SERVICE INQUIRY
ARMY PERSONNEL SERVICES GROUP

Service Inquiry Investigation into the death of a Service Person at Royal Military Academy Sandhurst on 6 February 2022

APSG/SI/22/[redacted]

PART 1.1 – COVERING NOTE

APSG/SI/2022/[redacted]

Service Inquiry into the circumstances surrounding the death of a Service Person at Royal Military Academy Sandhurst

1.1.1 The Service Inquiry (SI) Panel formally convened at Andover on 05 Sep 22 by order of **Major General JR Martin DSO OBE MC** for the purpose of investigating the circumstances surrounding the death of a Service Person, who was found deceased in the Wish Stream outside Churchill Hall at the Royal Military Academy Sandhurst on 6 Feb 22.

1.1.2 The following inquiry papers are enclosed for consideration:

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President

[Signature]

Lt Col [redacted]
President Service Inquiry
Army Personnel Services Group (APSG)

Panel Member

[redacted]
Maj
Panel Member 1

Panel Member

[redacted]
Maj
Panel Member 2

PART 1.2 – EXECUTIVE SUMMARY

1.2.1 **Introduction**

1.2.1.1 A Service Person (SP) died in the Wish Stream at the Royal Military Academy Sandhurst (RMAS). A Service Inquiry (SI) was convened to establish the facts surrounding the death and to make such observations and recommendations that could prevent any re-occurrence.

1.2.1.2 The SI Panel identified two potentially affected persons who were afforded their rights according to the Armed Forces (Service Inquiries) Regulations 2008, Regulation 18.

1.2.2 **Incident Overview**

1.2.2.1 The SP attended a social function, known as the Charity Dinner Night, held at RMAS on Fri 4 Feb 22. They consumed alcohol. They were asked to leave the function in the early hours of Sat 5 Feb 22 and subsequently failed to return either to their home or to their duty. After extensive searching they were discovered submerged in a water feature on the site and pronounced deceased on Sun 6 Feb 22.

1.2.3 **Circumstances of Death**

1.2.3.1 The SP fell into a body of water on a very cold night whilst under the influence of alcohol and did not self-rescue.

1.2.4 **Summary of Factors**

1.2.4.1 The Panel evaluated physical features on the site, environmental context and the actions of the SP and concluded that:

1.2.4.1.a An unguarded body of water was a **causal** factor in the SP's death.

1.2.4.1.b Consumption of alcohol **contributed** by degrading the SP's physical and mental capacity sufficiently for them to go near the water and not prevent themself from falling in.

1.2.5 **Other Observations**

1.2.5.1 The Panel considered the leadership and alcohol culture at RMAS, insofar as it contributed to the planning and delivery of dinner nights. It observed that:

1.2.5.1.a Army and RMAS alcohol policies were open to varying interpretation and the delivered training on the effects and dangers of excessive alcohol consumption lacked specific focus on safety. Measures to ensure that people were safe and fit for duty after consuming alcohol were either not adequate or properly exploited.

1.2.5.1.b Poor communication and divergent expectations between the Officer Cadets (OCdts) and the Chain of Command (CoC) led to poor decision-making and

poor behaviours, which sometimes went unchecked. Command relationships had eroded and become normalised over time.

1.2.5.2 The Panel considered the Safe System of Training (SST) at RMAS insofar as the SP was expected to support training on a firing range on the morning they failed to report for duty. It observed that:

1.2.5.2.a Policies that underpin safe planning and conduct of activities were not sufficiently clear. RMAS lacked the capability to assure policy compliance.

1.2.5.2.b Permanent Staff (PS) were under significant pressures, but prioritised safe training above all else. Safety was not compromised.

1.2.6 **Themes of Recommendations**

1.2.6.1 The SI has identified 21 recommendations which are broadly grouped into the following areas:

1.2.6.1.a **Physical Safety**. RMAS must review its Risk Assessment (RA) with specific regard to water hazards. Other MoD sites are invited to re-appraise their RAs.

1.2.6.1.b **Policies & Training**. The Army's messaging about the consumption of alcohol must be clear and constant. Alcohol limits for Safety Critical Duties (SCD) must be explicitly briefed. Existing powers to test fitness for duty should be exploited for their opportunity to inculcate positive behaviours around alcohol.

1.2.6.1.c **Command & Leadership**. RMAS must capitalise its influence on future Army leaders. It must realign its practices with policy and assure compliance. It should take measures to improve formal communication and re-set the command relationship between its staff and students. But it must also continue to provide relevant assessment opportunities to prevent undesirable behaviours being perpetuated in the wider Army.

1.2.7 **Observations**

1.2.7.1 **Good Practice**. The Panel observed that RMAS' focus was firmly on safeguarding its OCdts and improving their lived experience. It took formalised out-of-barracks security activities that comprise SHARKWATCH and incorporated additional measures to protect its people from unacceptable behaviours at in-barracks events. The Panel deemed this good practice but recommends formalising those activities under a different nomenclature to avoid confusion.

1.2.7.2 **Concurrent Improvements**. The Panel identified that a comprehensive cultural improvement plan was being implemented by a new senior leadership team at RMAS concurrent to this Inquiry. It included a full review of Commissioning Courses, employing additional staff and overhauling its policies, staff training and assurance mechanisms. The Panel offered comment on RMAS' significant progress where appropriate but acknowledged that the effect of those changes could not yet be fully evaluated. The Panel's recommendations have been bounded accordingly.

[redacted]
Lt Col
President

PART 1.3 – RECOMMENDATIONS

1.3.1 The following recommendations are made, noting that progress may have been made in resolving these issues in the period between the incident and the publication of this report.

1.3.2 **Recommendation 1.1.1**	1.5.6.3
1.3.2.1 RMAS **must** REVIEW the site RA to consider the risk routinely posed by each water feature individually. Risk to personnel unfamiliar with the site and access for children should also be considered. The unit should RE-ASSESS measures to be taken to prevent unintended access to each of the water features.	
1.3.3 **Recommendation 1.1.2**	1.5.6.5
1.3.3.1 MOD **should** UPDATE the Water Hazard section of the site RA checklist contained in JSP 835 Vol 1 Ch 8 to ensure Water Features and Bodies of Open Water are considered when assessing site risks.	
1.3.4 **Recommendation 2.1.1**	1.5.10.3
1.3.4.1 RMAS **should** EXPLORE whether SO 104 (extant version Sept 22) has had the desired effect, as well as ASSESS the second and third order consequences of its introduction.	
1.3.5 **Recommendation 2.1.2**	1.5.10.5
1.3.5.1 RMAS **should** CONSIDER opportunities that provide suitable latitude for RMAS OCdts to demonstrate their social behaviours. Opportunities should be EXPLOITED as formal assessments, with clear Assessment specifications that include After Action Reviews, to ensure maximum benefit is derived.	
1.3.6 **Recommendation 2.1.3**	1.5.10.8
1.3.6.1 LFC **should** REMIND via COs newsletter the requirement to report via NOTICAS SP missing from duty as soon as possible. This information should be disseminated to all ranks in order to prevent unnecessary delay to reporting.	

1.3.7 **Recommendation 2.1.4** 1.5.10.10

1.3.7.1 LFC **should** ISSUE guidance via CO's newsletter, that at functions at which alcohol is available, organisers should include reminders on alcohol limits for conducting SCD and driving in the safety brief delivered to all attendees. Suggestion that CoC perform a timely post event muster could also be included.

1.3.8 **Recommendation 3.1.1** 1.5.14.3

1.3.8.1 DLW **must** AMEND PAM 21 para 2-32 to increase clarity on written instruction changes to ensure compliance with the SST.

1.3.9 **Recommendation 3.1.2**

1.3.9.1 DPers **must** CONSIDER measures, including policy changes, for assuring fitness for performing safety critical duties. Measures should focus on enabling the CoC to discharge its risk management responsibilities for SCD and consequence management. Additionally, they should enhance the delivery of mandatory alcohol education and increase awareness of fitness for duty requirements. 1.5.14.5

1.3.10 **Recommendation 3.1.3** 1.5.14.7

1.3.10.1 RMAS **must** ESTABLISH a process, captured in local policy, to direct the completion of ITRs to an appropriate level for all PS. This must include identifying who is responsible for ensuring completion, recording, and providing assurance to the CoC. This will provide assurance to the safe people aspect of the SST.

1.3.11 **Recommendation 3.1.4** 1.5.14.9

1.3.11.1 SHA **must** AMEND relevant ITRs to include information regarding SCD and their associated limits in an easily digestible format. This should include the Key Learning Point (KLP) that the lower prescribed alcohol limit for certain common SCDs is one quarter of the drink drive limit for England and Wales (or under half that of the limit in Scotland).

1.3.12 **Recommendation 3.1.5** 1.5.14.10

1.3.12.1 SO1 Discipline **must** ADD to the Compendium of Standing Orders that the following (recommended wording) is included in Pt 1 Orders at an appropriate frequency:

1.3.12.1.a "SPs are reminded that when conducting certain Safety Critical Duties (SCD) the alcohol limit is 20mg of alcohol per 100ml of blood. That is equivalent to one quarter of the drink-drive limit for England and Wales. These duties include Guard Duty, Ranges, Blank and Live Fire exercises. The full list of SCD and alcohol limits can be found at Annex A to JSP 835. SPs are strongly advised not to drink alcohol for 24hours before conducting SCD – someone's life may depend on it!"

1.3.13 **Recommendation 3.1.6** — 1.5.14.11

1.3.13.1 The Unacceptable Behaviours team **must** AMEND the UAA course and UAB to include information regarding prescribed SCDs and their associated limits in an easily digestible format. This should include the KLP that the lower prescribed alcohol limit for certain common SCDs is one quarter of the drink drive limit for England and Wales (or under half that of the limit in Scotland).

1.3.14 **Recommendation 3.1.7** — 1.5.14.13

1.3.14.1 Director Land Warfare:

1.3.14.1.a **Must** UPDATE PAM 21 to clearly state all appointments within Range planning and conduct are classified as a SCD.

1.3.14.1.b **Must** UPDATE PAM 21 to make reference to SCD policy.

In order to increase awareness of the alcohol limits and enhance safety in the execution of SCD.

1.3.15 **Recommendation 3.1.8** — 1.5.14.16

1.3.15.1 RMAS **must** ESTABLISH a process, captured in local policy, to direct the completion of the SRM training to the appropriate level in accordance with ACSO 1200. This must include an assurance mechanism for recording and compliance. This will ensure that risks are being properly assessed and RAs authorised by competent persons.

1.3.16 **Recommendation 3.1.9** — 1.5.14.18

1.3.16.1 RMAS **must** UNDERTAKE a holistic review of PS output and workload. It should consider the allocation of additional resource in order to allow PS to fulfil the formal outputs of the Commissioning courses, and additional duties required, within a sustainable working week. This will ensure the delivery of safe, effective training is not compromised by fatigue.

1.3.17 **Recommendation 5.1.1** — 1.5.17.10

1.3.17.1 RMAS **must** REVIEW their planning and accounting processes with regard to social functions to ensure that CoC have oversight of financial transactions in order to ensure appropriate expenditure.

1.3.18 **Recommendation 5.1.2** — 1.5.18.13

1.3.18.1 RMAS **should** RE-ESTABLISH publication of Company (Coy) Orders and remove any imperative for PS and OCdts to officially communicate via personal means.

1.3.19 **Recommendation 5.1.3** — 1.5.19.11

1.3.19.1 RMAS **should** REDESIGNATE their version of SHARKWATCH. This will allow the intent of the duty to be achieved without giving the OCdts a confused understanding of the Defence security purpose of SHARKWATCH.

1.3.20 **Recommendation 5.1.4** — 1.5.20.15

1.3.20.1 RMAS **should** CONDUCT a thorough review on how to inculcate a psychologically safe environment in which PS and OCdts do not fear imperfection.

1.3.21 **Recommendation 5.1.5** — 1.5.21.14

1.3.21.1 RMAS **should** ENHANCE its local policy to describe a triage response process following an incident to determine appropriate interventions for each individual, so that they each get the right support.

1.3.22 **Recommendation 5.1.6** — 1.5.22.9

1.3.22.1 APSG **should** REVIEW the guidance issued to Units upon requesting a Learning Account (LA) to ensure that LAs are as accurate as possible while still being delivered in a timely manner.

PART 1.4 – NARRATIVE OF EVENTS

1.4.1 **Synopsis**

1.4.1.1 **What happened**. On the evening of Fri 4 Feb 22 the SP attended a ticketed black-tie dining event in New College (NC). The event had been organised by Inkerman Coy for the primary purpose of raising funds for charity. External guests were invited. Food, drink and entertainment were provided within the cost of the ticket.	T17p7
1.4.1.2 The SP participated in the events of the evening, eating, consuming alcohol, and socialising with OCdts and their guests. In the early hours of Sat 5 Feb 22 they were asked to leave on the basis that their demeanour towards an OCdt was perceived to be deteriorating. They left alone and without argument.	T9p19-20
1.4.1.3 Despite being observed walking towards their Service Families' Accommodation (SFA), the SP did not return home from the event, nor did they present for duty that morning at 0815 hours as expected.	T9p20 T17p7 T18
1.4.1.4 Extensive attempts to communicate with and informally establish the whereabouts of the SP the following day failed.	S6
1.4.1.5 Civilian Police were called onto site at 1930 hours on 5 Feb 22 once they were officially notified of a Missing Person. Dedicated search teams arrived on site at 0930 hours on 6 Feb 22.	T11 T21
1.4.1.6 The SP was located by specialised civilian search team members.	T11 T21 F1
1.4.1.7 **When**. Death was pronounced on discovery of the SP on the afternoon of 6 Feb 22, some 38 hours after they were last seen alive circa 0230hours on 5 Feb.	
1.4.1.8 Phone tracking data recovered post-mortem reveals the SP left the function circa 0230 hours and their movement ceased circa 0243 hours on 5 Feb 22.	F2
1.4.1.9 **Where**. The deceased was found submerged in the Wish Stream adjacent Churchill Hall at RMAS.	T11 T21
1.4.1.10 **How**. PM report states drowned, but this will be formally determined at the Coroner's Inquest.	F3

1.4.2 **Timeline**

Event	Date	RMAS event
Born		
Joined Army		
Assigned to Guards Coy, 2 ITB, Catterick as a Platoon Sgt		
Completed RMAS Instructors' Cadre 21		
Promoted to CSgt on arrival at RMAS Assigned to DCCW		
Attends RMAS Day Zero for start of their second term Attached to Inkerman Coy		RMAS Day Zero for PS
	10 Jan 2022	RMAS Day One CC212 starts Senior term
	11 Jan 2022	Planning for charity dinner night commenced
	17 Jan 2022	Initial Inkerman Coy Charity Dinner night organiser brief to CO NC
	1300 2 Feb 2022	Inkerman Coy Charity Dinner night organiser brief to CO NC Dinner night RA approved
	1400 2 Feb 2022	Inkerman Coy given pre-dinner night brief
	1330 to 1815 4 Feb 2022	Inkerman Coy setup for Charity Dinner night

SP	Time	Event
Arrives at NC for Charity Dinner night	1830 4 Feb 2022	
	1830 to 1900 4 Feb 2022	Charity dinner arrival drinks Medals bar open
	1900 to 2200 4 Feb 2022	Meal and charity auction
	2200 to 2359 4 Feb 2022	Entertainment, dancing and socialising in Dining Room
	2300 4 Feb 2022	Medals bar ceases serving
	2300 to 2359 4 Feb 2022	Some attendees move to Wavell Room. Others leave the function.
	2330 4 Feb 2022	Medals bar cleared and locked
Moves from NC Dining room to Wavell room	0001 5 Feb 2022	NC dining room cleared and locked
Arrives in Wavell room	0011 5 Feb 2022	
	c0220 5 Feb 2022	Witness [redacted] observes SP deep in conversation leaning towards Witness [redacted] Witness [redacted] asks SP to leave the function.
SP leaves Wavell room and NC Block A. Walks towards Montgomery Gym alone.	0233 to 0235 5 Feb 2022	Witness [redacted] observes SP walking towards Montgomery Gym in the direction of home. This is the last witness sighting of the SP.

