDSDO). This direction did not appear in ACSO 3216 or in any of the ARITC policy documents discussed above. However, direction to contact the 'Defence Staff Duty Officer' did appear at the RG policy level within Enclosure 19 (RG Incident, Accident and Casualty Reporting). The phone number listed in Enclosure 19 for the 'Defence Staff Duty Officer' was the same number as the DCDSDO's phone number[33] and it appeared to have been copied from Reference A to Enclosure 19, which was an Army discipline policy (G1 Incidents and Matters of Public Interest) dated 14 July 2014. It was the opinion of the SI Panel that the 'Defence Staff Duty Officer' referred to in Enclosure 19 (and in the Army discipline policy mentioned above) Exhibit 100 Exhibit 287 Exhibit 305 Exhibit 307 Exhibit 317

[33] Notwithstanding an error in Enclosure 19 which had wrongly transposed the dial code for London as 0702 (instead of 0207).

and the DCDSDO referred to in JSP 375 and DSA01 were the same Duty Officer within MOD Main Building, London.

Additional Organisations Involved in Reporting

1.4.288. Prior to discussion of the actions undertaken in the cases of the four candidates there is a requirement to understand the Army Personnel Services Group and its constituent parts which played a role in the reporting of these accidents.

1.4.289. **The Army Personnel Services Group (APSG).** APSG was a one-star (Brigadier) led branch of Home Command. It was tasked to deliver and assure specified, non-financial conditions of Service for the Army and advise, educate and audit the Army's approach to discipline, unit financial accounting and personnel administration. They also managed, administered and assured Service Complaints and delivered and assured the development of individuals in the Army, in order to deliver the Army's personnel support. Exhibit 318

1.4.290. **Bereavement and Aftercare Support (BAS).** BAS was a team within APSG. It was tasked to provide an enduring focus for bereaved families and to sustain a robust relationship between the Army and the Next of Kin of those who had died in Service. The BAS team was the conduit for the timely passage of information on investigations and inquiries into fatalities and serious injuries undertaken by the Army. Exhibit 319

1.4.291. **APSG Service Inquiries (APSG SI).** APSG SI was a team within APSG. It was tasked to conduct personnel-focused reviews of casualties, ranging from unlisted deliberate self-harm cases to serious illness and death, including cases of potential and completed suicide. The APSG SI team investigated incidents and accidents and provided, depending on the requirement, Learning Accounts and Learning Account Reviews. APSG also conducted single Service Army SIs. In addition, they provided a lessons team, tasked with analysing lessons learned and promulgating them for wider review and implementation across the Army. APSG SI was the Army conduit, through the Defence Inquest Unit, to produce relevant documentation for a Coronial Inquest. Exhibit 320 Exhibit 321

1.4.292. **Permanent President Service Inquiry (PPSI).** PPSIs were part of the APSG SI team. They were tasked to examine all incidents which crossed a specified threshold and, if necessary, preside over an Army Service Inquiry which was independent from the chain-of-command. A PPSI assisted the relevant unit or command in the production of a Learning Account and published a corresponding Learning Account Review which detailed the event, factors and any corrective actions which might have been required. Exhibit 386

1.4.293. **Learning Accounts (LAs) and Learning Account Reviews (LARs).** A LA was an initial account of an incident or accident, intended Exhibit 322-323

to provide a factual record of the event at the time of writing, along with immediate actions and recommendations intended to prevent reoccurrence. LAs were produced at the local unit level upon request of a PPSI. The PPSI then assisted the unit to ensure that the correct information was captured to allow HQ APSG to review. The writing and staffing of the LA were supported and a follow-on review, known as a LAR, containing the PPSI's assessment of the event, was produced. Once completed these LAs and LARs were sent to APSG who provided an additional level of staffing and review. APSG would then decide whether or not a SI was required and distribute the findings and recommendations for Army-wide consideration.

1.4.294. **Defence Inquest Unit (DIU).** The DIU was the focal point for the coordination and management of all Defence-related inquests into the deaths of Service and MOD civilian personnel, who died whilst at work or on MOD property, as a result of injuries sustained while on operations, as a result of training activity, or where the death of a veteran might have been linked to their previous military service. The DIU's key role was to assist Coroners so that they could complete their inquests fully, thoroughly and as quickly as possible and to support Service personnel providing evidence through the inquest process. Exhibit 324

Accident Reporting Timelines

1.4.295. In this section the chronology of the accident reporting for the four candidates will be discussed. For each candidate a detailed table is included providing timings and reporting actions, in as much detail as the SI Panel were able to determine during the investigation. Whenever possible, precise timings have been provided from the evidence available. However, other timings, by virtue of the evidence available, are approximate.

The accident involving Candidate 3

Time / Date	Action / Event	
08:20 6 June 2019	Candidate 3 collapsed.	Exhibit 294
Shortly after	ACM informed RG Hd of Selection[34] by telephone.	Exhibit 325
Time / Date	**Action / Event**	

[34] The RG Hd of Selection was a civilian member of RG who was the Line Manager responsible for the four ACMs.

14:57 10 June 2019	ACM emailed INCREP to RG Hd of Selection and RG multiuser email account[35].	Exhibit 326
10:35 11 June 2019	RG Hd of Selection emailed INCREP to four RG and ARITC personnel.	Exhibit 327
10:47 11 June 2019	ARITC distributed the INCREP to key personnel within the organisation.	Exhibit 327
10:56 11 June 2019	ARITC emailed the INCREP to the Chief of Staff (COS) ARITC and the ARITC Deputy Chief of Staff (DCOS).	Exhibit 327
11:26 11 June 2019	ARITC DCOS emailed INCREP to ARITC multiuser email account and key personnel within the organisation.	Exhibit 327
14:06 11 June 2019	ARITC multiuser email account emailed the INCREP to the Permanent President Service Inquiry (PPSI) responsible for ARITC.	Exhibit 327
14 June 2019	INCREP was updated with further information regarding Candidate 3's condition.	Exhibit 328
15:28 18 June 2019	Assessment Centre Sergeant Major (ACSgtM) contacted the RG H&S Manager regarding issues submitting a CASPER report.	Exhibit 329
09:23 21 June 2019	ACSgtM submitted a CASPER report.	Exhibit 98
Unknown	No details were provided to the SI Panel for the RG H&S Manager forwarding CASPER report to AINC. AF510s were additionally submitted for the accident and added to the AINC database on 9 Dec 2019.	Exhibit 99 Exhibit 330
14:29 24 June 2019	The PPSI team contacted ARITC regarding the creation of a LA for Candidate 3.	Exhibit 331
25 June 2019	Candidate 3 discharged from hospital.	Exhibit 90
27 June 2019	Candidate 3 was made Permanently Medically Unfit (PMU) for military service.	Exhibit 157
18:34 17 July 2019	First draft of LA sent to the PPSI.	Exhibit 331
17:35 19 July 2019	The PPSI returned the LA with review notes to ARITC.	Exhibit 331
Time / Date	**Action / Event**	

[35] Both RG and ARITC operated multiuser email accounts, one purpose of which was to distribute INCREPs within the respective organisation.