Changes direction and walks across the NC parade ground towards Churchill Hall.	0235 to 0239 5 Feb 2022	
SP enters the Wish Stream	0243 5 Feb 2022	
	c0300 5 Feb 2022	End of function in Wavell Room OCdts return to their individual rooms in NC All OCdts' guests depart RMAS grounds in vehicles
	0300 to 0415 5 Feb 2022	Duty staff ensure OCdts are in their rooms and all guests have left
	0352 5 Feb 2022	SP's spouse first phone call to SP Forwarded to voicemail
	0355 to 2327 5 Feb 2022	SP's spouse makes 37 calls to SP All forwarded to voicemail No other numbers call SP
	0730 to 1230 5 Feb 2022	Inkerman Coy on College Disposal. Clear up of Wavell Room and dining hall
	c0730 5 Feb 2022	SP's spouse informs Cadre [redacted] spouses via WhatsApp that SP has not returned home
	c0745 5 Feb 2022	Witness [redacted] informed by their spouse that SP has not returned home
SP expected to report for duty on Range	c0815 5 Feb 2022	Range staff arrive to conduct Blenheim Coy training
	c0820 5 Feb 2022	Witness [redacted] reports to Range to replace SP as safety staff

Time	Event
0845 5 Feb 2022	SP's spouse informs spouse of OC Duty NCO[1] that SP not returned home. OC Duty NCO informed by spouse.
1000 to 1500 5 Feb 2022	Informal searches, by PS and OCdts, triggered by message on Cadre [redacted] WhatsApp group
1452 5 Feb 2022	ADO[2] and OC RSM[3] informed of SP absence
1512 5 Feb 2022	ADO informs ADFO[4] ADFO informs NC RSM[5]
1715 5 Feb 2022	SP's spouse reports SP missing to Thames Valley Police
1930 5 Feb 2022	Thames Valley Police arrive at RMAS. Met by ADO and speak to SP's spouse. Start of Police searches accompanied by ADO.
0930 6 Feb 2022	Thames Valley Police return to RMAS with Hampshire Search and Rescue. Commence coordinated searches of RMAS grounds and water features.
1645 6 Feb 2022	SP discovered deceased in Wish Stream
1830 6 Feb 2022	Next of Kin, SP's spouse, informed by Police

[1] Old College Duty Non-Commissioned Officer
[2] Academy Duty Officer
[3] Old College Regimental Sergeant Major
[4] Academy Duty Field Officer
[5] New College Regimental Sergeant Major

PART 1.5 – ANALYSIS AND FINDINGS

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1.5.1 Introduction

1.5.1.1 The Panel approached the investigation into the events holistically rather than considering the TORs in isolation; however, the Panel reports on each TOR separately.

1.5.1.2 In relation to the deceased, the Panel primarily concentrated on the SP's behaviours at the event at which they were last seen alive. It also considered evidence relating to the SP's formal and informal routines from commencement of their employment at RMAS. It then considered the SP's previous career only so far as it may be pertinent to their prevalent attitudes and behaviours at the time of their death.

1.5.1.3 In relation to RMAS, the Panel determined the physical environment and prevalent organisational culture factors that were in place when the SP died. It focussed on those factors which could further improve the culture and prevent future occurrences. These broadly included:

1.5.1.3.a Site safety.

1.5.1.3.b Policies and training in relation to alcohol consumption.

1.5.1.3.c Policies and training in relation to the safe conduct of training.

1.5.1.3.d Authority, responsibility, and accountability (Command & Leadership).

1.5.2 Scope

1.5.2.1 In scoping the Inquiry, the Panel was made aware of numerous reforms that were being made at RMAS because of a previous incident in 2019. The Panel noted that at the time of the 2022 death RMAS' focus had been significantly fixed on improving OCdts' experience, whereas the subject of this Inquiry was a member of the PS. The Panel adopted a holistic approach, critically evaluating overlapping cultural improvement work-in-progress where appropriate.

1.5.3 **TOR 1 – Identify contributing, causal, or other factors by examining the events prior to the SP's death and establish the facts surrounding it, including those facts from their career history that are deemed relevant.**

1.5.4 **Evidence and Facts**

1.5.4.1 **The Service Person – Character and Qualification**

1.5.4.2 The SP joined the Army in [redacted]. Throughout their Army career they typified the model soldier - reliable, mature, intelligent and consummately professional.	S1p1 T1p14L44-26 T3p9L22-25
1.5.4.3 In 2019 the SP was assigned to duties as an instructor in the Infantry Training Battalion (ITB) in Catterick where they were responsible for developing trainee soldiers' military skills and inculcating the Army's values and standards. The SP was an exemplary instructor and role model who complied with extant policies and practices in the Basic training environment.	F4 T1 T3
1.5.4.4 Superiors consistently commented that the SP's self-discipline was faultless; peers admired their 'by the book' approach to work and commented that they had never previously failed to show for a duty parade. Nor had they ever presented for duty in an unfit or unprepared state. They were the individual to whom others most often looked for example and guidance.	T1, T3, S1, T18, T10
1.5.4.5 In May 21 they voluntarily participated in a 4-week selection process known as the Sandhurst Cadre. This SP was selected using a revised Cadre criteria which placed greater emphasis on Emotional Intelligence[6]. The SP excelled in all the criteria and was deemed 'selected'.	F5
1.5.4.6 In Aug 21 they were assigned to RMAS as a member of the PS.	F6
1.5.4.7 The SP moved into SFA on site with their spouse, having recently married. Their home life was settled, and they had never not returned at the end of their working day.	T17

6 Emotional Intelligence – the ability to understand, use and manage emotions to communicate effectively, empathize with others, overcome challenges and defuse conflict.

[redacted] In accordance with RMAS policy, the SP had attended a Sandhurst Context Course as well as Day Zero briefings [redacted]

1.5.4.9 **The Service Person - Attitude and Behaviours around Alcohol**	
1.5.4.10 The SP rarely consumed alcohol at home and limited their consumption when with wider family members. At a WOs & Sgts' Mess function at RMAS that they attended with their spouse, the SP drank very little and left early.	T17
1.5.4.11 Several character witnesses gave evidence that the SP did not routinely drink to excess but was not averse to having a social drink with their colleagues. Their behaviour when they did drink alcohol was unremarkable.	T1, T2, T3, T19
1.5.4.12 **The Service Person - At the Company Charity Dinner Night**	
1.5.4.13 The SP attended the Inkerman Coy Charity Dinner Night on 4 Feb 22. They had been associated with the Coy's training activities since 10 Jan 22, so they were invited as a paying guest to this event. PS spouses or partners were not included in the general invitation, so the SP attended unaccompanied.	T13 T17
1.5.4.14 On the evening the SP left their family home wearing a grey tweed woollen overcoat over a dinner jacket. They were also wearing George boots, which have smooth leather soles.	T17
1.5.4.15 They had known that drinks were included in the ticket price and had declined to take cash that their spouse had offered for them to buy a drink at the bar.	T17
1.5.4.16 The SP was not 'on duty' and was therefore eligible to drink alcohol, albeit in accordance with the RMAS Alcohol Policy.	F7
1.5.4.17 The evening commenced at 1832 hours in the Medals Bar (Figure 5-1). The SP accepted a pre-dinner drink.	T10, T15, T9.
1.5.4.18 The SP then moved through to the NC dining hall to take their seat for dinner. The SP sat at a table with their PS colleagues. They were observed drinking beer that they brought through from the Medals Bar.	T10, T15

1.5.4.19 They ate a meal, socialised with colleagues and OCdts and were observed consuming red wine and Peroni beer. Their behaviour throughout the night was largely unremarkable.	T10, T9
1.5.4.20 The meal and a charity auction concluded at approx. 2200 hours. Subsequently there was a band that played in the dining room until 2329 hours. Around 2330 hours many of the attendees continued the social activities by moving into the Wavell Room (Figure 5-1).	T9, T13 F8
1.5.4.21 The Wavell Room had low lighting. It had a disco set up in one corner and the furniture cleared to provide dancing space. In addition, there were several tables lined along one wall and fridge(s) in which various drinks were stored.	T11, T13, T24
1.5.4.22 The Panel noted that accounts vary, but available drinks included non-alcoholic soft drinks, bottled beers and spirits.	T13 F9
1.5.4.23 Approximately ten minutes before the SP left the function, Witness ██, who was the Officer in Charge (OIC) of the event, observed an interaction between the SP and an OCdt that gave them some concern. They had not overheard any of the conversation.	T9p20:
1.5.4.24 The OCdt was of similar age and the same gender as the SP. The OCdt described the conversation as 'professionally intense', relating to lived military experience. They had talked about the preparedness of the other OCdts to carry out operational tours on completion of the RCC. The SP had then pointed at the OCdt's chest saying words to the effect of '*you know what it's like*' [in battle] The OCdt recalled "*it was about, you know, combat… losing soldiers, losing friends*".	T24p9 L22 T24p10 L1
1.5.4.25 Witness ██ had observed the SP leaning in and pointing at the OCdt's chest and judged it wise to intervene.	T9
1.5.4.26 The OCdt stated that the SP "*had a bit of a stagger*" but insisted there had been no cause for concern from their perspective.	T24p10 L18
1.5.4.27 Witness ██ then used their outstretched arm to guide the SP out of the Wavell Room towards a door onto the NC parade ground. Witness ██ stated that the SP did not need any assistance to walk to the door and was not unsteady. According to Witness ██, the SP left calmly, without question. Their decision to direct the SP to leave was a precautionary measure to ensure that professional boundaries were respected.	T9, T24

1.5.4.28 Witness stated that in hindsight they may have been too strict in the application of their duty responsibilities.	T9
1.5.4.29 The OCdt did not accompany the SP or Witness out of the room.	T24
1.5.4.30 The SP left the building at 0231 hours and Witness observed them turning right and walking towards Montgomery gym (Figure 5-2). This was in the direction of the SP's SFA.	T9 F2
1.5.4.31 Witness did not observe any demeanour that suggested the SP would be unable to get home.	T9
1.5.4.32 The SP was wearing their coat. The weather was cold with a temperature of circa 2°C. There was a moon state of circa 20% that night.	F1
1.5.4.33 No-one else was observed leaving at the same time, nor did anyone else observe the SP thereafter.	T9
1.5.4.34 Witness resumed their duty on returning to the Wavell Room. The OCdt remained in the building throughout.	T9, T24
1.5.4.35 At 0235 hours the SP walked back across NC parade square (Figure 5-2). The exact path cannot be determined due to GPS accuracy.	F2
1.5.4.36 At 0243 hours the SP phone ceased to be connected to the mobile network.	F10
1.5.4.37 The SP was located at 1645 hours on Sun 6 February 23 submerged in the Wish Stream adjacent Churchill Hall. The phone was recovered on the SP's person.	T9, T21
1.5.4.38 PM toxicology report showed a blood alcohol level of mg/100mL.	F11
1.5.4.39 **Wish Stream**	
1.5.4.40 The section of the Wish Stream in which the SP died is immediately outside Churchill Hall - a lecture theatre facility which has no accommodation or social facilities within. Pedestrians in that area are not naturally channelled close to the water's edge other than to enter Churchill Hall. There are barriers across the bridge to the entrance of Churchill Hall, but these do not extend around the entirety of the water feature.	Figure 5-1 Figure C.6-1 See Annex C

1.5.4.41 There are Service Families' homes nearby, but the SP was not living in one of those. The SP had been living and working on the site for 5 months.	
1.5.4.42 The water is 1.2m at its deepest point. It is not sufficiently clean, clear water that the bottom can be seen from the water's edge.	F1
1.5.4.43 There was limited low level lighting around the building and the water feature. Trees line the top of the northern grassed slope which blocks the artificial lighting to an extent. The car park and road to the southern and western sides were not artificially lit.	
1.5.4.44 The grassed and concrete sides of the water feature can be slippery. It was 2°C on the morning of 5 Feb 22 and Witness [redacted] had stated that cars needed de-icing at approx. 0300 hours.	F1 T9
1.5.4.45 There is a site RA. It identifies the hazard of Water Features as a single hazard, despite the site containing several different types of water feature.	F12

Figure 5-1 Detailed map of RMAS (DELETED OFFICIAL SENSITIVE)

Figure 5-2 Phone track of SP on leaving Wavell Room (DELETED OFFICIAL SENITIVE)

1.5.5 **Analysis**

1.5.5.1 **Physical Safety – The Wish Stream adjacent Churchill Hall**

1.5.5.2 The Panel first considered the physical environment at the location at which the SP was found. Panel members walked the ground to determine the likelihood of anyone being able to enter the water in similar circumstances and not be able to self-rescue. The Panel also considered the part played by the climatic and light conditions prevalent on the night of the Charity Dinner Night.

1.5.5.3 There is no reason for PS or OCdts to spend time in the immediate vicinity out of working/training hours, less for transiting to other areas of the site or off site. The SP would have been aware of the location of the body of water.

1.5.5.4 The grassed and concrete sides of the water feature were highly likely to be very slippery on the night. The SP was wearing footwear with smooth leather soles which would have reduced traction on such surfaces making it easier for them to slip into the water. F1

1.5.5.5 The SP was above average height, tall enough to have stood head and shoulders above the water. They had passed their Military Swim Test. An average-height adult with full physical and mental capacity entering the water feet first would not likely fully submerge. They would very likely be able to stand, wade and scramble out of the feature or at least call for help. But, the water is sufficiently deep that anyone falling face first would not easily have the reach to push themselves off the bottom. F3

1.5.5.6 RMAS site RA includes water features as a single hazard. Each water feature varies in size, depth and proximity to pedestrian and other traffic etc. **In the Panel's opinion the various water features each present a different hazard and should be considered individually**.

1.5.5.7 **The SP – Alcohol Consumption**

1.5.5.8 The Panel evaluated the SP's sobriety and behaviours during the evening. Particularly from the time they exited the function insofar as it would have contributed to them arriving at the place where they died.

1.5.5.9 The SP had an exemplary character record. They had no disciplinary entries and had carried out their RMAS Instructor / role-model duties professionally in the 5 months prior to this incident. They had been briefed at least twice on the RMAS Alcohol Policy which stated that 'PS must not be drunk in front of OCdts'. There was no historical evidence to suggest they would break the rules or behave below the expected standard. However, on this occasion the SP's behaviour fell below the standards expected of RMAS PS.	F7 T9
1.5.5.10 Alcohol was freely available that night; drinks in the Wavell Room were on a serve-yourself basis. The SP had started drinking at 1830 hours and spent 8 hours at the function. One of the known early effects of alcohol is its ability to cloud an individual's judgement. The Panel noted that the SP was not known to make poor judgement calls when sober, so it is likely that, having consumed alcohol, the SP's judgement was impaired to some degree.	F8
1.5.5.11 OCdts had been known on occasions to 'try to get permanent members of staff drunk' during social functions because otherwise they were 'too rigid'. There was no evidence that the SP had been deliberately plied with alcohol.	T12p23 L42-44 T13, T16
1.5.5.12 There is no way of establishing exactly how much or what type of alcohol the SP had consumed.	F3, F11
1.5.5.13 The Panel observed that there were inconsistencies in evidence as to the degree of the SP's impairments associated with alcohol consumption from the last two people to have seen them. Witness claimed that the SP was displaying some behaviours and impairments associated with alcohol consumption, namely unsteadiness and lack of coordination. Witness indicated the SP was not behaving in a manner which would clearly indicate that they had drunk 'to excess' or breached any rules relating to alcohol consumption right up to the point at which they were seen leaning in towards the OCdt and were asked to leave.	T9, T24
1.5.5.14 The Panel acknowledged that witness observations may vary given the lighting in the room and their proximity to the SP. Observed behaviours are an unreliable indicator of sobriety where no formal, accurate testing has been conducted. On balance, Witness had spent some time talking to the SP, so the Panel prioritised their appraisal of the SP's behaviours.	

1.5.5.15 Despite the Panel accepting that the SP displayed some evidence of their behaviours being affected by alcohol consumption, those in attendance judged that the SPs behaviours did not give sufficient cause for concern to warrant any additional measures being put in place for their safety.	F13, T9, T24
1.5.5.16 **The SP – State of Mind**	
1.5.5.17 The Panel considered whether the circumstances in which the SP had been asked to leave the function had any bearing on them going to the Wish Stream.	
1.5.5.18 Prior to exiting the event, the SP had been participating in an intense, but non-confrontational conversation with an OCdt. When the SP was asked to leave as a precautionary measure, they had not argued or become agitated in any way. They were last observed walking in the direction of their SFA. It is the Panel's opinion that it was unlikely the SP had been so concerned by the circumstances under which they were asked to leave for it to have caused them to intentionally enter the Wish Stream.	T9, T24
1.5.5.19 The SP had consumed quantities of liquid (including alcohol) prior to exiting the event. It is the Panel's opinion that the diuretic effect of alcohol combined with cold climatic conditions probably exacerbated their need to urinate. On recovery it was noted that the SP's state of dress indicated that they were likely urinating in the Wish Stream. Having been asked to leave it is possible that they did not want to be found re-entering the NC building to use the facilities. Other adjacent buildings would have been locked. The SP likely chose to use the Wish Stream as an alternative, out of sight of anyone else exiting the building.	T9, T21
1.5.6 **Findings and Observations**	
1.5.6.1 On the balance of probabilities, the Panel found that:	
1.5.6.1.a An unguarded body of water was a **causal** factor in the SP's death.	
1.5.6.1.b Consumption of alcohol **contributed** by degrading the SP's physical and mental capacity sufficiently for them to go to the Wish Stream and fall in.	