July 2019	Candidate 3's collapse was raised in RG's Monthly Performance Report.	Exhibit 98
10:00 25 September 2019	Candidate 3 mentioned in an email relating to the collapse of Candidate 4 in an internal ARITC email conversation.	Exhibit 332
14:19 25 September 2019	The PPSI informed APSG of the accident involving Candidate 3's collapse by email.	Exhibit 333
10:19 26 September 2019	RG Hd of Selection emailed details of CW candidates who had collapsed, including Candidate 3, to ARITC.	Exhibit 161
NLT 27 September 2019	Draft LA / LAR provided to APSG by PPSI	Exhibit 334
September 2019	The trend of CW candidates collapsing was raised in RG Monthly Performance Report.	Exhibit 98
17:00 14 October 2019	The trend of CW candidates collapsing during training was raised in RG H&S meeting.	Exhibit 98
22 October 2019	Candidate 3's doctor wrote to RG as part of an initial appeal against being declared PMU.	Exhibit 158
13:21 30 November 2019	APSG requested LA and LAR for Candidate 3 from PPSI	Exhibit 335
13:06 2 December 2019	The PPSI responded to information request by APSG with LA and LAR.	Exhibit 335
9 December 2019	Candidate 3's accident was added to the AINC database.	Exhibit 330
22 February 2020	SO1 SI APSG commented and added their signature to the LAR.	Exhibit 334
26 February 2020	The Deputy Assistant Chief of Staff (DACOS) APSG commented and added their signature to the LAR.	Exhibit 334

Table 1.4-5 – Reporting actions for Candidate 3.

1.4.296. Candidate 3 collapsed during the morning of Day 2 of Soldier Selection while taking part in the 2km run element of the RFT (E) at AC (L) on 6 June 2019. Following Candidate 3's transfer to hospital the ACM informed the RG Hd of Selection.

1.4.297. Two reporting forms were submitted by AC (L) staff: the CASPER form and the RG INCREP. The INCREP was submitted on 10 June 2019 to RG and continued to be updated until 14 June 2019. Due

to technical difficulties with the CASPER system, the CASPER report for Candidate 3 was not submitted until 21 June 2019. This delay in submission was raised by AC (L) staff to the RG H&S Manager on 18 June 2019.

1.4.298. On 11 June the INCREP was distributed widely within RG, ARITC and the APSG PPSI team. The accident involving Candidate 3 was raised in the RG H&S Managers Monthly Performance Report (MPR) to the Senior Leadership Team (SLT) in July 2019. However, the accident involving Candidate 3 did not stand out to RG personnel at that time. Exhibit 387

1.4.299. On 27 September the PPSI provided APSG with draft copies of a LA and LAR for the accident involving Candidate 3. In addition, the issue of CW candidates collapsing during the RFT (E) 2km run was again raised with the RG SLT in the RG H&S Manager's MPR and the issue was also raised in the RG H&S meeting in October. The SI Panel could find no evidence that the DAIB had been informed of the accident involving Candidate 3. Exhibit 128

The accident involving Candidate 4

Time / Date	Action / Event	
10:10 19 September 2019	Candidate 4 collapsed.	Exhibit 187
Shortly after	ACM informed the RG H&S Manager.	Exhibit 336
12:14 19 September 2019	ACM submitted a CASPER report.	Exhibit 99
15:35 19 September 2019	The RG H&S Manager emailed information to Capita Global H&S Director.	Exhibit 336
16:42 19 September 2019	ACM submitted INCREP.	Exhibit 187
19:14 19 September 2019	RG multiuser email forwarded INCREP to ARITC multiuser email.	Exhibit 332
19 September 2019	AC (G) emailed the RG H&S Manager informing him of accident involving Candidate 4.	Exhibit 337
12:18 24 September 2019	The RG H&S Manager forwarded the CASPER report to the AINC.	Exhibit 99

Time / Date	Action / Event	
15:12 24 September 2019	ARITC multiuser email forwarded the INCREP to key personnel within the organisation.	Exhibit 332
15:18 24 September 2019	ARITC multiuser email notified the 6 DIV (6th Division) PPSI.	Exhibit 338
19:02 24 September 2019	ARITC Director Operations[36] (DOps) requested further information regarding the medical state of Candidate 4.	Exhibit 332
10:00 25 September 2019	ARITC multiuser email updated ARITC DOps with information about Candidate 4.	Exhibit 332
11:12 25 September 2019	ARITC multiuser email provided ARITC DOps and key personnel with an update on Candidate 4's condition.	Exhibit 332
11:19 25 September 2019	The PPSI advised RG to carry out a LA for Candidate 4.	Exhibit 339
11:40 25 September 2019	ARITC DOps confirmed receipt of the ARITC multiuser email and noted the importance of understanding the cause of the accident.	Exhibit 332
11:44 25 September 2019	ARITC multiuser email notified the PPSI.	Exhibit 340
25 September 2019	The PPSI notified APSG and requested information be added to a tracker.	Exhibit 341
26 September 2019	RG Hd of Selection sent details regarding Candidate 3 and 4 to ARITC.	Exhibit 161
September 2019	The trend of CW candidates collapsing, including Candidate 3 and 4, was raised in the RG MPR report.	Exhibit 98
17:00 14 October 2019	The trend of CW candidates collapsing, including Candidates 3 and 4, was raised in the RG H&S meeting.	Exhibit 98
15 October 2019	Candidate 4 discharged from hospital.	Exhibit 199
3 March 2020	LA and LAR published.	Exhibit 332

Table 1.4-6 – Reporting actions for Candidate 4.

[36] Director Operations (DOps) was a one-star Army Officer who worked directly for the General Officer Commanding ARITC.

1.4.300. Candidate 4 collapsed during the morning of Day 2 of Soldier Selection after completing the 2km run element of RFT (E) at AC (G) on 19 September 2019. Following Candidate 4's transfer to hospital the ACM notified the RG Hd of Selection, the RG H&S Manager and the Regional Estates Manager (REM).

1.4.301. Two reporting forms were submitted by AC (L) staff: the CASPER form and the RG INCREP. The CASPER report and the RG INCREP were submitted on 19 September 2019 and the RG INCREP continued to be updated with information on Candidate 4's condition. In addition to these reports the Glencorse REM also sent notification to the RG H&S Manager by email.

1.4.302. Shortly after receiving the CASPER report the RG H&S Manager notified the Capita Global H&S Director regarding the accident by email. In addition, the RG INCREP was forwarded from RG to ARITC shortly after its submission.

1.4.303. The CASPER report was forwarded to the AINC by the RG H&S Manager during the afternoon of 24 September 2019. Additionally, during the afternoon of 24 September the INCREP was widely promulgated within ARITC, including their attached PPSI. Further information was requested by ARITC and updates occurred over the course of the period of 24 to 26 September. In addition, the PPSI engaged with APSG to ensure that the accident was tracked. The accident involving Candidate 4 was not deemed to cross the Army threshold for the production of a LA, and a LA and LAR were not published until 3 March 2020, after the accident had been connected to the fatalities of Candidate 1 and 2. The SI Panel could find no evidence that the DAIB had been informed of the accident involving Candidate 4. Exhibit 128

The accident involving Candidate 1

Time / Date	Action / Event	
08:20 17 November 2019	Candidate 1 collapsed.	Exhibit 342
Shortly afterwards 17 November 2019	AC 2IC contacted RG Hd of Selection by telephone.	Exhibit 91
17 November 2019	The Chief Executive Officer (CEO) RG notified the General Officer Commanding (GOC) ARITC by telephone.	Exhibit 96 Exhibit 97
17 November 2019	GOC ARITC notified his Military Assistant (MA) by telephone.	Exhibit 96

Time / Date	Action / Event	
17 November 2019	The MA to GOC ARITC emailed notification to several key individuals, including some within Home Command.	Exhibit 96
Approximately 07:00 18 November 2019	CEO RG was notified by a text from RG Hd of Selection that Candidate 1 had died.	Exhibit 387
18 November 2019	Updated INCREP was sent to COS RG, MA to GOC ARITC and ARITC multiuser email.	Exhibit 74
Morning 18 November 2019	COS RG notified COS ARITC by telephone.	Exhibit 343
Morning 18 November 2019	COS ARITC informed Hd APSG by telephone.	Exhibit 343
10:00 18 November 2019	The Chief of the General Staff[37] was briefed about the death of Candidate 1.	Exhibit 387
NLT 11:00 18 November 2019	RG Hd of Selection updated the INCREP with information relating to three earlier CW candidates who had been hospitalised. This included Candidate 3 and Candidate 4.	Exhibit 94
14:45 18 November 2019	MA to GOC ARITC emailed INCREP to key personnel within ARITC and RG.	Exhibit 344
16:47 18 November 2019	ARITC multiuser email sent INCREP to the PPSI and key personnel.	Exhibit 344
18 November 2019	An informal meeting occurred between COS ARITC and the PPSI at The Royal Military Academy Sandhurst.	Exhibit 335 Exhibit 435
19 November 2019	The RG H&S Manager emailed by the AC (L) staff member deputising for the ACSgtM informing him of the fatality.	Exhibit 337
11:11 20 November 2019	A CASPER report was submitted by ACSgtM.	Exhibit 98
13:51 21 November 2019	DACOS APSG emailed requesting information regarding Candidate 1.	Exhibit 345
14:50 21 November 2019	The PPSI replied to the email from DACOS APSG with information and a copy of the INCREP.	Exhibit 345

[37]The British Army Officer appointed as Head of the Army.

Time / Date	Action / Event	
14:50 21 November 2019	APSG received the email from the PPSI. The attached INCREP was the first formal notification of the accident received by APSG.	Exhibit 345
15:28 21 November 2019	APSG officially informed the DIU and key APSG personnel.	Exhibit 332
21 November 2019	The DIU was informed by the PPSI.	Exhibit 74
13:49 23 November 2019	APSG emailed key RG and ARITC personnel requesting information for a LA.	Exhibit 332
09:25 27 November 2019	The CASPER report was forwarded to AINC by the RG H&S Manager.	Exhibit 99

Table 1.4-7 – Reporting actions for Candidate 1.

1.4.304. Candidate 1 collapsed during the morning of Day 2 of Soldier Selection while taking part in the 2km run element of the RFT (E) at AC (L) on 17 November 2019. Following Candidate 1's transfer to hospital AC (L) staff notified HQ RG who subsequently notified ARITC.

1.4.305. Two reporting forms were submitted by AC (L) staff: the CASPER form and the RG INCREP. The INCREP was submitted on the morning of 17 November 2019 and continued to be updated until after the accident involving Candidate 2. The CASPER form was submitted on the morning of 20 November 2019 and was subsequently forwarded to the AINC on 27 November 2019.

1.4.306. On 18 November 2019 a copy of the INCREP, updated with the information regarding Candidate 1's death, was sent to RG and ARITC. Additionally, during the morning of 18 November 2019 RG notified ARITC by telephone, who notified APSG.

1.4.307. During the afternoon of 21 November, after they became aware[38] of Candidate 1's accident, DACOS APSG sent an email requesting official notification. This email was answered by the PPSI with information regarding the accident and a copy of the INCREP. Following receipt of the INCREP APSG provided official notification to the DIU, who had already received unofficial notification from the PPSI. More information was requested by APSG on the afternoon of 23 November for the purposes of preparing a LA. The SofS and the DAIB were not informed about the accident involving, and subsequent death of, Candidate 1 at that time. Exhibit 128

[38] By this the SI Panel meant that APSG DACOS was informally notified, but they had not received the formal notification in the form of an INCREP.

The accident involving Candidate 2

Time / Date	Action / Event	
08:27 27 November 2019	Candidate 2 collapsed.	Exhibit 127
Approximately 08:45 27 2019	RG Hd of Selection contacted by telephone by the ACM.	Exhibit 332
Shortly after 8:45 27 November 2019	RG Hd of Selection informed CEO RG and COS RG who held an 'immediate' meeting with ARITC.	Exhibit 97
11:33 27 November 2019	ACM submitted a CASPER report.	Exhibit 98
13:22 27 November 2019	Army Secretariat (Manning) emailed APSG notifying them of Candidate 2's accident.	Exhibit 346
NLT 15:23 27 November 2019	ACM submitted an INCREP to RG.	Exhibit 343
15:23 27 November 2019	RG emailed the INCREP to ARITC.	Exhibit 347
27 November 2019	The RG H&S Manager emailed by the AC (L) staff member deputising for the ACSgtM informing him of Candidate 2 being hospitalised.	Exhibit 337
07:34 28 November 2019	APSG emailed DIU notifying them of Candidate 2's accident.	Exhibit 332
08:09 28 November 2019	DACOS APSG contacted the DAIB informing them of the accidents involving Candidate 1 and Candidate 2.	Exhibit 128
09:02 28 November 2019	The INCREP was updated by COS RG.	Exhibit 127
10:24 28 November 2019	ARITC multiuser email account emailed an updated INCREP to key ARITC and APSG personnel.	Exhibit 332
10:29 28 November 2019	The PPSI forwarded the INCREP to APSG.	Exhibit 332
Late on 27 or 28 November 2019	DCDSDO was notified.	Exhibit 100
Approximately 15:00 28 November 2019	In consultation with CEO RG, GOC ARITC ordered a stop to CW candidates taking part in RFT (E) 2km run.	Exhibit 97 Exhibit 435

Time / Date	Action / Event	
08:29 2 December 2019	The RG H&S Manager forwarded the CASPER report to AINC.	Exhibit 99
14:11 4 December 2019	APSG (BAS) confirmed that JCCC would provide full support for Candidates 1 and 2's next of kin.	Exhibit 332
3 March 2020	LA and LAR published.	Exhibit 332

Table 1.4-8 – Reporting actions for Candidate 2.

1.4.308. Candidate 2 collapsed during the morning of Day 2 of Soldier Selection while taking part in the 2km run element of the RFT (E) at AC (L) on 27 November 2019. Following Candidate 2's initial medical treatment AC (L) staff notified the RG Hd of Selection and the RG H&S Manager.

1.4.309. Two reporting forms were submitted by AC (L) staff: the CASPER form and the Army INCREP. The CASPER report was completed and submitted to the CASPER database monitored by the RG H&S Manager in the morning of 27 November 2019. The Army INCREP form was submitted on the afternoon of 27 November 2019 to RG and was promptly forwarded to ARITC and further distributed.

1.4.310. Following the receipt of the INCREP, ARITC promulgated information within ARITC and APSG and to the attached PPSI. During the morning of 28 November 2019, APSG informed the DIU and the DAIB.

Analysis of the Reporting Issues

Notification of the DAIB

1.4.311. While RG and ARITC were organisations containing both military and civilian personnel, both organisations sat within the Army command structure and were bound by the direction contained within ACSO 3216. Exhibit 348-349

1.4.312. ACSO 3216 stated that there was a requirement to inform the DAIB following any death or serious injury. ACSO 3216 provided two key pieces of direction regarding the responsibility to notify the DAIB: Exhibit 128 Exhibit 311

a. 'In addition to reporting incidents to AINC, all deaths, serious injuries or significant losses of equipment capability are to be reported to DAIB.'

b. 'Contact details for AINC and the DAIB POC [Point of Contact] must be included in all Exercise Instructions and Duty NCO, Officer, Staff Officer Folders etc.'