1.5.6.2 **The Panel observed that physical prevention of access to water features on the site would reduce the chances of a future reoccurrence**. It noted that there are occasions when some water features would need to be accessed intentionally and/or under supervision. There is a fishing lake on site for example which could not reasonably be fenced off. The site RA currently groups all water features as one hazard. 1.5.5.6

1.5.6.2.a **Afternote**. The Panel observed that RMAS has already installed lighting around the Wish Stream where the SP died. It erects appropriate temporary barriers around the Wish Stream near NC on occasions when large numbers of people who may be unfamiliar with the site are present, such as Bonfire Night or a commissioning parade. It is the Panel's opinion that this is good practice and temporary barriers should be the minimum preventative measure applied when there is a social function on site.

1.5.6.3 **Recommendation. RMAS must REVIEW the site RA to consider the risk routinely posed by each water feature individually. Risk to personnel unfamiliar with the site and access for children should also be considered. The unit should RE-ASSESS measures to be taken to prevent unintended access to each of the water features.** 1.5.5.6 1.5.6.2

1.5.6.4 RMAS is not the only MOD site to have water features within the grounds.

1.5.6.5 **Recommendation. MOD should UPDATE the Water Hazard section of the site RA checklist contained in JSP 835 Vol 1 Ch 8 to ensure Water Features and Bodies of Open Water are considered when assessing site risks.**

1.5.7 **TOR 2 – Examine the culture within RMAS, including understanding the alcohol policy and procedures, identifying any contributing factors.**

1.5.7.1 The Inkerman Coy Charity Dinner on the night of 4 Feb 22 set the backdrop for the SP's death. The starting point for the Panel's examination of RMAS culture was to determine the circumstances that led to the delivery of the function. It then considered evidence from its planning and execution that could point to wider attitudes towards leadership and behaviours around alcohol at the time. Finally, the Panel evaluated whether Army and RMAS' alcohol policies and training were fit for purpose.

1.5.8 **Evidence and Facts**

1.5.8.1 **Army Alcohol Policy**

1.5.8.2 AGAI Vol 2 Ch 63 gives direction on Alcohol misuse in the Army with an intent to assist commanders in the development of alcohol education, to exercise appropriate duty of care, and to optimise a culture of sensible drinking behaviour for all Army personnel. It provides a framework that enables commanders to make informed decisions about alcohol in their units and formations in order to maintain Operational Effectiveness. It provides authority and direction for commanders to deal with the negative impact that alcohol may have on operational effectiveness. F14

1.5.8.3 **Army Alcohol Awareness Training**

1.5.8.4 The Army provides alcohol awareness training to ensure that all military staff know the dangers of alcohol consumption. The training emphasises the UK Government's safe drinking limits and the health benefits of reduced alcohol intake. It shows Army statistics for occasions when alcohol has been a factor in disciplinary action. The training is delivered at either a centralised briefing, or via an e-learning course hosted on the Defence Learning Environment, a minimum of once each year. F15

1.5.8.5 Each Unit should have a complement of trained UAAs and practitioners. F14

1.5.8.6 **RMAS in Context** Annex C

1.5.8.7 RMAS is, at any given time, a place of work, a home, and a place of social activity as well as a Basic training environment for OCdts. Instructional staff and trainees sit within an Army hierarchy, the CoC, each with varying levels of authority, responsibility, and accountability. All staff and students are expected to lead by example; rules are expected to be followed and professional boundaries are expected to be respected.

1.5.8.8 RMAS' training culture reflects its need to balance treating the trainee (OCdt) cohort as adults and future leaders, with providing an appropriate level of supervisory care whilst they develop the behaviours and standards required of an Army Officer.

1.5.8.9 **Alcohol at RMAS**

1.5.8.10 RMAS is subject to the Army's alcohol regulations. It is also subject to policies that direct annual mandatory training for all staff and students. This includes the alcohol awareness training mentioned at 1.5.8.4.

F14
F15

1.5.8.11 RMAS also had its own local alcohol policy which applies to all staff and OCdts. It sets the conditions for the possession and sale of alcohol. Along with codes of conduct for PS and OCdts, it guided the behaviours expected in relation to the consumption of alcohol on the site. RMAS reminds its staff of its policy, at the very least, on a termly basis via the 'Day Zero' briefing. The OCdt Handbook directs that OCdts are not permitted to bring alcohol on to site.

F7
F18

1.5.8.12 As in most Army Units, RMAS provides facilities for its staff and students to consume alcohol. There are several locations that are licensed for the sale of alcohol through a contract with Aramark and several others where alcohol may be consumed. PS and OCdts have separate bars and do not routinely socialise together. On a limited number of authorised occasions PS and OCdts have an opportunity to consume alcohol in each-others' presence; the Charity Dinner Night was one such occasion.

F7

1.5.8.13 **Formative Assessment of OCdt Behaviours around Alcohol**

1.5.8.14 Formative assessment of behaviours is a key element of the overarching Assessment Strategy for all RMAS commissioning courses. Behaviours around alcohol would be no exception. On the RCC there are typically 4 opportunities to assess OCdts on their behaviour in an Officers' Mess. There are 3 authorised Regimental dinner nights. Those functions follow a formal programme, have a strict seating plan and OCdts are typically tasked with hosting official guests. Alcohol is served by the licensed contractor to those who wish to consume it. However, there are no formal assessment specifications for these training events.

S9, S10

1.5.8.15 The Coy Charity Dinner Night was programmed in to the CC212 senior term. It was the other authorised function and was used as an opportunity to assess OCdts at a less-formal Officers' Mess event. OCdts could invite their own guests, choose their own seating plan, socialise with whom they wished, participate in entertainment, and consume alcohol if they chose. The main feature, a charity auction, would typically involve OCdts bidding on goods or 'services' that had been offered by external agencies, or the PS. Some PS would be there on duty, others could attend as paying guests.	F16
1.5.8.16 According to the staff, the Charity Dinner Night also presented the opportunity for some of the higher-quality OCdts to be assessed on their planning and organisation skills.	T9
1.5.8.17 **Inkerman Company Charity Dinner Night - planning & execution**	
1.5.8.18 In week 1 of the senior term, Witness █ volunteered to be the Function Officer in Charge (OIC). OCdts from the Coy volunteered to be part of the organising committee. Witness █ volunteered as OCdt IC.	T9, T13
1.5.8.19 The College Senior Major sent an email to the Function OIC on 11 Jan 22 regarding the planning. They included a link to SOI 104 - the RMAS Alcohol Action Plan. The e-mail directed the organisers to use the Aramark contract for the purchase of all drinks. The organisers were told to come up with a plan and then let the Commanding Officer New College (CO NC) know the detail.	F17 F7
1.5.8.20 The Function OIC forwarded that e-mail to OCdt IC but added some notes from the organisers of the previous term's event in Oct 21. Those notes stated that the OCdts in Oct 21 did not use the Aramark contract to purchase alcohol. It strongly recommended that for the Inkerman Coy Charity Dinner night they 'try to get away from' [sic] the Aramark contract.	F19
1.5.8.21 The OCdt IC checked what the costs would be using the Aramark contract and concluded that they would get more for their money by purchasing elsewhere. Having been given the option, the OCdt chose not to use Aramark.	T13
1.5.8.22 On 17 Jan 22, the Function OIC, OCdt IC, Inkerman Coy OC and CSM met with CO NC to outline the initial plan for the main events of the night and seek approval of the broad concept.	F8, F20, F21 T7, T9, T23

1.5.8.22.a At that meeting the organisers verbally requested permission for the event to continue beyond the closure of the licensed bar at 2330 hours. The Wavell Room was an authorised area where the collective consumption of alcohol was permitted by SOI 104. Alcoholic drinks would not be for sale. However, they wanted to provide some drinks in there so that there was not a hard stop to the evening. One of the OCdts had been a DJ and had offered to set up a 'disco'.	T13, T23
1.5.8.22.b CO NC assessed that as there was no sale of alcohol, nor did the drinks constitute a night tray or honesty bar, the timings in the SOI did not apply.	T23
1.5.8.22.c CO NC verbally granted permission for extended hours. This decision was based on a rationale which was not explicitly communicated to the organisers. This was:	T23
1.5.8.22.c.(1) To '*control and contain people*' in a safe environment and avoid the necessity or desire for OCdts to go off-site to less-well regulated, possibly unsafe, venues. They reasoned that the OCdts would at least benefit from overwatch and guidance by the staff who were experienced in Care of Trainees.	T23p18 L38-41
1.5.8.22.c.(2) To reduce or eliminate the likelihood of undesirable or unacceptable behaviours. They were fully aware of previous tragic events at RMAS. They also knew that the senior leadership team's focus at that time was on OCdts' safety (particularly females).	T23
1.5.8.22.c.(3) The anteroom was a safe space for OCdts to socialise after the main events. They envisaged a '*gradual tapering off and people drifting off to bed*'.	T23

1.5.8.22.d CO NC agreed to having drinks available but only verbally articulated the condition that there was '*to be beers, no spirits within there and soft drinks available*'.	T23p19 L21-22
1.5.8.22.e CO NC verbally communicated their intent for the function to the organisers. That was to:	T23
1.5.8.22.e.(1) Demonstrate how to deliver an event well.	
1.5.8.22.e.(2) Show off the Coy and the NC facilities to their friends.	
1.5.8.22.e.(3) Enjoy themselves.	
1.5.8.23 The OCdts drew a cash float of £5000 with which to purchase goods and services for the function at their discretion.	T13 T21
1.5.8.24 One week before the function, 2 of the OCdts went off-site and bought provisions for the event. When deciding what alcohol to purchase, the OCdt IC reasoned that they wanted people to be able to have some alcohol available after the dinner, but that they did not want people drinking heavily at the end of the night. They also reasoned that they ought to provide alternatives for those who would not want beer or soft drinks. That rationale led them to purchasing bottles of spirits to combine with mixers as well as the beer, cider, wine, port and soft drinks. The purchase of spirits was contrary to the direction given by CO NC (see 1.5.8.22.d) and contravened the code of conduct contained in the Cadet Handbook. None of the PS or the CoC checked on the quantity or type of alcohol purchased prior to the event and in spite of CO NC direction that no spirits were to be consumed, turned a blind eye to the type of alcohol that was being consumed during the event.	T13 F9
1.5.8.25 They brought their purchases back to the site and secured some in the [redacted] Platoon CSgt's storeroom, with the balance in their own private cars.	T13 T18
1.5.8.26 The Coy OC planned a rehearsal for 1 Feb 22. It would involve the Function OIC, OCdt IC, Coy OC and CSM. This did not take place as the Coy OC and CSM were medically absent from 30 Jan 22 until 7 Feb 22.	T7, T8

Paragraph	Reference
1.5.8.27 On 2 Feb 22 Function OIC and OCdt IC briefed CO NC again. They collectively reviewed the written RA which had been produced by and They went through point by point verbally. Relevant aspects are:	T13, T23
1.5.8.27.a The RA showed 'alcohol' as a hazard.	F21
1.5.8.27.b Mitigation measures for this hazard were listed as: SHARKWATCH activity by 4 PS, inviting the ADO and all 3 Inkerman Coy CSgts to remain until the end of the night to ensure no guests remain on camp.	
1.5.8.27.c In addition, the opening brief was to remind all personnel to hydrate and behave.	
1.5.8.28 CO NC signed off the RA at the end of that meeting.	T23
1.5.8.29 The Function OIC briefed OCdts on 2 Feb 22 covering safety matters with a focus on Alcohol and the behavioural standards expected of them and their guests.	T9
1.5.8.30 On 4 Feb 22, Inkerman Coy OCdts set up the Wavell room and dining hall for the charity dinner from 1300 hours onwards. They placed a selection of alcoholic and non-alcoholic drinks in the Wavell Room which would be available on a 'help-yourself' basis. These included beers, spirits and mixers as well as soft drinks.	T11, T13, T24
1.5.8.31 The OCdt IC also recalled that some ('*no more than ten*') of the Coy's cadets had expressed concern that there would not be sufficient alcohol, so had gone out in their own private capacity and '*bought their own the afternoon before the dinner*'. During the set-up, that alcohol was placed in areas of the building, including classrooms, where it could be easily accessed after the dinner by those who purchased it. This was not authorised, or known, by the CoC and, again, contravened the code of conduct contained in their Cadet Handbook.	T13p21 L19 T13p21 L7-10
1.5.8.32 Function OIC was present for some of the set-up time prior to getting changed into uniform at approximately 1800 hours. In the absence of the Coy OC, they were the senior member of PS that night. The Function OIC delivered the pre-event brief primarily dealing with COVID-19 and fire safety.	T9

1.5.8.33 The Medals Bar opened at 1830 hours and the function proceeded as planned. The bar was operated by Aramark staff in accordance with policy under UK licencing rules for the sale and consumption of alcohol. It ceased selling at 2300 hours and was clear and closed by 2330 hours.	F7
1.5.8.34 Anyone who had not already moved down to the Wavell Room area did so after the bar closed. RMAS SHARKWATCH OIC recalled that some OCdts had clearly had enough to drink by that stage and he had sent them to bed. Those remaining continued socialising, dancing or drinking according to their preference.	T9, T11
1.5.8.35 **RMAS SHARKWATCH activity at the Inkerman Company Charity Dinner Night**	Annex C for SHARKWATCH background
1.5.8.36 There were approximately 200 people at the function, including civilian guests. RMAS SHARKWATCH was active. 4 members of PS had been nominated for the duty, which exceeded the minimum directed of 1. On the night 1 was medically absent and did not attend. A second left early at approximately 0030 hours with the consent and prior knowledge of Function OIC, leaving 2 to oversee the activities during the final stages of the function.	F22 T7, T9, T10, T11 F21
1.5.8.37 All those on the duty understood, despite having no RMAS-specific written orders, that they were there to prevent excessive alcohol consumption, unacceptable behaviours and to maintain standards. In addition to the incident involving the SP, Function OIC recalled dealing with other minor incidents that night.	T9, T10, T11
1.5.8.38 At the end of the function, the remaining RMAS SHARKWATCH carried out checks to make sure civilian guests had left the building and OCdts had gone to their respective rooms. In accordance with the conditions on the RA, they were assisted by the Coy's CSgts who had not been on RMAS SHARKWATCH that evening and had consumed alcohol.	T9, T11, T12
1.5.8.39 At approximately 0400hours Function OIC found '*a group of people still drinking*' in one of the Platoon coffee-rooms. They noted a bottle of spirits was present. They identified a guest that had not left the building and, at some point, drove them to the camp gate. There were also two OCdts '*having a spat*' which they had to physically break up. Function OIC recalled finishing their duty circa 0445 hours.	T9p18 L24 T9p18 L 34 T9 T11

1.5.8.40 On the morning of 5 Feb 22, Inkerman Coy were programmed for 'College Disposal' from 0730 hours to 1230 hours. During this time they were expected to clear up the Wavell Room and dining hall ready for the Blenheim Coy Charity Dinner that was being held that evening. OCdt IC co-ordinated the efforts and believed that they started around 1100 hours.	F23 T13
1.5.8.41 The OCdts were programmed for sports parade at 1330 hours. This was the first time that the PS formally mustered and accounted for all the OCdts.	

1.5.9 **Analysis**

1.5.9.1 **Army Alcohol Policies**

1.5.9.2 The Panel considered whether the Army alcohol policy was fit for purpose. It noted that some aspects of AGAI Vol 2, Ch 63 are sufficiently open to interpretation as to be unhelpful. It refers to curbing 'excessive' alcohol consumption and provides guidance for dealing with someone who is a 'danger' to themselves or others through alcohol. However, without the means to conduct accurate testing, or even an indication of representative behaviours, people must rely on their subjective judgement, as happened in this case.

1.5.4.26, 1.5.4.31, 1.5.5.13

1.5.9.3 It also gives Commanding Officers (CO) the authority to test where they have reasonable cause to believe that an individual may be unfit for duty due to alcohol consumption. However, this power is rarely exercised due to the practicalities, complexities and legality of testing and the presumption that the test is precursor to disciplinary action.

1.5.9.4 **RMAS Alcohol Policy - SOI 104**

1.5.9.5 This policy is supposed to be read by all PS at RMAS. Its essential content is routinely briefed on Day Zero at the start of each term and on the Staff Context Course. The policy contained sufficient detail with regard to timings, alcohol sales and authorised events such as the Charity Dinner Night. Some elements could be open to differing interpretations, such as what constitutes 'drunk' with 'impaired judgement' or 'consumption' rather than 'sale' of alcohol. SOI 104 exacerbated the lack of clarity observed in AGAI Vol 2, Ch 63 and further weakened the Army's stated position with regard to improving its alcohol culture.

1.5.9.2

1.5.9.6 Even if it were clear, the detail and importance of SOI 104 would likely be lost in a day filled with numerous other briefings. There is an assumption that individuals who have been briefed are able to fully understand and immediately implement the policy. Policies and instructions are made available to the staff electronically and all senior staff operate an 'open door' policy for those who seek clarification. However, as soon as the OCdts arrive on their course the staff have an exceptionally busy schedule. They frequently work long hours and simply do not have sufficient opportunity to read and reflect on policies, check their own understanding, or raise issues through the CoC when they observe inconsistencies or contradictions.

1.5.9.7 SOI 104 was superseded by SO 104 in Sep 22. It has removed inconsistencies regarding sale versus consumption of alcohol, provides clarity on authorisation requirements and describes much tighter control over alcohol consumption in general.	F24
1.5.9.7.a Junior term OCdts are now restricted to consuming no more than 4 units of alcohol per day. Alcohol is only served Thursday, Friday and Saturdays from 1900 hours to 2100 hours. At the dinner night they may only consume wine at the table that is served by contracted staff.	F24
1.5.9.7.b Intermediate term OCdts can now only be served alcohol throughout the week from 1900 hours to 2200 hours. At their dinner night they may only consume wine at the table that is served by contracted staff and a single alcohol drink afterwards.	F24
1.5.9.7.c Senior term OCdts can now only be served alcohol throughout the week from 1900 hours to 2200 hours. At the dinner night they may consume one pre-dinner drink, wine at the table that is served by contracted staff, and other alcohol until 2300 hours.	F24
1.5.9.8 Unacceptable and undesirable behaviours have occurred since the policy change; the panel have not explored them or their direct correlation to the SO 104 revision.	T22

1.5.9.9 **Alcohol Awareness Training**

1.5.9.10 The training largely focuses on the health and disciplinary aspects of alcohol consumption. There is insufficient emphasis on the safety aspects including details of SCD and their alcohol limits. This is also relevant to TOR 3.

1.5.12.19

1.5.9.11 The Panel observed that attendance at training and briefs does not necessarily translate to changed behaviours.

1.5.9.12 **Formative assessment of behaviours around alcohol**

1.5.9.13 The Panel considered it reasonable to hold an informal function during training, which is representative of those that the OCdts will attend in the wider Army. RMAS should provide opportunities to expose attitudes and behaviours during training so that they can be corrected or eliminated early; therefore, using the function to formatively assess the OCdts' behaviours around alcohol was valid. It is the Panel's opinion that all the PS at these functions should be on duty to act as assessors.

1.5.9.14 **Inkerman Company Dinner night planning**

1.5.9.14.a **Authority to extend the function timings**. The SOI focussed on the sale of alcohol and the licensed bar timings. The organising committee found the Aramark costs too high and chose to purchase their own drinks outside of the Aramark contract as previous Charity Dinner nights had done. The wording of the extant SOI 104 allowed the function to run until 0300 hours, with alcohol available for consumption in the Wavell Room.

1.5.9.14.b In the Panel's opinion an extension to the licensed bar provided by the contractor would have provided an additional element of control over alcohol consumption.

1.5.9.14.c **Communication**. The CO NC directly communicated the type of alcoholic drinks that could be available in the Wavell Room to the organisers, if only verbally. The OCdt IC's action in purchasing spirits was inconsistent with CO NC's direction and intent. The organisers had opportunities to tell the CO NC that they had bought spirits, but they did not do so. In the Panel's opinion it was reasonable that the CO NC did not cross-check; they trusted the Function OIC and OCdt organising committee and had no reason to think that their original instructions were not being followed.

1.5.9.14.d OCdts bringing alcohol onto the site contravened policy. OCdt IC assumed they had been granted permission to bring alcohol onto the site for this function by virtue of being given permission to purchase all the goods and services for it. The email that originated with the Senior Major, sent via Function OIC, contained contradictory information and, in the Panel's opinion, encouraged and gave authority for the OCdts to purchase drinks off-site. Actions by the PS, namely enabling the alcohol to be stored in a Platoon storeroom, only served to reinforce those assumptions.

1.5.9.14.e **Risk Assessment and Mitigation**. The written RA did not contain sufficient detail to ensure that all risks could be properly mitigated. CO NC considered that the greatest risk factor was unacceptable behaviours; their focus was their duty of care to the OCdts, specifically female OCdts, but this was not explicitly documented on the RA.

1.5.9.14.f The additional risk that was introduced by the purchase of high-Alcohol By Volume (ABV) drinks for the Wavell Room had been underestimated by the OCdt organising committee. It was not briefed up the CoC or documented on the RA.

1.5.9.14.g Risk mitigation included SHARKWATCH activity. The RMAS SHARKWATCH team was clear on their purpose despite having no policy guidance. They used their experience and training to decide for themselves what constituted 'excessive' consumption or 'unacceptable' behaviours and what actions would be appropriate.

1.5.9.14.h The Panel questioned whether there were sufficient staff allocated to the duty given the numbers of people expected at the function and its extended duration. After the main events, CO NC had expected a significant wind down; the OCdts had envisaged socialising and dancing the night away. The RMAS SHARKWATCH team was depleted to just two members of staff at the time in the function that it was most needed. This was below the number declared as a mitigating factor in the RA. In the Panel's opinion there were insufficient numbers of PS on duty for the duration of the event.

1.5.9.14.i **Duty of Care (DoC)**. CO NC highlighted that they were concerned for the safeguarding of the OCdts. However, to mitigate the effects of a long night, the OCdts had been given the morning off and PS would not be checking on them until the sports parade in the afternoon of 5 Feb 22. This gave a period of time, after a function, where OCdts and PS were unaccounted for.

1.5.9.14.j The RA considered the hazard of alcohol consumption and a late night. These were mitigated for Inkerman Coy attendees by programming a late start. However, there were attendees from outside the Coy who were not able to take advantage of the late start. The pre-event brief could have been an opportunity to remind all attendees of their responsibility to ensure they would be fit for duty the following day and reinforce the alcohol limits for driving/SCD.

1.5.10 **Findings and Observations**

1.5.10.1 **The Panel found a distinct divergence of expectations between the CoC and the OCdts. People, under time pressure and pressure to perform, made assumptions that they were acting within their delegated authority or failed to seek clarity. The desire to put on a good event and raise money for charity seemed to override the application of appropriate controls and exposed weaknesses in the RMAS' command relationships and attitudes to alcohol.**

1.5.8.19
1.5.8.20
1.5.8.22.d
1.5.8.22.e
1.5.8.24

1.5.10.2 **The Panel observed that RMAS' comprehensive review of Direction and Guidance, and the subsequent production of SO 104, could be seen as an attempt to resolve issues relating to alcohol, unacceptable behaviours and relaxed attitudes**. The new restrictions relating to alcohol consumption on site may be having unintended consequences and generating additional risk. It does not allow OCdt interactions with alcohol in barracks to be exploited as the behaviour-shaping opportunities that they could be.

1.5.9.7
1.5.9.8
1.5.9.13

1.5.10.3 **Recommendation. RMAS should EXPLORE whether SO 104 (extant version Sept 22) has had the desired effect, as well as ASSESS the second and third order consequences of its introduction.**

1.5.10.4 **The Panel observed that the Coy Charity Dinner nights were not properly designed in accordance with training objectives, or sufficiently well-regulated, to fully exploit the opportunity to develop and assess the OCdts' behaviours around alcohol**. RMAS has now removed the Coy Charity Dinner Night from the OCdt training programme. SO 104 now tightly controls alcohol consumption at formal functions. There is now no opportunity for OCdts behaviours to be assessed, monitored, challenged, and corrected if required, in a safe environment in which alcohol is freely available. This consequently transfers a risk of alcohol-related poor behaviour(s) to wider Army units.

1.5.9.12

1.5.10.5 **Recommendation. RMAS should CONSIDER opportunities that provide suitable latitude for RMAS OCdts to demonstrate their social behaviours. Opportunities should be EXPLOITED as formal assessments, with clear Assessment specifications that include After Action Reviews, to ensure maximum benefit is derived.**

1.5.10.6 In the Panel's opinion RMAS SHARKWATCH, whilst under-staffed, were clear about their purpose and the rationale for extending SHARKWATCH principles to an internal function was sound.

1.5.10.7 **The Panel observed that the CoC programmed a late start following the function to mitigate the effects of alcohol consumption and a late evening, however there is no evidence that an appropriate, timely DoC check was programmed or carried out. Some attendees were programmed to perform SCD on the morning after the function.** A muster of military personnel in the morning after an event would identify early any personnel absent or missing from their place of work or residence. It would reassure the CoC that all military personnel were accounted for. Where personnel are absent, a timely investigation or search could be initiated with the aim of reducing the time taken to find them.

1.5.9.14.i

1.5.10.8 **Recommendation. LFC should REMIND via COs newsletter the requirement to report via NOTICAS SP missing from duty as soon as possible. This information should be disseminated to all ranks in order to prevent unnecessary delay to reporting.**

1.5.10.9 **The Panel observed that some attendees would be required to perform SCD following the function, but the organisers were unaware of this**. Whilst Army policy and training emphasizes that individuals must take responsibility for their own fitness for duty, the CoC should provide a timely reminder to attendees of the information they need to make the right choices about their alcohol consumption prior to an event. This is in addition to the organisation's responsibilities to provide and assure a Safe System of Work which is evaluated in TOR3 below.	1.5.12.2below
1.5.10.10 **Recommendation. LFC should ISSUE guidance via CO's newsletter, that at functions at which alcohol is available, organisers should include reminders on alcohol limits for conducting SCD and driving in the safety brief delivered to all attendees. Suggestion that CoC perform a timely post event muster could also be included.**	1.5.9.14.j

1.5.11 **TOR 3 –Identify and understand how the SST policy is implemented and assured at RMAS, in particular, but not limited to, Safety Critical activities.**

1.5.11.1 The Panel investigated the SST insofar as it is relevant to this incident. The Panel firstly considered the SP's duty for the morning of 5 Feb 22, namely, to assist with the conduct of a static range on the local training estate. Secondly, the panel considered the safe planning and conduct of the Charity Dinner night.

1.5.12 **Evidence and Facts**	
1.5.12.1 **Safe System of Work (SSW)**	
1.5.12.2 The MOD employs the Safe System of Work (SSW) for all Activities across Defence to comply with UK Health and Safety legislation. In addition to the requirement for a SSW, training environments must employ a SST. The SST comprises of Safe Persons, Safe Equipment, Safe Place and Safe Practice.	F25 F26 F27
1.5.12.3 **SCD**.	
1.5.12.4 SCD are either:	F28
1.5.12.4.a Those that are prescribed in Regulations (JSP 835) as SCD. These are referred to as Prescribed Safety Critical Duty (PSCD).	
1.5.12.4.b Those that a CO reasonably believes to be safety-critical within the meaning of the term as set out in section 93I of the Armed Forces Act 2006 as amended.	
1.5.12.5 The alcohol limits for breath and alcohol are defined in Armed Forces (Alcohol Limits for Prescribed Safety Critical Duties) Regulations 2013, SI 2013/2787, and JSP 835 Annex A.	F29 F28

1.5.12.6 For non-specialist Army personnel PSCD, the following duties (among others) are subject to the lower prescribed alcohol limit:	F28
1.5.12.6.a Of any person in relation to the handling and use of a firearm when he has in his possession the firearm and ammunition capable of being discharged from the firearm.	
1.5.12.6.b To supervise a person carrying out a duty in relation to the handling and use of a firearm when he has in his possession the firearm and ammunition capable of being discharged from the firearm.	
1.5.12.7 For non-specialist Army personnel PSCD, the following duties (among others) are subject to the higher prescribed alcohol limit:	F28
1.5.12.7.a As a driver or commander of a mechanically propelled vehicle.	
1.5.12.8 The lower prescribed alcohol limit is 9 micrograms of alcohol in 100 millilitres of breath, 20 milligrams of alcohol in 100 millilitres of blood or 27 milligrams of alcohol in 100 millilitres of urine.	F28
1.5.12.9 The higher prescribed alcohol limit is 35 micrograms of alcohol in 100 millilitres of breath, 80 milligrams of alcohol in 100 millilitres of blood or 107 milligrams of alcohol in 100 millilitres of urine.	F28
1.5.12.10 AGAI Vol 2 Ch 63 and JSP 835 describe the power given to a CO by the Armed Forces Act 2006, to test when the CO has reasonable cause to believe that a person is unfit through alcohol or drugs or has exceeded legal alcohol limits, for PSCD. Unfitness or misconduct through alcohol or drugs is contrary to section 20 of the Armed Forces Act 2006 and is a disciplinary matter. A disciplinary charge can only be brought when it is supported by an evidential test conducted by Service Police.	F28 F14
1.5.12.11 Preliminary testing, prior to evidential testing, may be conducted to provide an indication whether someone's ability to perform a SCD is likely to be impaired or whether they may be over the relevant prescribed alcohol limit.	F28
1.5.12.12 There is no method for COs to practically carry out preliminary testing, other than visual observation, without recourse to the Service Police.	F28

1.5.12.13 Mandatory annual training presentations make soldiers aware that there are (a) SCD and (b) alcohol consumption limits. The training does not explicitly link the two or provide details. It provides a reference to JSP 835 and indicates that exceeding the alcohol limit for SCD is an offence under the Armed Forces Act.	F15 F30
1.5.12.14 **Training regulations for ranges - PAM 21**.	F31
1.5.12.15 This is the principal policy when planning and conducting a range. There is no mention of SCD or alcohol limits in PAM 21.	
1.5.12.16 **Military Annual Training Tests (MATTs)**.	F32 T21, T23
1.5.12.17 These are part of the Army's assurance system that underpins the SSW. MATTs were mandatory for all Army personnel in Defence to maintain core military skill competence. MATTs were to be recorded on the digital training record system. There were conflicting views on who was recording, checking and assuring MATTs completion within RMAS.	S9, S10
1.5.12.18 MATTs were superseded on 1 Apr 22 by Individual Training Requirements (ITRs). This training remains mandatory for all Army personnel. In non-deployable Units, Core Combat skills are at the CO's discretion.	F33
1.5.12.19 **Alcohol Awareness training**.	
1.5.12.20 As previously mentioned in 1.5.8.4, the UAA course and the Unit Alcohol Brief (UAB) provide information on the dangers of alcohol, the UK Government safe drinking limits and the health benefits of reduced alcohol intake. There is no information in either the course or the brief about SCDs and their associated alcohol consumption limits.	
1.5.12.21 **Safe planning and conduct of Ranges – 5 Feb 22**	
1.5.12.22 The SP was due to be a Safety Supervisor conducting a PSCD at 0830 hours on the morning of 5 Feb 22. The SP did not arrive for this duty.	T19
1.5.12.23 The individual in charge of the activity, the Range Conducting Officer (RCO) noted the SP's absence and, although concerned, they were confident that search activities were being conducted. They judged that their priority was to ensure the training was completed in the time allocated.	T19

1.5.12.24 The RCO was able to proceed with the training despite the SP's absence. The absence was overcome by Witness [redacted] reporting to the range to replace the SP as Safety Supervisor.	T14, T19
1.5.12.25 The RCO had conducted planning for LFMT (Live Fire Marksmanship Training) Long Range Assessment on Barossa A Range. The RCO received range date and staff details from the DCCW training programme issued by DCCW Wing Sergeant Major (WSM). The planned date was 8 Feb 22. Range planning was completed on 11 Jan 22 when the Senior Planning Officer (SPO) approved the written safety instruction known as the Range Safety Document (RSD).	F34 T6, T19
1.5.12.26 The Barossa range complex was booked with DIO through BAMS from 2 Feb to 3 Mar 22. The RSD for 8 Feb 22 was not uploaded onto BAMs.	F35
1.5.12.27 The RSD was amended manually on 5 Feb 22 prior to activity commencement. The date and all the named Safety Supervisors were changed. Subsequently the range was conducted as planned. The SPO was informed of the RSD amendment after completion of the range.	F34 T19
1.5.12.28 DCCW PS had a well-established unofficial process to cover last minute, and planned, absences. This typically involved messaging peers, by personal means, either individually or collectively to request a replacement.	T12, T14, T18, T19
1.5.12.29 At approximately 0730 hours on 5 Feb 22 Witness [redacted] spouse was informed by the SP's spouse on the Cadre [redacted] spouse WhatsApp group that the SP had not returned home. Witness [redacted] spouse told Witness [redacted] that the SP was missing. Witness [redacted] immediately attended the range to cover for the SP.	T14
1.5.12.30 **Safety Risk Management (SRM)**	
1.5.12.31 In support of the SSW all military training and activity is subject to a SRM policy to ensure the risk is tolerable and as low as reasonably practical. Activities should be risk-assessed by suitably trained and qualified personnel, or someone nominated as competent. The resulting RA must be authorised by a suitably qualified and empowered person.	F26

1.5.12.32 **SRM training**. F26

1.5.12.33 ACSO 1200[7] states that anyone conducting a RA must hold the risk assessor competency. However, policy allows that, until all personnel have received formal training in RAs and have been awarded the Army Risk Assessment qualification, the CoC can nominate and record 'competent' personnel to complete RAs.