The DAIB were made aware of the accidents involving Candidate 1 and Candidate 2 by APSG, following Candidate 2's accident. The SI Panel could find no evidence that the DAIB had been informed of the accidents involving Candidate 3 and Candidate 4.

1.4.313. As shown in Figure 1.4-21, the requirement to notify the DAIB following a serious accident or fatality was established in the pan-Defence tier of policy. This requirement was repeated in the Army single Service policy document ACSO 3216. These documents provided direction that the DAIB should be contacted directly and contact details were provided. However, this direction was not included in the ARITC Handbook, or the subsequent tier of RG policy. However, direction to contact the DAIB did appear in the ARITC Safety, Health and Environment Two-Year Plan in relation to reporting heat injuries. Exhibit 300-301 Exhibit 309

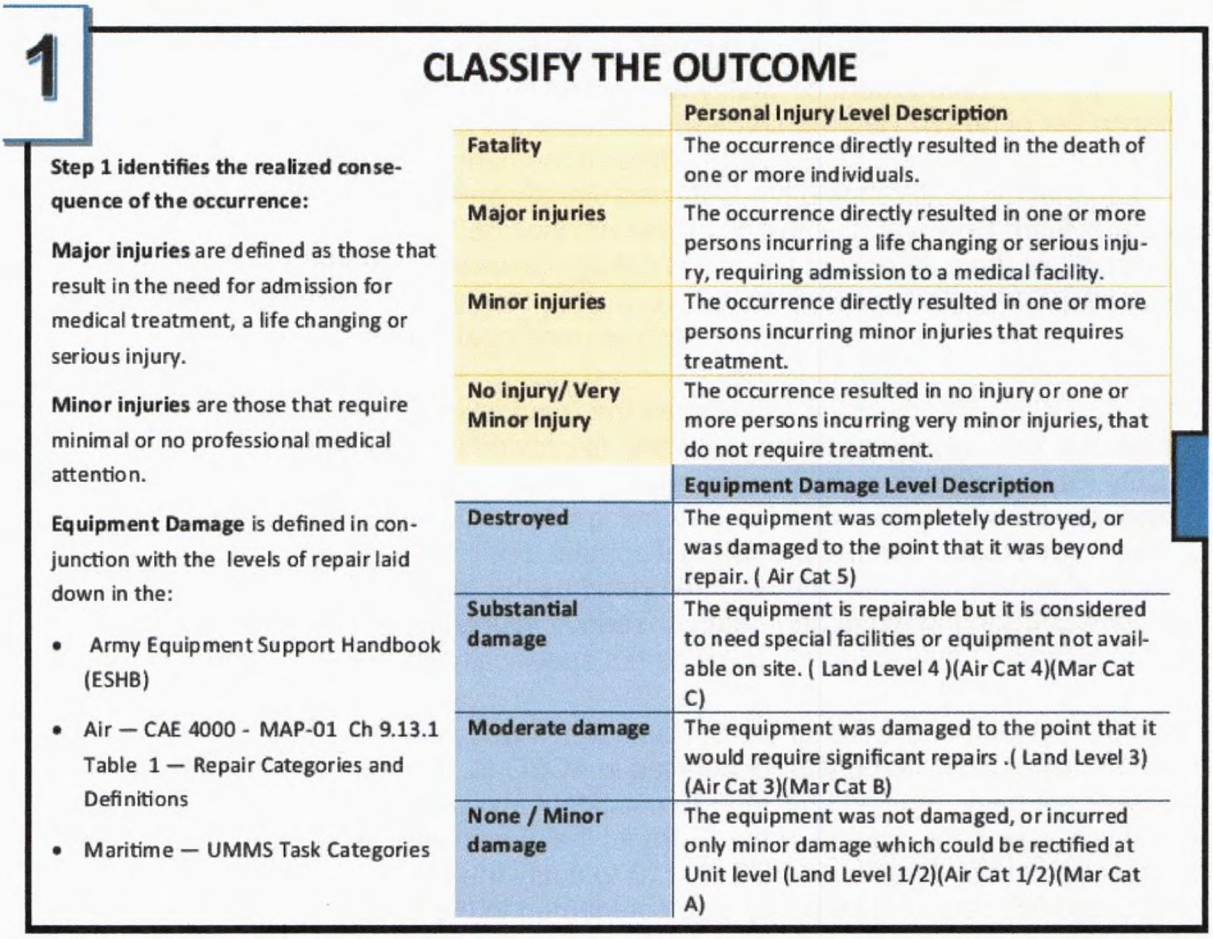
1.4.314. While this direction established the requirement to report all deaths and serious injuries to the DAIB and to provide contact details in all Duty Personnel folders, it did not specify the role, organisation or individual who was responsible for performing this notification. While the SI Panel considered that the provision of contact details in all Duty Personnel folders could have been interpreted as the requirement to notify the DAIB in the event of a death or serious injury, in the form of an implied task for Duty Personnel, this was not specifically stated. Exhibit 309

1.4.315. It was the opinion of the SI Panel that it was very likely that the absence of clear responsibility detailed in ACSO 3216 contributed to the DAIB not being notified until after the accident involving Candidate 2. In addition, it was the opinion of the SI Panel that it was very likely that the absence of the direction in ACSO 3216 to notify the DAIB in the ARITC and RG tiers of H&S policy also contributed to the DAIB not being notified until after the accident involving Candidate 2.

1.4.316. While APSG was the organisation which informed the DAIB following the accident involving Candidate 2, onwards notification of the DAIB was not APSG's responsibility. While any individual could have contacted the DAIB to notify them of an accident, it was the opinion of the SI Panel that APSG's notification of the DAIB on 28 November 2019 was driven by the proactive personalities involved, as well as the good working relationship between APSG and the DAIB, rather than any reporting requirements directed in policy.

1.4.317. The DAIB Deployment Decision Support Matrix (DDSM) shown in Figure 1.4-22 indicated the factors and principles that were used by the DAIB to help determine if an event required the deployment Exhibit 350

of a DAIB Triage Team[39]. The DDSM classified, in Step 3, all instances where a fatality had occurred as ones which 'should probably be investigated by the DAIB' and as ones where a Triage Report would inform further action. The SI Panel understands that this decision-making process occurred following the accident involving Candidate 2, resulting in a DAIB Triage Team being mobilised, and a Triage Report was produced which led to this SI being convened.



1

CLASSIFY THE OUTCOME

Step 1 identifies the realized consequence of the occurrence:

Major injuries are defined as those that result in the need for admission for medical treatment, a life changing or serious injury.

Minor injuries are those that require minimal or no professional medical attention.

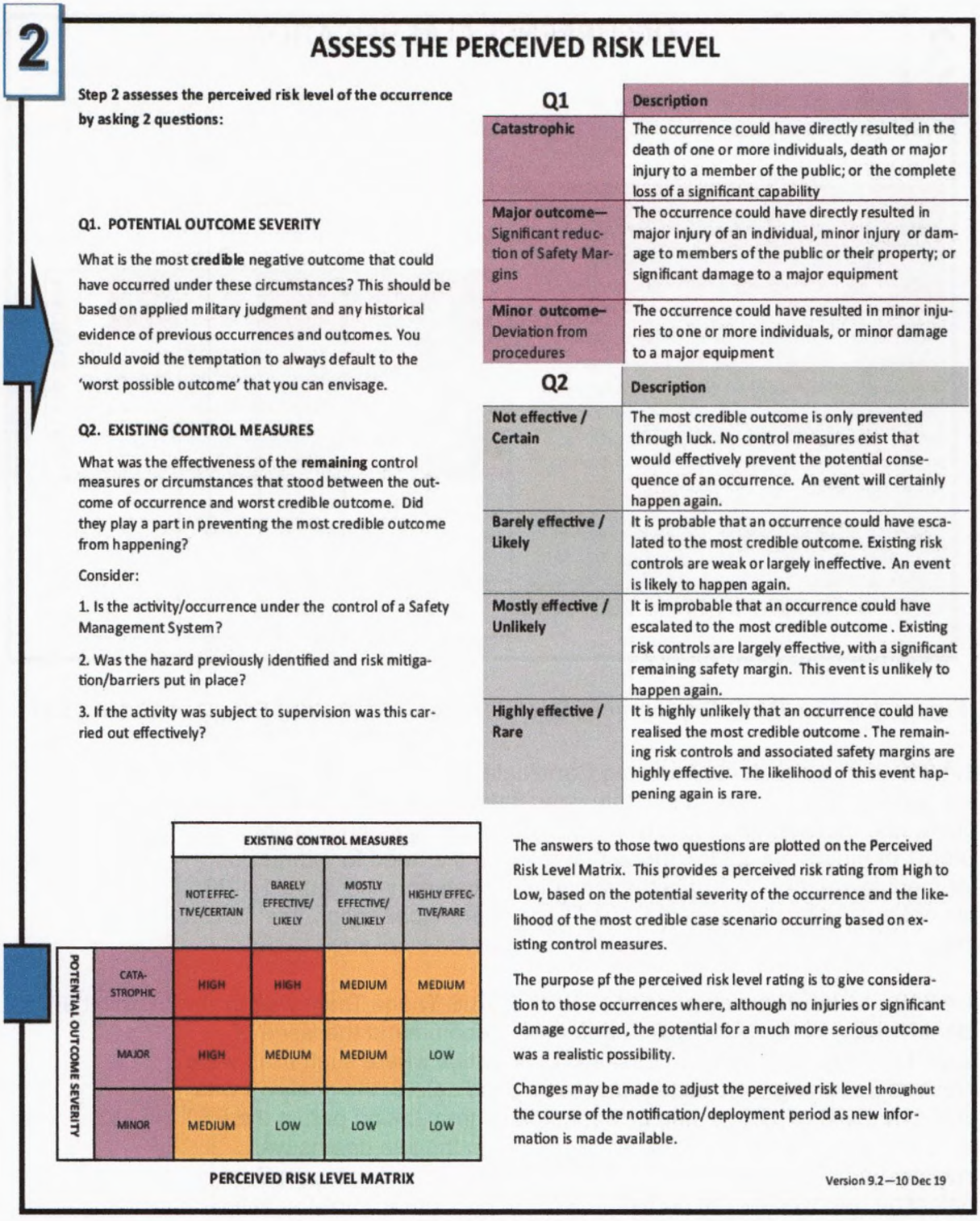
Equipment Damage is defined in conjunction with the levels of repair laid down in the:

- Army Equipment Support Handbook (ESHB)
- Air — CAE 4000 - MAP-01 Ch 9.13.1 Table 1 — Repair Categories and Definitions
- Maritime — UMMS Task Categories

	Personal Injury Level Description
Fatality	The occurrence directly resulted in the death of one or more individuals.
Major injuries	The occurrence directly resulted in one or more persons incurring a life changing or serious injury, requiring admission to a medical facility.
Minor injuries	The occurrence directly resulted in one or more persons incurring minor injuries that requires treatment.
No injury/ Very Minor Injury	The occurrence resulted in no injury or one or more persons incurring very minor injuries, that do not require treatment.
	Equipment Damage Level Description
Destroyed	The equipment was completely destroyed, or was damaged to the point that it was beyond repair. (Air Cat 5)
Substantial damage	The equipment is repairable but it is considered to need special facilities or equipment not available on site. (Land Level 4)(Air Cat 4)(Mar Cat C)
Moderate damage	The equipment was damaged to the point that it would require significant repairs .(Land Level 3) (Air Cat 3)(Mar Cat B)
None / Minor damage	The equipment was not damaged, or incurred only minor damage which could be rectified at Unit level (Land Level 1/2)(Air Cat 1/2)(Mar Cat A)

Figure 1.4-22 – DAIB Deployment Decision Support Matrix: Step 1. Exhibit 350

[39] A Triage Team was a team that consisted of DAIB investigators who produced a report (the Triage Report) and could make urgent safety recommendations to the DG DSA, who would use the information provided to assess whether a SI or an NSI was required.



2 ASSESS THE PERCEIVED RISK LEVEL

Step 2 assesses the perceived risk level of the occurrence by asking 2 questions:

Q1. POTENTIAL OUTCOME SEVERITY

What is the most **credible** negative outcome that could have occurred under these circumstances? This should be based on applied military judgment and any historical evidence of previous occurrences and outcomes. You should avoid the temptation to always default to the 'worst possible outcome' that you can envisage.

Q2. EXISTING CONTROL MEASURES

What was the effectiveness of the **remaining** control measures or circumstances that stood between the outcome of occurrence and worst credible outcome. Did they play a part in preventing the most credible outcome from happening?

Consider:

1. Is the activity/occurrence under the control of a Safety Management System?

2. Was the hazard previously identified and risk mitigation/barriers put in place?

3. If the activity was subject to supervision was this carried out effectively?

Q1	Description
Catastrophic	The occurrence could have directly resulted in the death of one or more individuals, death or major injury to a member of the public; or the complete loss of a significant capability
Major outcome– Significant reduction of Safety Margins	The occurrence could have directly resulted in major injury of an individual, minor injury or damage to members of the public or their property; or significant damage to a major equipment
Minor outcome– Deviation from procedures	The occurrence could have resulted in minor injuries to one or more individuals, or minor damage to a major equipment

Q2	Description
Not effective / Certain	The most credible outcome is only prevented through luck. No control measures exist that would effectively prevent the potential consequence of an occurrence. An event will certainly happen again.
Barely effective / Likely	It is probable that an occurrence could have escalated to the most credible outcome. Existing risk controls are weak or largely ineffective. An event is likely to happen again.
Mostly effective / Unlikely	It is improbable that an occurrence could have escalated to the most credible outcome . Existing risk controls are largely effective, with a significant remaining safety margin. This event is unlikely to happen again.
Highly effective / Rare	It is highly unlikely that an occurrence could have realised the most credible outcome . The remaining risk controls and associated safety margins are highly effective. The likelihood of this event happening again is rare.

POTENTIAL OUTCOME SEVERITY	EXISTING CONTROL MEASURES: NOT EFFECTIVE/CERTAIN	BARELY EFFECTIVE/LIKELY	MOSTLY EFFECTIVE/UNLIKELY	HIGHLY EFFECTIVE/RARE
CATASTROPHIC	HIGH	HIGH	MEDIUM	MEDIUM
MAJOR	HIGH	MEDIUM	MEDIUM	LOW
MINOR	MEDIUM	LOW	LOW	LOW

PERCEIVED RISK LEVEL MATRIX

The answers to those two questions are plotted on the Perceived Risk Level Matrix. This provides a perceived risk rating from High to Low, based on the potential severity of the occurrence and the likelihood of the most credible case scenario occurring based on existing control measures.