1.5.12.34 All NCOs and Officers should complete SRM Safety Practitioner Training and have the competency recorded.

1.5.12.35 All Officers (Capt and above) and Warrant Officers should complete SRM Training for Safety Leaders and have the competency recorded.

1.5.12.36 **Safe planning and conduct of the Charity Dinner night 4 Feb 22.**

1.5.12.37 The RA was carried out by [redacted], the Activity Deliverer, and approved by [redacted], the Activity (Risk) Owner. There are no records to show that the Activity (Risk) Owner and the Activity Deliverer were recorded or nominated as competent.

1.5.12.38 RMAS had no local policy to direct the completion of SRM training or identify who should ensure and assure its completion. There are only limited records and these show that not all the RMAS PS are recorded as competent.

1.5.12.39 **PS workload**

1.5.12.40 The MoD is subject to the Working Time Regulation (WTR) 1998, which brought into force the EU Working Time Directive (EWTD). The WTR provide protection of Health and Safety of workers by ensuring that they are not required to work excessive hours. Personnel should be working no more than 48 hours on average over a 17-week reference period. The Armed Forces are exempt in certain circumstances from this direction, however this is not a blanket exclusion. F36

1.5.12.41 Fatigue, immediate and chronic, acts as a stressor on individuals degrading their performance. Specifically, fatigue is known to degrade decision-making ability and increase risk appetite.

[7] The Army's Safety and Environmental Management System

1.5.12.42 PS at RMAS are typically working in excess of 60 hours per week, in term time, to deliver the OCdt training programme and their additional duties. This is compounded by 4 or 5 weeks of exercises per term. PS are granted an extra 5 days leave for each term in recognition of this workload.	T4, T7, T8, T11, T12, T15, T22

1.5.13 **Analysis**

1.5.13.1 The Panel found no areas of concern to investigate under Safe Equipment and Safe Place. The Panel therefore focussed on Safe Practices and Safe Persons. Practices are safe when they are conducted in accordance with drills and instructions laid down by the Service authorities and normally contained in documentation. F26

1.5.13.2 **Safe Practices – Firing Ranges**

1.5.13.3 Normally an activity requiring the production of a Range Action Safety Plan (RASP), Exercise Action Safety Plan or Range Safety Trace would be uploaded onto Defence's Booking and Allocation Management System (BAMS). These instructions allow other estate users to deconflict activities, supporting a Safe Place. Range Safety Documents (RSDs) are used typically for static ranges where there is only one user. In this case, a RASP was not required and the RSD was not required to be uploaded to BAMS to confirm the range bid. F37

1.5.13.4 The Blenheim Coy LFMT Long Range assessment was initially planned for Tuesday 8 Feb 22, but was changed to Saturday 5 Feb 22. The Panel could not determine when the date change occurred or why. The date on the RSD was manually changed from 8 Feb 22 to 5 Feb 22 on the 5 Feb 22 prior to the conduct of the range. The change was made after the SPO authorised the instruction and the SPO was not informed until after range conduct. F34 T6, T19

1.5.13.5 Normally any minor changes to written instructions would not compromise the planning process, but a major change would. The RCO and other qualified personnel were unclear on whether this constituted a minor or major amendment. **The Panel observed that PAM 21 was unclear whether a date change on a written instruction would constitute a minor or major change**. T19

1.5.13.6 The named Safety Supervisors and IC Console were amended on the RSD on 5 Feb 22 prior to the conduct of the range, a minor amendment. This change was made after the SPO authorised the instruction and the SPO was not informed until after range conduct. This was due to different PS reporting for duty at the range, which was a normal occurrence at RMAS. **In the Panel's opinion best practice would make the changing of range PS the exception rather than the norm.** T19

1.5.13.7 The SPO must be informed of all written instruction amendments after SPO sign off. Not informing the SPO of changes after sign off is a non-conformity with policy that did not compromise the SST in this instance. **The Panel observed that the requirement to inform the SPO of all amendments after authorisation was not fully understood due to lack of clarity in PAM 21**. — T19

1.5.13.8 Policy on written instruction amendment in PAM 21 is a single block of text. It covers 3 key points regarding written instruction amendments. Firstly minor changes, secondly major changes and thirdly changes after SPO countersignature. **The Panel observed that it was difficult to understand the written instruction amendment process in PAM 21, particularly making changes after SPO countersignature**.

1.5.13.9 Despite minor administrative non-conformities the practices used to conduct the Range were safe.

1.5.13.10 **Safe Persons**

1.5.13.11 **The SPs fitness for duty**. Given the professionalism, character and history of the SP, described in 1.5.4.4, it is highly likely they would have been aware of the requirement to be fit for duty. — 1.5.4.4

1.5.13.12 The Panel noted that there was a wide lack of knowledge about what constitutes a SCD and the associated alcohol limits. Most understood that supervising and firing on a range are SCD. None knew the lower legal alcohol limit for PSCD is a quarter of the drink drive limit. Most, incorrectly, assumed it was the drink drive limit. It is therefore unlikely that the SP knew the alcohol limits for the SCD and highly likely they assumed the limit was the drink drive limit like many of their colleagues. — T15, T18, T19, T8

1.5.13.13 The character and experience of the SP makes it highly unlikely that they would have reported for duty if they felt they were unfit. Despite not being aware of the lower PSCD limits for alcohol, it is highly likely the SP, , would have considered themselves unfit for duty. They would have likely used the unofficial process to ask one of their colleagues to stand in for them.

1.5.13.14 In the Panel's opinion it is unlikely the SP would have reported unfit for a SCD and highly likely the SP would have arranged a suitable replacement.

1.5.13.15 A person exceeding the lower alcohol limit for PSCDs (0.02% BAC (Blood Alcohol Content), a quarter of the drink drive limit in England and Wales) would unlikely be identified as such by visual means. Typically, a person can appear 'unaffected' until they reach approximately 0.029% BAC. They would not likely cause sufficient concern for them to be formally tested and could therefore carry out a duty whilst legally unsafe.	F28 F13
1.5.13.16 A typical person with BAC between 0.03% and 0.059% may start to display behaviours of mild euphoria, joyousness or talkativeness. Again, these behaviours are highly unlikely to cause sufficient concern to justify evidential testing.	
1.5.13.17 **In the Panel's opinion, personnel may not visually display any signs of alcohol intoxication despite being above the legal limit and unfit for some PSCD therefore a CO cannot rely on a visual assessment of fitness for a SCD**.	
1.5.13.18 JSP 835 implies that all testing must be conducted by the Service Police. There is likely to be a delay before the Service Police can conduct testing. This has two implications. Firstly, the tested BAC will not reflect the BAC at the time the duty was to be carried out. Secondly, it does not provide timely assurance to the CO that SCD are being carried out by Safe Persons without unnecessary delay and disruption to the duty. The CO has no means to carry out timely preliminary testing.	F28
1.5.13.19 Preliminary testing could be conducted at unit level, for non-evidential purposes. This would have two effects: to assure the CO that a person is fit to conduct SCDs; and to deter personnel from risking being unfit for a SCD through alcohol consumption.	
1.5.13.20 **The Panel observed that COs should have a unit held method for testing alcohol levels, which gives instant results.**	
1.5.13.21 Persons are safe when they are trained, qualified, experienced, current and authorised.	F26 p63
1.5.13.22 PAM 21 states Safety Supervisors must be qualified and competent on the weapon system they will be supervising. Additionally, FASO 301 required all Army personnel in Defence to complete MATTs. Weapon Handling Tests (WHTs) must be recorded.	F31 F32

1.5.13.23 The SP and the Range Staff for 5 Feb 22 were all trained, experienced qualified and authorised to conduct the range. There was no evidence that all the Safety Supervisors and the RCO were current due to a lack of recorded WHTs. However, all DCCW staff are qualified Skills at Arms Instructors therefore able to assess WHTs. All would regularly assess WHTs for OCdts.	F38 T19
1.5.13.24 There was an oversight in record keeping, which demonstrates a non-conformity with policy. However, in the Panel's opinion the Safety Supervisors, RCO and SP would have been safe and competent on the weapon system.	
1.5.13.25 As a result of this finding, the Panel conducted a check of MATTs on the records management system for NC PS and found limited documentary evidence PS were in date for MATTs. RMAS had no local policy to direct the completion of MATTs or identify who should ensure and assure their completion.	
1.5.13.26 **The Panel observed that mandatory training (MATTs and specifically WHTs) for PS was not being recorded**.	
1.5.13.27 **Awareness of PSCD**	
1.5.13.28 The Panel noted that there was a wide lack of knowledge about what constitutes a SCD and what the alcohol limits are. Most understood that supervising and firing on a range are SCD. None knew the lower legal alcohol limit for PSCD is a quarter of the drink drive limit. Most, incorrectly, assumed it was the drink drive limit.	T15, T18, T19, T8
1.5.13.29 The UAA & UAB are not sufficiently detailed to ensure that personnel are aware of the lower alcohol limit acceptable ahead of conducting SCD.	F39 F40
1.5.13.30 **The Panel observed that there is little awareness of the legal alcohol limits when conducting some common PSCD.**	
1.5.13.31 **PSCD in range policy.**	
1.5.13.32 The principal policy staff refer to when planning and conducting a range, PAM 21, does not specify that it is a PSCD to which the lower alcohol limit applies. It does not reference the content of the AFA06 or JSP 835 to make a link between range planning and conduct and SCDs.	

1.5.13.33 PS conduct ranges for OCdts and instruct and assess OCdts in the running of ranges. OCdts (who commission) are qualified as an RCO and Safety Supervisor on ranges. In the Panel's opinion this shortfall in PS knowledge will be passed onto future Officers and will impact range conduct in the wider Army.

1.5.13.34 **The Panel observed that there is no information in PAM 21 that refers to PSCD or their associated alcohol limits**.

1.5.13.35 **Safety Risk Management – Charity Dinner night**

1.5.13.36 The RA for the Inkerman Charity Dinner night was produced and authorised by personnel without recorded competency. The RA did not fully identify the all the risks. In the Panel's opinion the lack of detail in the RA could have been avoided if personnel had been properly trained.

1.5.13.37 In the Panel's opinion it was not reasonable to expect those personnel to include the water feature on the event RA as it was already included in the site standing RA.

1.5.13.38 **The Panel observed that RMAS had limited records to demonstrate compliance with SRM training competency**.

1.5.13.39 **PS workload**

1.5.13.40 The Commissioning Course programme does not explicitly show PS working in excess of 60-hour weeks, except on exercise. Their actual working time is generated from the additional responsibilities and non-training programme activities such as Regimental Selection Boards, Sports OICs, OCdt report writing, trainee interviews, G1 issue resolution, mandatory training, continuous improvement, CPD to name but a few. — T7, T9, T11

1.5.13.41 A study[8] identified that after being awake for 17 hours a person's ability to operate due to fatigue is equivalent to a BAC of 0.05%. BAC of 0.02% is the SCD lower limit and 0.08% is the driving limit. It would be reasonable to infer that personnel working in excess of 60-hour weeks will suffer from those effects.

1.5.13.42 At the end of each term PS are compensated with an extra week of leave. This does not reduce the likelihood that PS will suffer from tiredness during the term, as sleep cannot be 'banked' or caught up on. Working in excess of 60-hour weeks is likely to be contributing to PS operating with constant sleep deprivation, potentially leading to chronic fatigue. Some PS perceived they were suffering from chronic fatigue. — T22

1.5.13.43 In the Panel's opinion, PS fatigue presents a Safe Person hazard in the SST.

1.5.13.44 **The Panel observed that the PS (Academy and SSU) are routinely working in excess of 60 hours per week during term time**.

[8] Dawson, D., Reid, K. Fatigue, alcohol and performance impairment. *Nature* **388**, 235 (1997). https://www.nature.com/articles/40775

1.5.14 **Findings and Observations**

1.5.14.1 The Panel found that overall RMAS complies with the SSW. It noted that there were some minor administrative non-compliances that did not impact on the safe conduct on training. People, under time pressure and pressure to perform, are de-prioritising mandatory training and its associated assurance. This potentially compromises the Safe Persons element of the SSW.	
1.5.14.2 **The Panel observed that it was difficult to understand the written instruction amendment process in PAM 21, particularly making changes after SPO countersignature.**	1.5.13.2 1.5.13.8
1.5.14.3 **Recommendation. DLW must AMEND PAM 21 para 2-32 to increase clarity on written instruction changes to ensure compliance with the SST.**	
1.5.14.4 **The Panel observed that COs should be better supported in discharging their responsibilities for ensuring and assuring fitness for SCD.**	1.5.13.17 1.5.13.19 1.5.13.20
1.5.14.5 **Recommendation. DPers must CONSIDER measures, including policy changes, for assuring fitness for performing safety critical duties. Measures should focus on enabling the CoC to discharge its risk management responsibilities for SCD and consequence management. Additionally they should enhance the delivery of mandatory alcohol education and increase awareness of fitness for duty requirements.**	
1.5.14.6 **The Panel observed that mandatory training (MATTs and specifically WHTs) for PS was not being recorded.**	1.5.13.23 1.5.13.26
1.5.14.7 **Recommendation. RMAS must ESTABLISH a process, captured in local policy, to direct the completion of ITRs to an appropriate level for all PS. This must include identifying who is responsible for ensuring completion, recording, and providing assurance to the CoC. This will provide assurance to the safe people aspect of the SST.**	
1.5.14.8 **The Panel observed that there is little awareness of the legal alcohol limits when conducting some common Prescribed Safety Critical Duties (PSCD).**	1.5.13.27 1.5.13.30

1.5.14.9 **Recommendation. SHA must AMEND relevant ITRs to include information regarding SCD and their associated limits in an easily digestible format. This should include the Key Learning Point (KLP) that the lower prescribed alcohol limit for certain common SCDs is one quarter of the drink drive limit for England and Wales (or under half that of the limit in Scotland).**	1.5.13.27
1.5.14.10 **Recommendation. SO1 Discipline must ADD to the Compendium of Standing Orders that the following (recommended wording) is included in Pt 1 Orders at an appropriate frequency:**	1.5.13.27
1.5.14.10.a "SPs are reminded that when conducting certain Safety Critical Duties (SCD) the alcohol limit is 20mg of alcohol per 100ml of blood. That is equivalent to one quarter of the drink-drive limit for England and Wales. These duties include Guard Duty, Ranges, Blank and Live Fire exercises. The full list of SCD and alcohol limits can be found at Annex A to JSP 835. SPs are strongly advised not to drink alcohol for 24hours before conducting SCD – someone's life may depend on it!"	
1.5.14.11 **Recommendation. The Unacceptable Behaviours team must AMEND the UAA course and UAB to include information regarding prescribed SCDs and their associated limits in an easily digestible format. This should include the KLP that the lower prescribed alcohol limit for certain common SCDs is one quarter of the drink drive limit for England and Wales (or under half that of the limit in Scotland).**	1.5.13.27
1.5.14.12 **The Panel observed that there is no information in PAM 21 that refers to PSCD or their associated alcohol limits.**	1.5.13.31 1.5.13.34
1.5.14.13 **Recommendation. Director Land Warfare:**	
1.5.14.13.a **Must UPDATE PAM 21 to clearly state all appointments within Range planning and conduct are classified as a SCD.**	
1.5.14.13.b **Must UPDATE PAM 21 to make reference to SCD policy.**	
1.5.14.14 **In order to increase awareness of the alcohol limits and enhance safety in the execution of SCD.**	
1.5.14.15 **The Panel observed that there are limited records to demonstrate compliance with SRM training competency.**	1.5.13.35 1.5.13.38

1.5.14.16 **Recommendation. RMAS must ESTABLISH a process, captured in local policy, to direct the completion of the SRM training to the appropriate level in accordance with ACSO 1200. This must include an assurance mechanism for recording and compliance. This will ensure that risks are being properly assessed and RAs authorised by competent persons.**	1.5.13.35
1.5.14.17 **The Panel observed that the PS (Academy and SSU) are routinely working in excess of 60 hours per week during term time**. It noted that PS are allocated additional duties on top of RCC delivery. The combined workload is potentially leading to chronic fatigue.	1.5.13.39 1.5.13.44
1.5.14.18 **Recommendation. RMAS must UNDERTAKE a holistic review of PS output and workload. It should consider the allocation of additional resource in order to allow PS to fulfil the formal outputs of the Commissioning courses, and additional duties required, within a sustainable working week. This will ensure the delivery of safe, effective training is not compromised by fatigue.**	

1.5.15 **TOR 4 – What changes are recommended in order to avoid future recurrences?**

1.5.15.1 The Panel has made recommendations which relate to each TOR throughout this report. Therefore, there are no recommendations specifically related to TOR 4.