The purpose pf the perceived risk level rating is to give consideration to those occurrences where, although no injuries or significant damage occurred, the potential for a much more serious outcome was a realistic possibility.

Changes may be made to adjust the perceived risk level throughout the course of the notification/deployment period as new information is made available.

Version 9.2—10 Dec 19

Figure 1.4-22 – DAIB Deployment Decision Support Matrix: Step 2. | Exhibit 350

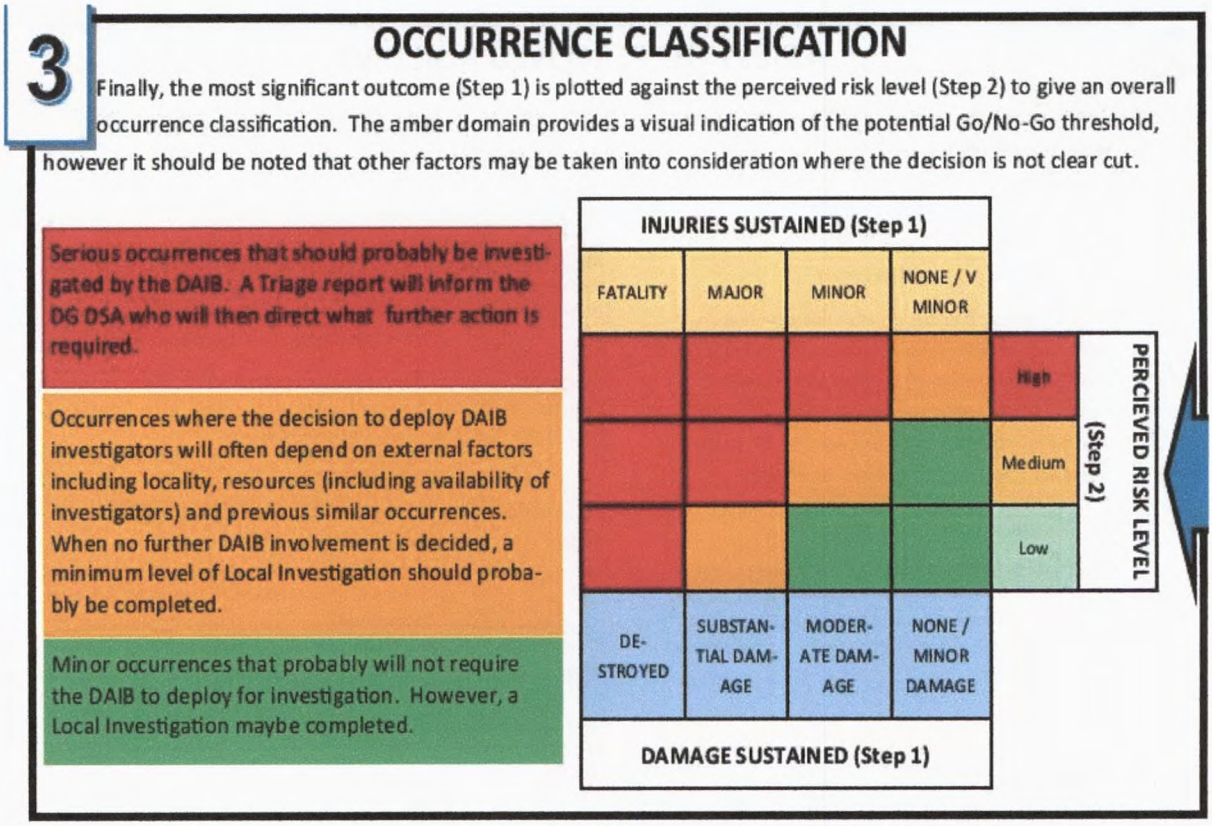


Figure 1.4-22 – DAIB Deployment Decision Support Matrix: Step 3. Exhibit 350

1.4.318. The accidents involving Candidate 3 and Candidate 4, although not fatal, did result in both candidates being hospitalised for prolonged periods, and therefore did fit the major injury criteria shown in Step 1 of Figure 1.4-22 for 'those that result in the need for admission for medical treatment'. While the major injury category in Figure 1.4-22 did not automatically suggest DAIB Triage Team mobilisation, the DDSM made it clear that this action would be considered in all such cases. Exhibit 350

1.4.319. A key function performed by the DAIB Triage Team was to identify enduring risks to life and potentially recommend the issue of urgent safety advice for the cessation of activities where such risks were present. Following the accident involving Candidate 2, the decision was made by GOC ARITC to stop CW candidates from taking part in the RFT (E) 2km run while the circumstances regarding the two deaths was investigated. The removal of this serial for all CW candidates on Soldier Selection removed the immediate risk of reoccurrence while the safety investigation was ongoing. While it was impossible to say whether the candidates would have experienced these injuries at a different point in time, regardless of their participation in the RFT (E) 2km run, it was almost certain that had the decision to remove this serial for CW candidates occurred following the accident involving Candidate 1, the Exhibit 97

accident involving Candidate 2 would not have occurred on 27 November 2020.

1.4.320. As these accidents were related to a medical condition which was rare and poorly understood at the time, it was the opinion of the SI Panel that it was unlikely that the accident involving Candidate 3, even had it been brought to the attention of the DAIB, would have resulted in CW candidates being stopped from taking part in the RFT (E) 2km run at that time. However, as the number of accidents continued to grow during 2019, following the accidents involving Candidate 3, Candidate 4 and Candidate 1, the likelihood that serious attention would have been given to this emerging trend by the DAIB would have increased. Increased attention would, in turn, have increased the likelihood that a measure, such as stopping CW candidates participating in the RFT (E) 2km run, would have been put in place.

1.4.321. Therefore, the SI Panel concluded that it was unlikely that the timely notification of the DAIB of the accident involving Candidate 3 would have prevented the accident involving Candidate 4. However, the SI Panel concluded that had the DAIB been informed of the accidents involving Candidate 3 and Candidate 4 at the time of the accidents, it was more likely than not that action would have been taken prior to the accident involving Candidate 1. This action would have increased the likelihood that the accidents involving Candidate 1 and Candidate 2 could have been prevented. In addition, the SI Panel concluded that had the DAIB been informed of the accidents involving Candidate 3, Candidate 4 and Candidate 1 at the time of the accidents, it was very likely that preventative action would have been taken prior to the accident involving Candidate 2. Such action would have almost certainly prevented the accident involving Candidate 2.

1.4.322. The Service Inquiry Panel finds that not notifying the Defence Accident Investigation Branch of the accidents involving Candidate 3 and Candidate 4 was a **Contributory Factor** in the accidents involving Candidate 1 and Candidate 2.

1.4.323. **Recommendation. The Deputy Chief of the General Staff should ensure that the responsibility, in addition to the requirement, to contact the Defence Accident Investigation Branch (DAIB) is clearly articulated within Army Command Standing Orders, in order to ensure that the DAIB is immediately notified of serious incidents, accidents and fatalities.**

1.4.324. **Recommendation. The General Officer Commanding Army Recruiting and Initial Training Command should ensure that the responsibility, in addition to the requirement, to contact the Defence Accident Investigation Branch (DAIB) is clearly articulated in Army Recruiting and Initial Training Command policies, in order**

to ensure that the DAIB is immediately notified of serious incidents, accidents and fatalities.

Notification of the SofS

1.4.325. Within the MOD, the SofS was regarded as the 'employer' and was answerable to Parliament in respect of the MOD's compliance with the H&S requirements set out in UK law. JSP 375 stated: 'All work-related fatalities to any person (Service or Civilian) on the Defence estate or as a result of Defence activities must be reported to the TLB for the SofS to be notified as soon as possible.' In addition, DSA01.1 stated: 'TLBs/DEAs are responsible for ensuring that the SofS and the DSA, through the Deputy Chief of Defence Staff Duty Officer (DCDSDO), are notified immediately of any work-related fatalities.' Exhibit 287 Exhibit 352

1.4.326. The DCDSDO was not made aware of the accident involving Candidate 1 and was informed of the accident involving Candidate 2 late on either 27 November or 28 November 2019. As the accidents involving Candidate 3 and Candidate 4 did not result in a fatality, those accidents did not meet the criteria for reporting to the SofS. Exhibit 100

1.4.327. JSP 375 and DSA01.1 referred to the requirement to report civilian and military fatalities, however both used the qualifying term 'work-related fatalities'. Candidates taking part in Soldier Selection were not Service personnel subject to military law and discipline or in paid employment during their voluntary participation in the Soldier Selection process. Therefore, if the term 'work-related' was viewed as only applying to individuals taking part in paid employment activities, the candidates taking part in Soldier Selection would not qualify and no obligation for this reporting action would exist. Exhibit 297 Exhibit 307

1.4.328. The SI Panel concluded that an alternative interpretation was that, as the candidates were taking part in Soldier Selection which was a Defence activity delivered by Defence employees on the Defence estate, the deaths of Candidate 1 and Candidate 2, as a result of taking part in this activity, could have been deemed to be 'work-related'.

1.4.329. DSA01.1 followed the quoted passage in paragraph 1.4.325 with a list of information required to be included in the report made to the DCDSDO, first of which was the following: Exhibit 307

> 'Fatality to: Military personnel / MOD civilian / Defence contractor / member of the public as a result of Defence activity.'

The final category of 'member of the public as a result of Defence activity' did not imply any requirement for paid employment to be present for the fatality to qualify for notification of the DCDSDO. It was the opinion of the SI Panel that the inclusion of this information category

justified an interpretation of the term 'work-related' that included the accidents involving Candidate 1 and Candidate 2.

1.4.330. The candidates taking part in Soldier Selection were civilians, as they had not yet been enlisted in the Army. However, the Soldier Selection process which took place at AC (L) was a Defence activity and was conducted on the Defence estate. Therefore, in accordance with JSP 375 the deaths of Candidate 1 and Candidate 2 should have been reported to the SofS as soon as possible.

1.4.331. While the requirement for notification was established in pan-Defence policy, these documents did not provide explicit guidance for any specific individual, role or organisation responsible, outside of the TLB[40], for conducting notification following a fatality. The SI Panel could not identify any individual in the reporting chain who believed that they were responsible for performing the notification of the DCDSDO. When questioned, ARITC staff felt that the reporting was a TLB function and not one to be performed by HQ ARITC. Although the SI Panel were unable to find any one organisation (including the BAS and the Army Secretariat) that believed notification of the DCDSDO was their responsibility, one organisation did state that they believed that notification was a function performed by the JCCC. Exhibit 349 Exhibit 391-392

1.4.332. However, the JCCC was an organisation that provided support and reporting for fatalities and injuries to Service personnel and specific categories of nominated civilians only; categories which did not include the civilian candidates taking part in Soldier Selection. In accordance with ACSO 3216, accidents involving candidates at Soldier Selection should have been reported to the SofS. However, the JCCC, which typically performed this notification, did not include candidates taking part in Soldier Selection within their categories of notifiable casualties. Exhibit 351

1.4.333. The JSP 751 definitions of notifiable casualties included members of the Cadets, while on training activities, as reportable to the JCCC. Like the candidates taking part in Soldier Selection, members of the Cadet forces were civilians. The inclusion of Cadets indicated a willingness to extend the support of the JCCC to civilians taking part in Defence activities. Exhibit 351

1.4.334. Enclosure 19 – RG Incident, Accident and Casualty Reporting stated: 'RHQ RG will notify HQ ARITC (COS, DCOS, MA to GOC or XO if a serious event deemed particularly sensitive or serious enough to warrant immediate notification). In the event of an incident deemed to be of major media interest, advice will be sought from COS ARITC by RHQ Exhibit 305

[40] Defence was organised into six Top Level Budgets (TLBs): the four Front Line Commands, of which Army Command was one; the Defence Infrastructure Organisation; and Head Office and Corporate Services. A responsibility held by a TLB was ultimately held by the head of the TLB (TLB holder) and, when appropriate, delegated within the TLB.

RG.' There was further direction that if it was outside working hours or if RG HQ were unable to be contacted, the incident officer should inform the 'Defence Staff Duty Officer' at MOD Main Building directly and contact telephone numbers for this were listed.

1.4.335. Within Enclosure 19 there was a reference to 'PS2(A) Discipline Policy – 11/2014 G1 Incidents and Matters of Public Interest'. This was an Army discipline policy, published on 14 July 2014, which gave direction on the reporting requirements for 'Incidents involving a criminal, disciplinary or security aspect, death or serious injury, or ammunition or weapons.' This document included the same out-of-hours contact direction as Enclosure 19[41]. Upon testing by the SI Panel, it was confirmed that the out-of-hours contact telephone numbers given in PS2(A) were correct for the DCDSDO's office. Exhibit 317

1.4.336. Although the terminology of 'Defence Staff Duty Officer' differed from the terminology of DCDSDO used in JSP 375 and DSA 01, the terms were very similar. Noting the contact telephone numbers were essentially the same, it was the opinion of the SI Panel that it was very likely that the 'Defence Staff Duty Officer' fulfilled a very similar role to the DCDSDO and that a change in terminology had occurred since the publication of PS2(A) in 2014.

1.4.337. In response to a query from the SI Panel regarding the requirement in DSA01.1 to notify the office of the SofS through the DCDSDO, in relation to the accidents involving Candidate 1 and Candidate 2, ARITIC stated that they were neither aware of the existence of DSA01.1 (as they stated that the document had not been cascaded to them since their establishment in February 2018), nor aware of the reporting requirement stipulated within DSA01.1. However, Enclosure 19 was taken from the 'Commanding Officer Recruiting Group Directive 2016/17' (Directive 2016/17), published on 1 June 2016, and was extant during the period when the accidents involving all four candidates occurred. Exhibit 305-307 Exhibit 407

1.4.338. The SI Panel concluded that the lack of awareness, within RG and ARITC, of this reporting requirement and of the details contained within their own incident and accident reporting policy, was a factor in the DCDSDO, and hence the SofS, not being notified following the death of Candidate 1.

1.4.339. It was the opinion of the SI Panel that had the DCDSDO been notified following the death of Candidate 1, it was very likely that some interaction between the DCDSDO and the DSA would have occurred. The SI Panel concluded that any interaction between the DCDSDO and the DSA would very likely have resulted in the DAIB mobilising a Triage

[41] Notwithstanding an error in Enclosure 19 which had wrongly transposed the dial code for London as 0702 (instead of 0207).

Team to investigate the circumstances surrounding the death of Candidate 1.