1.5.16 **TOR 5 – Investigate all other matters pursuant to the inquiry as appropriate.**

1.5.16.1 As part of the wider investigation the Panel identified various areas where practices could be improved. These did not fit within the other TORs and have therefore been examined here.

1.5.17 **Accounting Procedures**

1.5.17.1 **Evidence and Facts**.

1.5.17.2 Funding for the Charity Dinner night was provided from non-public funds, allocated by the NC Senior Major, and ticket sales. A £5000 cash float was issued from non-public funds to the OCdts to purchase decorations, entertainments and drinks. F41 T13 T21

1.5.17.3 Issuing a float was standard practice for dinner nights to purchase items. The money was all non-public funds. The recipient of the float was classed as a debtor to the fund. The Regimental Accountant was responsible for managing payments in and out of the fund. The fund manager was NC Senior Major. T21

1.5.17.4 On completion of the event the cash float was repaid to the accountant from ticket sale monies. No receipts were submitted when repaying the cash float. The account was audited and closed for the financial year in line with MOD policy. T13 T21

1.5.17.5 **Analysis**

1.5.17.6 The fund manager would normally expect receipts to be submitted to the Regimental Accountant to clear the debt and any remaining unspent float repaid in cash. This would leave a full record of the nature and amount of expenditure for the event. T21

1.5.17.7 The OCdts did not have to provide receipts so this gave rise to an opportunity for unassured and unaccounted spending of non-public money. It contributed to the OCdts' opportunity to purchase a large quantity of alcohol, including spirits. If receipts were required, the CoC would have had a greater awareness of the quantity and nature of drinks purchased.

1.5.17.8 **Findings and observations**

1.5.17.9 **The Panel observed that clearing the cash float with cash ticket sales masked the purchase of a large quantity of alcohol, including spirits**.

1.5.17.10 **Recommendation. RMAS must REVIEW their planning and accounting processes with regard to social functions to ensure that CoC have oversight of financial transactions in order to ensure appropriate expenditure.**	1.5.17.6 1.5.17.7
1.5.18 **Command relationships**	
1.5.18.1 **Evidence and facts**	
1.5.18.2 JSP 440 Leaflet 5A is the MOD policy for social media which includes WhatsApp. Supplementary guidance states that information sent via social media must not be classified any higher than OFFICIAL. It directs that messaging applications are not to be used for issuing orders or conducting command and control. Field Army CoC direction is that WhatsApp is not to be used for work related communications and only to be used in circumstances where failure to do so would result in either death or serious injury.	F44, F45, F46
1.5.18.3 WhatsApp was used as a means to disseminate information between PS and duty OCdts at Coy level. PS had OCdts' phone numbers stored on their personal phones and vice versa. WhatsApp and email, from personal accounts, was used as the primary means to organise the Charity Dinner night. Inkerman Coy did not publish Coy or Platoon Orders.	T8, T10, T12, T18 F19
1.5.18.4 PS were asked for, and offered, their services as auction lots to raise money for charity at the dinner nights. The examples of prizes that were offered in many cases breached the threshold of the professional relationship between the PS and OCdts and were evident in many of the historical OCdt charity dinner nights, not merely the Company dinner night in question. Some of the seemingly benign examples include PS delivering breakfast in bed to an OCdt and PS to allow an OCdt to high five them at any time.	F16 T12
1.5.18.5 **Analysis**	
1.5.18.6 Units typically disseminate information through written unit and sub-unit Orders. This provides a recorded and auditable means of direction and communication with which personnel can be held to account. Units may use Defence Connect to communicate with personnel without MODnet access or when on the move.	

1.5.18.7 The use of WhatsApp allows RMAS to exploit the speed and efficiency of technology-enabled communication. This would seem to be a huge benefit to rapidly passing on amendments to the programme or time critical messages. However, it appears to have become a means of official communication at Coy level and below. A WhatsApp message is not an authorised means of official communication. Any direction delivered via WhatsApp does not constitute a legal order and there is no official permanent record that information has been received.

1.5.18.8 It is the Panel's opinion that the widespread use of WhatsApp, and the need for PS to have OCdts' personal phone numbers, is enabling more personal contact than is acceptable or desirable within a phase 1 training environment CoC.

1.5.18.9 The Panel observed that lots at the auction included PS agreeing to carry out routine tasks that OCdts were responsible for, and in some cases being assessed on. On the face of it some seem relatively benign, but a female PS auctioning a date night with her, and other such lots, had historically descended to a level that demeaned the authority of the PS and had seemingly gone unchallenged by the CoC. This would erode the established and desirable professional boundaries in a training environment where OCdts are learning about respect for superiors and appropriate behaviours in a strongly hierarchical organisation. — 1.5.18.4

1.5.18.10 **In the Panel's opinion some of the auction lots articulated were inappropriate and degraded the authority of the PS and eroded command relationships between OCdts and PS. That these charity lots had become the acceptable norm, perpetuates an inappropriate culture that undermines the Army's efforts to eradicate unacceptable behaviours and uphold its Values and Standards.**

1.5.18.11 **Findings and observations**

1.5.18.12 **The Panel observed that command relationships between PS and OCdts were blurred**.

1.5.18.13 **Recommendation. RMAS should RE-ESTABLISH publication of Company (Coy) Orders and remove any imperative for PS and OCdts to officially communicate via** personal means. — 1.5.18.8, 1.5.18.10

1.5.19 **RMAS SHARKWATCH**

1.5.19.1 **Evidence and Facts**

1.5.19.2 In the wider Army SHARKWATCH is a well-established routine whereby a nominated individual, or individuals, are responsible for ensuring the safety and security of others attending social functions at public venues.	
1.5.19.3 At RMAS it has been repurposed as a duty that involves monitoring attendees at internal social functions for excessive alcohol consumption and undesirable/unacceptable behaviours.	F24
1.5.19.4 SHARKWATCH at RMAS is mentioned as a mitigating factor at events on and off site where alcohol is available for consumption. It was a mitigating factor on the Inkerman Coy Charity Dinner night RA. There were no orders or guidance as to what was expected of those on duty.	F24 F21
1.5.19.5 **Analysis**	
1.5.19.6 The intent behind RMAS SHARKWATCH was well understood by those on duty on 4 Feb 22 despite the lack of formal orders. RMAS SO 104 now details orders for RMAS SHARKWATCH.	T9, T10, T11 F24
1.5.19.7 OCdts are learning the purpose of SHARKWATCH from the RMAS perspective rather than the wider Army's. This is creating a cohort of OCdts who have a misaligned understanding of the term SHARKWATCH. This will be perpetuated for future cohorts as long as RMAS continue to use this designation.	
1.5.19.8 In the Panel's opinion the monitoring of behaviours at internal social function could be considered best practice. It could serve to promote desirable and acceptable behaviours.	
1.5.19.9 **Findings and observations**	
1.5.19.10 **The Panel observed that the RMAS interpretation of SHARKWATCH differs from the Defence official definition.**	
1.5.19.11 **Recommendation. RMAS should REDESIGNATE their version of SHARKWATCH. This will allow the intent of the duty to be achieved without giving the OCdts a confused understanding of the Defence security purpose of SHARKWATCH.**	1.5.19.7 1.5.19.8
1.5.20 **Fear of perceived imperfection**	
1.5.20.1 **Evidence and facts**	

1.5.20.2 The SNCOs instructing at RMAS are a very high-quality cohort performing largely the same role.	T7, T10
1.5.20.3 The reluctance to highlight the absence of the SP was frequently stated by witnesses. They did not want to get the SP into trouble. Colleagues assumed that the SP would just 'turn-up' at some point.	T14, T15, T16, T17, T19 S6
1.5.20.4 Informal communications via social media led to informal searches for the SP. They were officially notified as 'missing' only when all reasonable explanation had been exhausted.	S5, S6 T17
1.5.20.5 The SP was not officially reported missing earlier because no-one wanted them to 'get into trouble' for failing to report for duty.	T14, T17p8 L31, T19
1.5.20.6 As soon as the SP was officially notified as a missing person the Duty staff acted promptly and in accordance with their orders.	T11, T21
1.5.20.7 **Analysis**	
1.5.20.8 There is competition between PS to be considered the best. A highly competitive cohort striving for the top spot creates self-imposed pressure on individuals to be perfect. Being late or missing a parade was perceived as a failing that would disproportionately impact their professional reputation.	T12
1.5.20.9 The SP's colleagues were not initially overly concerned because they assumed that the SP would 'turn up' at some point having slept off their alcohol consumption. This assumption was based on a generalisation rather than on expectations of this SP. In fact, it was judged to be totally out of character for this SP.	S6, S4, S5 T16, T17
1.5.20.10 In the Panel's opinion the fear of getting the SP into trouble influenced the behaviours of the colleagues. It delayed the formal notification of the CoC and resulted in external Search and Rescue agencies not being brought in during daylight hours.	

1.5.20.11 The organisation places great emphasis on loyalty to others. It is one of the core Values of the British Army. **In the Panel's opinion the tension between loyalty to peers and loyalty to the CoC has been highlighted by these events. Loyalty is frequently only considered from the individual perspective and wins out over common sense. This then inculcates a 'cover-up' culture which does the wider Army and its people a disservice.** SPs should be encouraged to report concerns or admit to mistakes. They should be motivated by positive and proportionate responses to shortcomings rather than the threat of punishment.

1.5.20.3

1.5.20.12 **In the Panel's opinion the increased speed and efficiency, either in reporting the missing person or searching for them, would not have changed the outcome for this SP. However, it could have lessened the stressful impact on others involved and, in other circumstances, could save a life.**

1.5.20.13 **Findings and observations**

1.5.20.14 **The Panel observed a belief amongst RMAS PS that perceived imperfections will have a disproportionate effect on an individual's professional reputation**.

1.5.20.15 **Recommendation. RMAS should CONDUCT a thorough review on how to inculcate a psychologically safe environment in which PS and OCdts do not fear imperfection.**

1.5.20.8
1.5.20.9
1.5.20.10
1.5.20.11

1.5.21 **Post event management**

1.5.21.1 **Evidence and Facts**

1.5.21.2 **Trauma Risk Management (TRiM) policy**.

F42

1.5.21.3 TRiM is an initiative that aims to capitalize on the social cohesion available within units by training personnel in the early recognition of symptoms associated with post-traumatic stress. TRiM is a peer-delivered, evidence informed psychological support strategy. TRiM is not a treatment in itself. After a traumatic event, TRiM trained personnel will advise commanders about best practice in relation to traumatic stress. They will carry out structured assessments of risk to those exposed to the event, identifying whether individuals might benefit from additional support.

1.5.21.4 Inkerman and Blenheim Coy OCdts were informed of the SP's death on Mon 8 Feb 22. RMAS immediately identified the requirement to offer support. NC and RMAS HQ discussed Trauma Risk information Management (TRiM) policy. The Academy TRiM coordinator was OC 44 Sqn in SSU, supported by TRiM practitioners across the Academy.	T22, T23
1.5.21.5 TRiM policy support was given initially to the first responders – Witness █ and Witness █ – as well as the last 2 people who had interacted with the SP - Witness █ and Witness █.	T23
1.5.21.6 Over the period 8 to 10 Feb, the CoC discussed policy support for the wider cohort of OCdts and PS. There were different views on the application of TRiM policy in cases of grief rather than trauma. RMAS HQ made the decision to offer TRiM policy support to all those who felt they were affected. Subsequently TRiM policy support for NC was coordinated by the NC coordinator.	T22, T23
1.5.21.7 **Analysis**.	
1.5.21.8 TRiM policy support, as advised by the TRiM advisers, is about identifying and assessing those who might be at risk of developing problems as a result of being involved in an incident. It is not about forced emotional expression or the relief of strong suppressed emotions.	F43 F42
1.5.21.9 Grief management is available through various avenues, including Unit resources, Army Welfare Service, and bespoke counselling services. It is the Panel's opinion that there is a lack of awareness regarding options available.	
1.5.21.10 RMAS HQ directed the offer of TRiM policy support to all those who felt they were affected. In this instance TRiM policy was blanket-applied in response to a tragic rather than traumatic event. In the Panel's opinion this has left a cohort of junior leaders with a skewed view of the purpose of TRiM.	
1.5.21.11 The Panel did not seek further evidence of how effectively the TRiM process was conducted. Its use for those directly involved at the point the SP was found is not in question.	
1.5.21.12 **Findings and Observations**	
1.5.21.13 **The Panel observed that TRiM policy was inappropriately applied in the follow up to the tragic event**.	

1.5.21.14 **Recommendation. RMAS should ENHANCE its local policy to describe a triage response process following an incident to determine appropriate interventions for each individual, so that they each get the right support.**

1.5.21.8
1.5.21.9
1.5.21.10

1.5.22 **Learning Account (LA)**

1.5.22.1 **Evidence and Facts**

1.5.22.2 Army Personnel Services Group (APSG) issues generic guidance to units upon requesting a LA. It states that units are to identify the facts of a matter quickly and highlight immediate actions taken to prevent recurrence.

1.5.22.3 The LA was written by RMAS DCOS in collaboration with Academy Adjt and SO2 G1. The initial gathering of information was done verbally by interview from 7 Feb 22 and the information passed to the LA authors. Oral accounts were taken from the ADFO, ADO, Function OIC and Witness ██. Written statements were not taken from those interviewed. Documents were collected in support of the LA such as the MEL and RA.

T9, T20, T21

1.5.22.4 **Analysis**

1.5.22.5 A LA should establish the facts from those as close to the source activity as possible. It should establish what did happen rather than what should have happened. The APSG guidance does not explicitly state this.

1.5.22.6 LAs should be reviewed by those people directly involved in events to confirm accuracy. In this case, those who would have been able to give the most accurate information did not review the LA.

T9, T20, T21

1.5.22.7 **Findings and Observations**

1.5.22.8 **The Panel observed that the LA was written by personnel who had no direct contact with those involved in the event and it was not reviewed by those involved for accuracy**.

1.5.22.9 **Recommendation. APSG should REVIEW the guidance issued to Units upon requesting a Learning Account (LA) to ensure that LAs are as accurate as possible while still being delivered in** a timely manner.

1.5.22.5
1.5.22.6

PART 1.6 – CONVENING AUTHORITY COMMENTS

1.6.1 As the Convening Authority (CA) for this Statutory Inquiry (SI), I am grateful to the President and the Panel for the thoroughness of the Report in meeting the Terms of Reference (TOR).

1.6.2 **Timeline**. I directed and formally convened the SI on 5 Sep 22. The Report was submitted for review on 13 Mar 23.

1.6.3 **Conduct of the Panel**. I find that the SI has been conducted properly and that the Panel has complied with The Armed Forces (Service Inquiries) Regulations 2008 (the Regulations), as well as extant policy on the conduct of SI. Having considered the contents of the report I find that the SI has met its TOR.

1.6.4 **Findings of the Inquiry**. The SI had 5 broad TOR. Having considered the Report, I am of the opinion that the death and the wider circumstances (including adherence to policy) have been fully investigated, and that no further inquiries are required.

1.6.5 **Potentially Affected Persons (PAP)**. Two individuals were identified as PAP during the SI. I am content that they were both afforded the appropriate protections as per Reg 18 of the Regulations.

1.6.6 **Recommendations of the Inquiry**. The Panel have made 21 recommendations. They cover all aspects of the SI and each has been linked to the appropriate agency for implementation. I consider all the recommendations to be appropriate and commend them to Army Personnel Services Group (APSG). I would observe, however, that in my opinion none of the issues that these recommendations seek to treat were specifically material to the death of [redacted]

1.6.7 **Summary**. The SI has investigated the death of [redacted]. [redacted] drowned having fallen into the Wish Stream at RMAS following a charity dinner night; he had not been drinking to excess and there was no one else directly involved. It was a tragic occurrence that could not have reasonably been foreseen by those planning and delivering the dinner night.

1.6.8 In addition to investigating matters on the night in question, consistent with their TORs, the Panel have been able to discern three broad themes to their recommendations which warrant comment upon.

> 6.8.1 **Physical safety** – The training environment at RMAS is a safe one, with an overarching Risk Assessment that remains broadly fit for purpose. That said, every effort must be made to ensure that those responsible for the delivery of training are adequately signposted to the relevant assessments and are appropriately educated on how to deliver training in a safe manner. This should be replicated Army wide across our training enterprise.
>
> 6.8.2 **Policy and training** – The findings of the Panel support a conclusion that extant policy remains broadly fit for purpose. There may, however, be scope to provide further opportunities to facilitate the Chain of Command in conducting breath testing, where appropriate, when it supports operational and training delivery.

Complementary to that, is the need to reinforce alcohol awareness training and highlight the *markedly lower threshold for those conducting Safety Critical Duties.*

6.8.3 **Command and leadership** – The Report has shone a light on a number of leadership practices present at the time which were inconsistent with the Army's Values and Standards. However, it is only right to recognise the very significant efforts that were already being brought to bear to address these. I do not anticipate that any of the areas identified within the Report will be revelatory to those in the RMAS chain of command and will only galvanise them in their ongoing efforts to achieve the very highest of standards in both Permanent Staff and Officer Cadets.

1.6.9 I endorse the SI's findings, and the recommendations made herein, and submit it to Hd APSG as the final report.

Finally, on behalf of the Army, I offer my deepest condolences to [redacted] and the family, friends and loved-ones of [redacted]

J R MARTIN DSO OBE MC 23 Mar 23
Major General
GOC 3rd (United Kingdom) Division

PART 1.7 – REVIEWING AUTHORITY COMMENTS

Context

1.7.1 On Friday 4 February 2022 [redacted] attended a Charity Dinner Night and failed to return to their SFA, also failing to report for duty at 0815 hours as range safety staff. Following an extensive search of RMAS [redacted] body was discovered in the Wish Stream. The Port-Mortem report declared the cause of death as drowning. There are no known suspicious circumstances surrounding this tragic case. The Service Inquiry has considered the circumstances and made observations to assist HM Coroner with determining the manner of death as well as to enable the Army, and where appropriate wider Defence, to make amendments to policy and practice which will reduce the risk – likelihood and impact – of a reoccurrence.

Service Inquiry

1.7.2 On Thursday 1 September 2022 the Army's Single Service Inquiries Coordinator (SSIC(A)) directed that a Service Inquiry be convened to investigate the circumstances surrounding the death by drowning of [redacted] at RMAS. The purpose was for the Army to identify any lessons that would help prevent a recurrence and to enable any appropriate changes to policy, processes, and procedures.

1.7.3 General Officer Commanding 3 (United Kingdom) Division convened the Service Inquiry on Monday 5 September 2022 and subsequently approved the completed report on 23 March 2023.

1.7.4 The Service Inquiry panel afforded Regulation 18 Status to two potentially affected people. I am satisfied that this was appropriate and that these individuals were treated in accordance with the requirements of Joint Service Publication 832.

1.7.5 I am grateful to the President for their thoroughness of their Inquiry, and I am satisfied that the Terms of Reference were appropriately pursued and answered.

RECOMMENDATIONS OF THE SERVICE INQUIRY

1.7.6 **Recommendations.** The Inquiry made 21 recommendations across three areas:

a. **Physical Safety** – specifically focused on the water hazards.

b. **Policies and Training** – highlighting the extremely low alcohol limits for Safety Critical Duties.

c. **Command and Leadership** – ensuring the correct Army policies and procedures are consistently delivered within an appropriate command culture in a vital training environment.

Management of the recommendations

1.7.7 **Management.** Of the 21 recommendations which have all been endorsed, seven have already been actioned and closed. The remaining 14 endorsed recommendations are

owned by; 1x MOD, 1x APSG, 1x DLW, 1x DPers and 10x RMAS. The 14 recommendations that are yet to be actioned and closed will all be complete by 30 Apr 24.

1.7.8 **Record keeping.** These recommendations, their associated progress to completion and supporting evidence will be recorded on the Defence Lessons Identified Management System (DLIMS). Progress is monitored and assured by the APSG Lessons Fusion Cell.

Summary

1.7.9 I am satisfied that [redacted] death has been comprehensively investigated. The President identified several areas for improvement making 21 appropriate recommendations, of which 14 currently remain open and their resolution will follow the publication of this report.

1.7.10 The Post-Mortem report has published the cause of death is drowning but this case has yet to be determined by a Coroner.

1.7.11 Commandant RMAS has conducted a comprehensive root and branch cultural review of the training delivered, methodology used, policies, procedures and how assurance is effectively conducted. Although significant progress has been made the implementation has been undertaken concurrently to this Service Inquiry investigation.

1.7.12 On behalf of the Army, I offer my sincere condolences to [redacted] family, friends, and colleagues.

E J R Chamberlain
17 April 2023
Brigadier
Head Army Personnel Service Group and
Single Service Inquiry Coordinator (Army)

Annex A Convening Order and Terms of Reference

CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL JR MARTIN DSO OBE MC

GENERAL OFFICER COMMANDING 3rd (UNITED KINGDOM) DIVISION

1. A Service Inquiry (SI) is to be convened, in accordance with Section 343 of the Armed Forces Act 2006 (AFA 06), to investigate the circumstances surrounding the death of a Service Person, who was found deceased in the Wish Stream outside Churchill Hall at The Royal Military Academy Sandhurst on 6 February 2022.

2. An SI is to assemble in Andover on 5 Sep 2022. The SI is the Panel's priority task and takes precedence over any other duties.

3. The SI Panel comprises:

   a. President: [redacted] Lt Col [redacted]

   b. Member: [redacted] Maj [redacted]

   c. Member: [redacted] Maj [redacted]

4. The legal advisor to the SI is: Maj [redacted]

5. The Panel is to investigate and report the circumstances surrounding the incident, recording all evidence and expressing opinions in accordance with the Terms of Reference at Annex A. The Panel is not to attribute blame, negligence or recommend disciplinary action.

6. General Officer Commanding 3 (UK) Div convening the SI directs that the evidence is to be taken on oath or by affirmation, as required, in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008. Any document or other matter produced to the Panel by a witness, for use as evidence, shall be made an exhibit and treated in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008.

7. Any person who, in the opinion of the President, may be affected by the findings of the Panel shall be treated in accordance with Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008. The President is to ensure that any such person is notified as early as reasonable possible.

8. The Panel may hear evidence from any such other witnesses or subject matter experts as it deems appropriate and may dispense with the attendance of any witness if it concludes that the witness evidence will not assist the SI. The President should note that a witness statement taken by the RMP/SIB may not be admitted as evidence to the SI, unless the express consent of the witness providing the statement has been obtained.

9. If it appears to the Panel at any time during the SI that any person may have committed an offence against Service Law, including a criminal conduct offence contrary to Section 42 of the Armed Forces Act 2006, the President is to adjourn the SI immediately and seek legal advice.

10. The President is to inform all witnesses that a transcript of the SI, whilst primarily for internal MOD use, may subsequently be released into the public domain. All such material accessible to

the public would be released in a redacted form according to current Service policy on disclosure and adhering to current legislation, including the Data Protection Act 1998 and the Freedom of Information Act 2000.

11. The SI Panel is to express its opinion with regards to any material conflict in the evidence which may arise and give reasons for reaching that opinion. Any conflict in the evidence should be determined on the balance of probabilities.

12. The President is required to submit monthly progress reports to the CA Authority and APSG SI Branch in accordance with Appendix 4 to Annex G to Chapter 2 of JSP 832.

GENERAL ADMINISTRATION

13. 3 (UK) Div is to provide the following:

a. A professional Verbatim Court Recorder to be present to record evidence at Hearings as required. This must be requested via HQ APSG.

b. An Orderly to assist at the Hearings as confirmed by the President.

c. Stationery as required by the Panel.

d. Travel and subsistence for the Panel for SI related business away from their primary place of residence.

e. Travel and subsistence as required by any witnesses (for SI business).

f. Access to clerical support as required.

g. IT including Laptop, as appropriate and as required, for the Panel members.

14. The costs of the Service Inquiry are to be charged to UIN

Original signed

JR MARTIN DSO OBE MC
Major General
General Officer Commanding 3 (UK) Div Date: 1 September 2022

Annex:

A Terms of Reference

Annex A to
GOC 3 (UK) Div
SI Convening Order
Dated 1 Sep 22

SERVICE INQUIRY TERMS OF REFERENCE

1. The Panel is to investigate the circumstances surrounding the death of a Service Person, who was found deceased in the Wish Stream outside Churchill Hall at The Royal Military Academy Sandhurst (RMAS) on 6 February 2022.

Terms Of Reference

2. The Service Inquiry (SI) is to address the following Terms of Reference (ToR):

a. ToR 1 – Identify contributing, causal or other factors by examining the events prior to [redacted] death and establishing the facts surrounding it, including those facts from his career history which are deemed relevant.

b. ToR 2 – Examine the culture within RMAS, including understanding the alcohol policy and procedures, identifying any contributing factors.

c. ToR 3 – Identify and understand how the SST policy is implemented and assured at RMAS, in particular, but not limited to, Safety Critical activities.

d. ToR 4 – Which changes are recommended in order to avoid future recurrences?

e. ToR 5 – Investigate all other matters pursuant to the inquiry as appropriate.

Output

3. Within the SI Report the Panel is to include an executive summary of the case, addressing each of the ToR listed above. The Panel should:

a. Set out the facts established by the evidence, on the balance of probabilities.

b. Make appropriate recommendations for the unit(s), the Army and Defence.

c. Set out any additional facts relevant to the matter under inquiry, disclosed from the evidence given to the Panel and any other evidence which the President decides should form part of the record.

d. Include transcripts of oral evidence, copies of witness evidence given to the Panel and any other evidence which the President decides should form part of the record.

e. Note that the President may amend the ToR if required in consultation with the CA and Reviewing Authority.

Annex B Glossary

Acronym / Abbreviation	Definition
AAP	Alcohol Advice Practitioner
ABV	Alcohol by Volume
ACSO	Army Command Standing Order
ADFO	Academy Duty Field Officer
ADO	Academy Duty Officer
AFA06	Armed Forces Act 2006 as amended
AGAI	Army General Administrative Instruction
AGC ETS	Adjutant General's Corps Educational & Training Services
APSG	Army Personnel Services Group
Aramark	The contractor for RMAS providing food and other services
ATSB	Australian Transport Safety Bureau
BAC	Blood Alcohol Content – the percentage of alcohol in a persons bloodstream.
BAMS	Bidding and Allocation Management System
C2	Command and Control
Capt	Captain
CC	Commissioning Course
CC212	Commissioning Course 212
CCS	Commissioning Course Short
CI	Chief Instructor
CO	Commanding Officer
CoC	Chain of Command
Comd	Command
CoT	Care of Trainees
Coy	Company
CPD	Continuous Professional Development
CSgt	Colour Sergeant
CSM	Company Sergeant Major
DAIB	Defence Accident Investigation Branch
DCCW	Dismounted Close Combat Wing
DCOS	Deputy Chief of Staff
DIN	Defence Information Note
DLW	Director Land Warfare
DoC	Duty of Care
DTc	Defence Training course
EWTD	European Working Time Directive
FASO	Field Army Standing Order
G1	Ground staff area 1 - Typically this encompasses personnel and administration
G7	Ground staff area 7 - Staff area covering training
GOC	General Officer Commanding
GPS	Global Positioning System

HOE	Head Of Establishment
HQ	Headquarters
HSEP	Health Safety & Environmental Protection
IC	In Charge
INCREP	Incident Report
IPCC	Intergovernmental Panel on Climate Change
ITB	Infantry Training Battalion
ITR(s)	Individual Training Requirement(s)
JSP	Joint Services Publication
KLP	Key Learning Point
LA	Learning Account
LEOC	Late Entry Officer Course
LFC	Lessons Fusion Cell
LFMT	Live Fire Marksmanship Training
LFSO	Land Forces Standing Order (Legacy document – most have become either FASO or ACSO)
Lt	Lieutenant
Maj	Major
MATT(s)	Military Annual Training Test(s)
MEL	Main Events List
MJP	Military Judgement Panel
MOD	Ministry of Defence
NC	New College
NCO	Non-Commissioned Officer
NOTICAS	Notification of a Casualty
OC	Old College / Officer Commanding
ODCR	Observation, Discussion, Conclusion, Recommendation
OCdt	Officer Cadet
OIC	Officer In Charge
PAM 21	Pamphlet No 21 Training Regulations for Armoured Fighting Vehicles, Infantry Weapon Systems and Pyrotechnics
Pl	Platoon
PS	Permanent Staff
PSCD	Prescribed Safety Critical Duty
RA	Risk Assessment
RASP	Range Action Safety Plan
RC	Regional Command
RCC	Regular Commissioning Course
RCO	Range Conducting Officer
RMAS	Royal Military Academy Sandhurst
RSB	Regimental Selection Board
RSD	Range Safety Document
RSM	Regimental Sergeant Major
SCD	Safety Critical Duty
SFA	Service Families' Accommodation
Sgt	Sergeant
SHA	Senior Health Authority

SI	Service Inquiry
SJAR	Soldier Joint Appraisal Report
SMI	Sergeant Major Instruction
SNCO	Senior Non-Commissioned Officer
SO	Standing Order
SOI	Standing Operating Instruction
SO2	Staff Officer Grade 2 (Typically a Major)
SP	Service Person
SPO	Senior Planning Officer
SRM	Safety Risk Management
SST	Safe System of Training
SSU	Sandhurst Support Unit
SSW	Safe System of Work
TESSOC	Terrorism, Espionage, Sabotage, Subversion and Organised Crime
TEWT	Tactical Exercise Without Troops
TOR	Terms Of Reference
TRiM	Trauma Risk Management
UAA	Unit Alcohol Advisor
UAB	Unit Alcohol Brief
UB	Unacceptable Behaviours
WHT	Weapon Handling Test
WO	Warrant Officer (Either Class 1 or Class 2)
WO1	Warrant Officer Class 1
WO2	Warrant Officer Class 2
WSM	Wing Sergeant Major
WTR	Working Time Regulation

Annex C Background

C.1 Overview of the Royal Military Academy Sandhurst (RMAS).

C.1.1 Located in Berkshire and comprising the Academy site (Figure C.1-1) of approximately 2km^2, with additional dedicated training area, RMAS is the Army's initial training unit for all Commissioned Officers. The Academy comprises numerous office and training classroom buildings, some incorporating accommodation for students, gymnasium, shops, church, SFA for its staff, heavily wooded rural training areas, 2 expansive fishing lakes, sports pitches and a stream that is channelled into water features at various locations. This is the Wish Stream.

C.1.2 Routinely there are approximately 2000 individuals living, working and training on the site.

C.1.3 The element of RMAS responsible for the delivery of training is the Academy. The organisation structure is shown in Figure C.1-2.

S9, S10, T20

C.1.4 Old College (OC) is the part of the Academy responsible for the Junior term of the Regular Commissioning Course (RCC), Short Courses, Cadres and Overseas Engagement.

C.1.5 New College (NC) is the part of the Academy responsible for the Intermediate and Senior terms of the RCC.

C.1.6 RMAS commissioning courses provide learning activities that develop people into officers who can participate in military operations, up to and including war, and leaders capable of analysing complex situations, making decisions, inspiring, managing and developing others. Some of these people come with previous experience of military service and, or specialist professional qualifications such as lawyers or doctors. Approximately 1000 individuals progress through the training pipeline every year.

C.1.7 The RCC is the main vector for young people to become a Regular Army officer. The course is conducted over 44 weeks and combines learning basic infantry skills with leadership development, interwoven with activities that inculcate the trainees (OCdts) with the Values and Standards, and behaviours expected, of the British Army.

Figure C.1-1 Map of RMAS estate including training areas (DELETED OFFICIAL SENSITIVE)

T23

C.1.8 The average age of OCdt is 24 and many join the Army straight from university. They come from all walks of life, with varying exposure to military knowledge or experience, and from numerous countries around the world. For this reason, RMAS makes every effort to ensure that its leaders and instructors are the very best in terms of qualification, experience and character.

C.1.9 The CC is one of a number of courses held at the RMAS. The purpose of the course is to train all OCdts in basic soldiering and leadership before joining their elected Regiments or Corps. The RCC programme consists of 3 terms, named Juniors, Intermediate and Seniors.

C.1.10 The Junior term focuses on the basics of military skills, fitness and decision making.

C.1.11 The Intermediate term develops command and conceptual thinking with the aim of developing professional combat leaders. During this term, OCdts are assessed for their suitability for their chosen Corps or Regiment.