1.4.340. It was the opinion of the SI Panel that had the DAIB been informed of the accident involving Candidate 1, via interaction between the DCDSDO and the DSA, at the time of the accident, it was very likely that information concerning the accidents involving Candidate 3 and Candidate 4 would have been brought to the attention of the DAIB at this time. Should this have occurred, it was the opinion of the SI Panel that it was very likely that some action would have been taken prior to the accident involving Candidate 2. Such action would have almost certainly prevented the accident involving Candidate 2.

1.4.341. The SI Panel concluded that the combination of the following factors was likely to have resulted in the probability being reduced that the DCDSDO was notified of the death of Candidate 1:

a. The civilian status of the candidates that meant they did not fall within the categories of nominated civilians in JSP 751 for reporting to the JCCC.

b. The lack of a robust reporting process in place for notification of fatalities to the DCDSDO within the Army TLB.

c. The lack of organisational awareness by RG and ARITC of the requirement to notify the DCDSDO.

Additionally, while it cannot be determined with certainty whether notification of the DCDSDO would have resulted in action that would have prevented the accident involving Candidate 2, the SI Panel concluded that such action was very likely. Not notifying the DCDSDO of Candidate 1's death certainly removed the possibility of such action taking place prior to the accident involving Candidate 2.

1.4.342. The Service Inquiry Panel finds that not notifying the Deputy Chief of the Defence Staff's Duty Officer of Candidate 1's death was a **Contributory Factor** in the accident involving Candidate 2.

1.4.343. **Recommendation. The Chief of Defence People should investigate whether it is appropriate that civilians taking part in Defence recruitment activities are included within the categories of nominated civilians in Joint Service Publication 751 for reporting to the Joint Casualty and Compassionate Cell, in order to facilitate the reporting of fatalities during Defence recruitment activities to the Deputy Chief of the Defence Staff's Duty Officer.**

1.4.344. **Recommendation. The Director Health, Safety and Environmental Protection should update and clarify the reporting measures for fatalities and serious injuries in Joint Service**

Publication 375, in order to ensure that all civilian casualties injured on the Defence estate or as a result of Defence activities are reported. Within 12 months of the update, the Director Health, Safety and Environmental Protection should conduct third party assurance of the Front Line Commands, Defence Equipment and Support and the Defence Infrastructure Organisation, in order to determine the level of compliance with fatality and serious injury reporting requirements in Joint Service Publication 375.

1.4.345. **Recommendation. The Deputy Chief of the General Staff should ensure that a robust reporting process is in place for notification of fatalities to the Deputy Chief of the Defence Staff's Duty Officer, in order to fulfil the reporting requirements in Joint Service Publication 375 for the notification of the Secretary of State.**

Definitions of incidents and accidents

1.4.346. Prior to analysing the use of the INCREP form it is important to clarify the difference between incidents and accidents in MOD policy. JSP 375 defined the terms as: Exhibit 287

a. '**Accident**

(1) Any injury or occupational disease to a person or which caused/had the potential to cause a RIDDOR dangerous occurrence.'

b. '**Incident**

(1) An event which causes loss or damage to property, plant or equipment due to a shortfall in safety measures.

(2) An intervention or enforcement notice from an internal or external regulatory body.

(3) Contamination of an individual or workplace by an article contaminated with Chemical, biological or radioactive (CBR) material.

(4) A CBR contaminated article being lost from institutional control.'

1.4.347. Within the RG accident investigation policy, the following definitions were provided: Exhibit 304

a. 'An Accident is defined as 'an abnormal, unplanned, undesirable occurrence that has resulted in injury or harm to anyone employed or contracted by Capita, someone visiting the workplace or under our direct supervision such as a member of

the public or contractor and also includes damage to property or the environment.'

b. 'An Incident or Near Miss is defined as 'an abnormal, unplanned, undesirable event that has a potential to cause harm to people, property or the environment.'

1.4.348. It was the opinion of the SI Panel that this non-uniformity in terminology could have resulted in an event which had the potential to cause harm being defined as an incident in accordance with RG policy and as an accident by JSP 375. Correct understanding of an event being defined as an incident or as an accident was important in this context because the definition of an event affected which reporting method was directed by policy. For example, the RG INCREP began with clarification that its principle purpose was to report incidents whereas it stated that accidents were to be reported through the CASPER system. Therefore, inconsistent terminology relating to incidents and accidents had the potential to lead to an incident or accident being incorrectly categorised and incorrectly reported. Exhibit 94

1.4.349. The Service Inquiry Panel finds that the inconsistent terminology across Defence relating to incidents and accidents was an **Other Factor**.

1.4.350. **Recommendation. The Director Health, Safety and Environmental Protection should implement uniform definitions for incidents and accidents (and their reporting), in order to reduce the risk of misreporting across Defence and to assist with trend analysis.**

Use of the incident report (INCREP) form

1.4.351. The INCREP form was a reporting format that originated in Army General and Administrative Instructions (AGAI) 62 Discipline Policy. AGAI 62 gave a range of discipline-related guidance dealing primarily with events which had breached military regulations or civil law. The purpose of an INCREP was to inform the chain of command, Senior Officers and Ministers, without delay, of an incident which may have aroused public interest or provoked criticism. Examples of incidents that would have required submission of an INCREP included serious incidents involving ammunition, drink-driving and murder. Exhibit 352

1.4.352. The RG policy, and the RG INCREP itself, directed that reports for accidents should have been submitted using the CASPER system. In the cases of the accidents involving Candidate 3 and Candidate 1, CASPER reports were submitted after, rather than before, the INCREPs were submitted. In the cases of the accidents involving Exhibit 94 Exhibit 305

Candidate 4 and Candidate 2, CASPER reports and INCREPs were submitted on the same day.

1.4.353. In the cases of Candidate 3 and Candidate 1, the requirement for the accident to be reported promptly was fulfilled. However, the method used was not in accordance with the RG policy, as an INCREP form was used initially, instead of a CASPER report. However, as the CASPER report was submitted later in both cases, this deviation from policy did not negatively affect the outcome of the reporting process.

1.4.354. It was the opinion of the SI Panel that, while reporting was not conducted in accordance with RG policy in the cases of Candidate 3 and Candidate 1, AC (L) staff reported the accident, and ensured information was communicated, in a timely manner.

1.4.355. The Service Inquiry Panel finds that the use of a reporting method outwith Recruiting Group policy was an **Observation**.

INCREP version use

1.4.356. The accidents involving Candidates 3, 4 and 1 were reported on a different version of the INCREP than the accident involving Candidate 2. In the cases of Candidates 3, 4 and 1, an RG INCREP was submitted and in the case of Candidate 2, an Army INCREP was submitted. AGAI 62 directed that incident reports should have been submitted using the Army INCREP contained within AGAI 62. The use of a different RG-specific version of the INCREP was a deviation from this direction. This deviation from Army policy was identified during the LA process immediately following the accident involving Candidate 1. The change to use the Army INCREP in place of the RG INCREP was quickly implemented, as can be seen by the accident involving Candidate 2, 10 days later, being reported on an Army INCREP form.

Exhibit 3
Exhibit 74
Exhibit 94
Exhibit 127
Exhibit 187
Exhibit 328

1.4.357. AGAI 62 stated that the unit or formation with knowledge of the incident was to send the INCREP by email or fastest other means to all of the following:

Exhibit 252

a. The Brigade HQ in which the incident has occurred (Media Operations and Discipline departments).

b. The Brigade HQ to which the unit belonged (Media Operations and Discipline departments).

c. The parent two-star HQ of the unit involved in the incident (Media Command and Discipline departments) where the latter was to assess the requirement to inform the three-star HQ.