C.1.12 The final, Senior term enables OCdts to practise their new military and Leadership skills through a series of complex and demanding training exercises in the UK and overseas. The focus of this term is on developing professional, agile-thinking, ethical and robust leaders, who, with further pre-employment training, can take up their first leadership position.

C.1.13 The RMAS timetable comprises of 3 Regular CC intakes throughout the year[9]. Jan and May intakes generally consist of 2 Coys equating to approximately 180 OCdts per intake. The Sept intake is often larger and comprises of up to 3 Coys, equating to approximately 270 OCdts. Each Coy is commanded by a Major (Maj) and is made up of 3 platoons. Each platoon is commanded by a Platoon Commander (Pl Comd) who is normally a Captain (Capt) assisted by a Colour Sergeant (CSgt) or Staff Sergeant (SSgt).

[9] In addition, RMAS run the SNCO Selection Cadre, Lucknow Platoon (ongoing Rehabilitation Pl), the Late Entry Officers' Course (9 courses annually), Commissioning Course Short for the Reserves and Professionally Qualified Officers (3 courses annually) and the Leaders Development Course (3 annually).

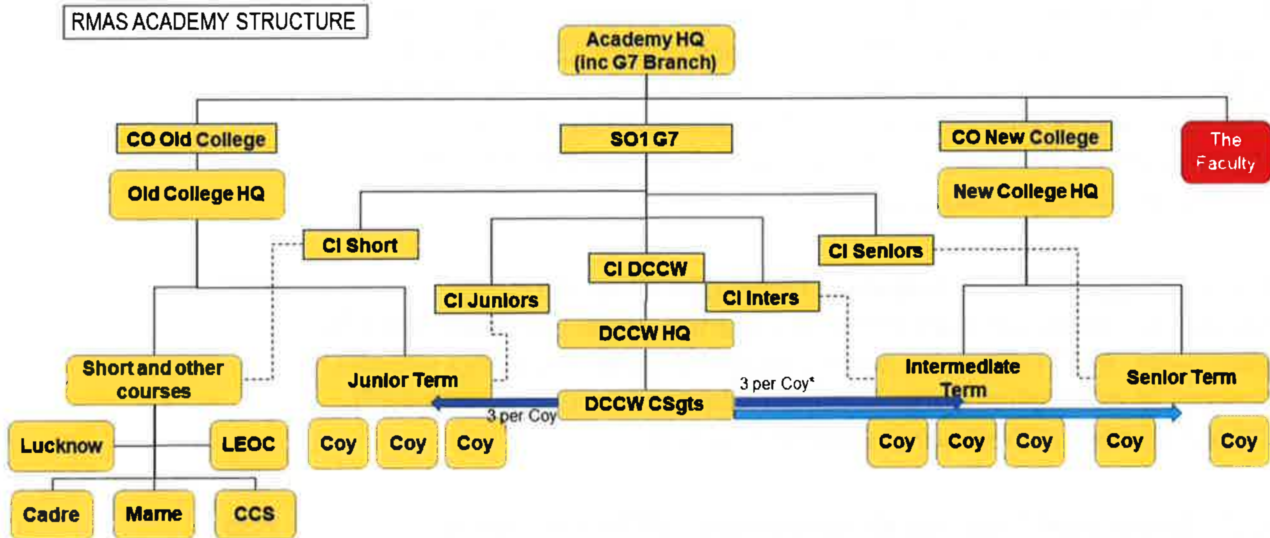

Figure C.1-2 RMAS Academy Structure

C.2 Overview of PS (PS) Instructor capability

C.2.1 The PS cohort is comprised of SNCOs and Officers. All are selected for their suitability to instruct trainees and typically represent the top performing individuals in their respective ranks from the wider Army.

C.2.2 **RMAS Instructor Cadre**. The RMAS SNCO Instructor Cadre is a 4-week selection process that is designed to expose and assess all aspects of a candidate's ability, character, teamwork, fitness and intellect. Candidates are assessed throughout, and the final selection takes into consideration all aspects of a candidate's performance and behaviours.

C.2.3 **Defence Trainer course (DTc)**. PS have to pass the DTc which teaches them the key techniques of assessment, coaching and development. The course involves 3 teaching practices and a module on Care of Trainees (CoT), as well as a series of tutorials and workshops. It is mandatory for all instructors at Phase 1 and 2 military training establishments.

F27

C.2.4 **Sandhurst Staff Context (SSC) Course**. This is a modular course which is done by all PS instructors on arrival at RMAS. Module A is a mandatory workplace induction. Module B covers RMAS Training and is done by all Officer Cadet-facing staff. Module C is Mental Resilience Training for Captains and Colour/Staff Sergeants. Module D is training for International Leadership Trainers, also for Captains and Colour/Staff Sergeants.

C.2.5 **RMAS Day Zero**. This is a briefing delivered at the start of each term to all Academy PS. It provides a reminder of extant policy and focuses on key issues prior to OCdts arriving on site. The brief is split into 2 parts. Part 1 is delivered by Academy Headquarters. For Part 2, PS receive further briefing from their respective College Headquarters.

C.2.6 **Military Annual Training Tests (MATTs)**. All Army personnel, wherever they serve in Defence, must complete MATTs each year. MATTs assess basic soldiering skills, including Values, standards and behaviours. They provide the foundation on which individual competence and readiness is built. F32

C.2.7 **Individual Training Requirements (ITRs)**. All Army personnel are to complete the ITR irrespective of where they are serving across Defence, as required by their role, readiness, or operational outputs. The ITR is the means by which the Army maintains the minimum standard of individual military knowledge, skills, experience, and behaviours required of a competent soldier. It is a simple training system and conditioning framework that prepares people to succeed in their everyday jobs, during training events, and in readiness for deployment on operations. The ITR replaced MATTs, Basic Close Combat Skills, and the Soldier First Syllabus packages from 1 Apr 22. F33

C.2.8 **Safety Risk Management (SRM) training**. Personnel employed within the Army (miliary and civilian) should be trained to understand their obligations for managing risk. This underpins the Army's Health & Safety compliance and the Safe System of Work/Training. All Officers and NCOs should be trained to be a Risk Assessor and Safety Practitioner. All Warrant Officers, Captains and above, should also complete SRM training for Safety Leaders. F26

C.2.9 **Unit Alcohol Brief (UAB)**. This is a mandatory brief that is to be delivered annually to every Service Person in all units, by the qualified Unit Alcohol Advisor (UAA) or trained Alcohol Advice Practitioner (AAP), regardless of rank or appointment. The aim of the brief is to provide education around alcohol misuse and to provide SP with options to improve their relationship with alcohol. It also provides signposting to internal and external organisations, from which additional support can be gained if necessary. F14

C.3 Alcohol at RMAS

C.3.1 RMAS is subject to the Army's overarching rules and regulations with regard to the consumption of alcohol. Given that Army sites typically comprise home(s), place(s) of work and places F14

to conduct social activity, there are few occasions when a total alcohol ban is applied. Instead, the CoC determines local risk factors and imposes such restrictions deemed necessary to protect its people and its business outputs.

C.3.2 The RMAS Alcohol Policy sets the overarching direction and guidance for alcohol purchase and consumption. Its message is reinforced through the extant: F7 F24

Cadet Handbook

Verbal Briefings – Day Zero / Context Course

MATTs (subsequently ITRs)

Unit Alcohol Briefing

Local briefing on expected behaviours immediately prior to each event delivered by a commissioned officer of the College staff.

C.4 Charity Dinner Nights

C.4.1 Charity Dinner Nights were[10] one of a small number of events in the RCC training programme where OCdts could expect to participate in semi-formal social activity. Each Coy would run a Charity Dinner night, equating to 8 of these events per year. They would typically occur during Week 4 of Senior Term.

C.4.2 They would typically be organised by volunteer OCdts from each Coy under the guidance of a senior member of their PS.

C.4.3 The alcohol state for such events would be ROUTINE. This means that alcohol consumption would not be limited or monitored, but attendees would still be expected to ensure they would be fit for duty the next working day. F14

C.4.4 From the perspective of the RMAS CoC, the formal purpose of this event was to: S9 T23

a. Provide another opportunity for OCdts to learn about appropriate conduct / behaviours at semi-formal functions.

b. Provide the opportunity for some OCdts to learn about how to organise a function, including planning and resourcing goods and services.

c. Provide opportunity for OCdts to show the Academy and their development into an Army Officer to a select group of invited friends or family guests.

[10] Charity Dinner Nights have been removed from RMAS training programme.

d. Raise money for designated charities through the auction of goods and services and a raffle.

C.4.5 For the OCdts the Charity Dinner would be an opportunity for socialising with their friends or family and RMAS training staff.

C.4.6 PS (PS) who were closely associated with Coy training activities would routinely be invited as paying guests. The invitation would typically extend to their spouse / partner.

C.4.7 All PS would be expected to follow the code of conduct, lead by example and not be 'drunk' in the presence of OCdts. F7

C.4.8 Some PS members would undertake supervisory activity. This was known locally as SHARKWATCH. It involved being sober and on duty for the duration of the event to provide overwatch and guidance as and when required. They would be expected to exercise the full range of their disciplinary powers if necessary. F24

C.5 SHARKWATCH

C.5.1 SHARKWATCH is a well-established practice whereby nominated individual(s) are responsible for ensuring the safety and security of their colleagues attending social functions at public venues. SHARKWATCH adds a layer of security to counter the threat from Terrorism, Espionage, Sabotage, Subversion and Organised Crime (TESSOC). Its purpose is to prevent incidents that may cause harm to personnel, the MOD, or more widely the Armed Forces and National Security. Personnel who undertake SHARKWATCH duties must be sober, alert and appropriately empowered.

C.6 Locations involved

C.6.1 **New College Dining Room**. This is a large communal dining room that is normally configured with long tables for up to 300 people to eat. The room can be reconfigured with round tables and a dance floor, as was the case for Charity Dinner nights.

C.6.2 **Medals Bar**. A licenced bar operated by ARAMARK that is adjacent to the New College Dining Room. F7

C.6.3 **Wavell Room**. This is a large communal lounge type room within the New College building complex, Figure 5-1 serial 3. It is furnished with comfortable seating so OCdts have somewhere relax and socialise. It does not have a licensed bar, although the consumption of alcohol *is* permitted in this room. F7

C.6.4 **Montgomery Gymnasium**. The primary building for physical training at RMAS, Figure 5-1 serial 4. It is approximately 50m from the Wavell Room.

C.6.5 **Churchill Hall**. This is a lecture theatre which is open as required during normal training hours. There is no accommodation, café, or bar facility within. It is approximately 300m from the Wavell Room.

C.6.6 **Wish Stream**. A body of flowing water through the RMAS grounds. The stream starts on the Training area in the east and flows through the grounds, forming a series of ponds, to a lake.

C.6.7 The Wish Stream pond, Figure 5-1 ser 5 and Figure C.6-1, where the SP was found deceased. This is immediately outside Churchill Hall and 300m from the Wavell Room.

C.6.8 To its western side is a roadway, Figure C.6-2. Its side drops at 90 degrees onto a large concrete pipe which is surrounded by foliage. There are no permanent barriers.

C.6.9 To its eastern side is a concrete bridge (Figure C.6-3). This leads to the main entrance of Churchill Hall, across the steam from the car park. This bridged area has concrete barrier topped with metal.

C.6.10 To the southern side is a sloped concrete bank (approximately 30 degrees) Figure C.6-4. There were white concrete 'sleepers' and bollards at intervals along this periphery.

C.6.11 The northern side is a sloped grass bank (approximately 35 degrees at the steepest corner), Figure C.6-5. The grass leads to the water edge. Below the grassed edge and beneath the waterline is a further sloped concrete ramp of similar construction and slope to that on the southern side. There are no permanent barriers.

C.6.12 The water is approximately 1.2m at its deepest point. The water is dark, and the bottom is not visible from the surface. F1

Figure C.6-1 Wish Stream pond (DELETED)

Figure C.6-2 Wish Stream pond (western side)

Figure C.6-3 Wish Steam pond (eastern side)

Figure C.6-4 Wish Stream pond (southern side)

Figure C.6-5 Wish Stream pond (northern side)

Annex D Terminology and Evidence

D.1 Terminology

D.1.1 **Probabilistic Language**. The probabilistic terminology detailed below clarifies the terms used in this report to communicate levels of uncertainty within the report. It is based on terms published by the Intergovernmental Panel on Climate Change (IPCC) in their Guidance Note for Consistent Treatment of Uncertainties[11] as well as the ATSB in their paper on Analysis, Causality and Proof in Safety Investigations[12]. Figure D.1-1 shows a visual representation of the probabilistic language used.

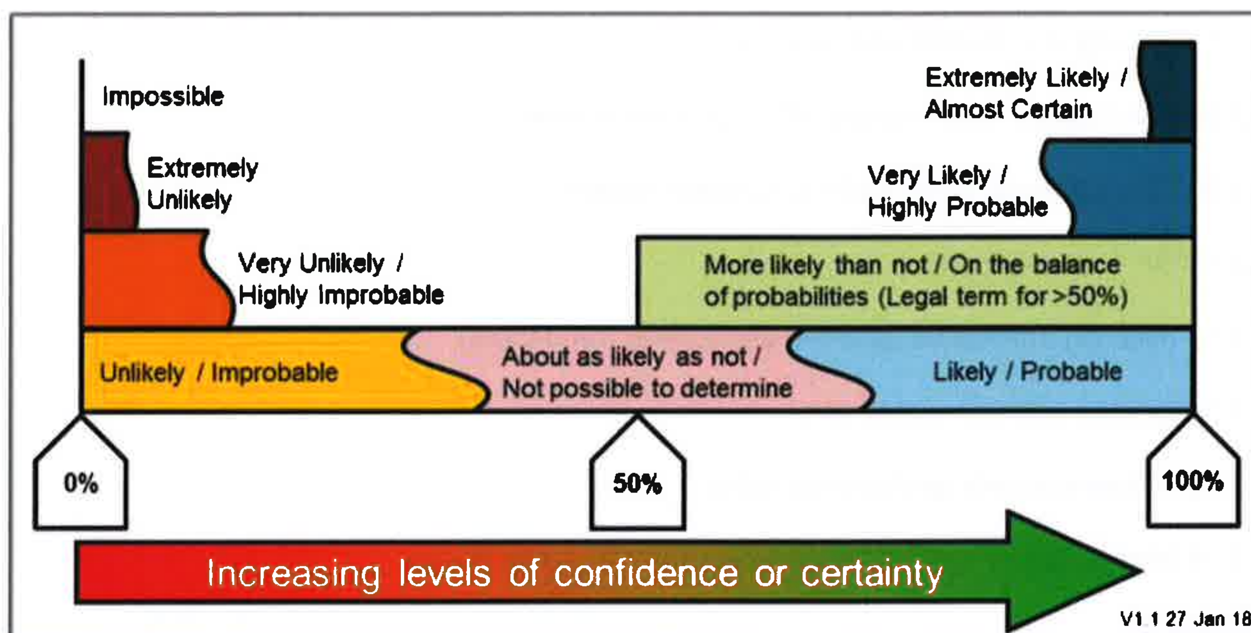

Figure D.1-1 Probabilistic Terminology

D.1.2 **Definitions of must, should and could in recommendations.** Throughout the report the Panel has made a series of recommendations. The Panel has used the terms 'must', 'should' and 'could', within the recommendations:

D.1.3 ***Must***. Describes an activity that is mandatory and which has to be followed without exception.

D.1.4 ***Should***. Describes an activity that is considered to be good practice. If the activity is followed, then this will be considered sufficient to demonstrate compliance with the recommendation. However, alternative approaches may be utilised where this produces an outcome as good as required by the recommendation.

D.1.5 ***Could***. Describes an activity that is optional, carrying it out would made improvements. Alternative approaches may be utilised to achieve an outcome similar to the recommendation.

D.2 Evidence

[11] https://pure.mpg.de/rest/items/item_2147184/component/file_2147185/content
[12] https://www.atsb.gov.au/sites/default/files/media/27767/ar2007053.pdf

D.2.1 The Panel had access to the following key evidence:

D.2.2 RMAS Learning Account.

D.2.3 Learning Account Review by APSG.

D.2.4 DAIB report.

D.2.5 Post-Mortem and toxicology report.

D.2.6 Policy documents.

D.2.7 Training documents and records.

D.2.8 RMAS policy, training and other documentation.

D.2.9 Other unit policy and training documentation.

D.2.10 SP career records.

D.2.11 Hearing interviews (and the supporting transcripts).

D.2.12 Written witness statements.

D.2.13 Witness emails and photographs.

D.2.14 Mobile phone data disclosed by Thames Valley Police.