ARMY

REPORT
OF THE SERVICE INQUIRY
INTO THE CIRCUMSTANCES SURROUNDING THE ROAD TRAFFIC COLLISION INVOLVING A 6-TONNE MAN SV TROOP CARRYING VEHICLE FITTED WITH ENHANCED SEATING AT HOHENFELS TRAINING AREA, GERMANY ON 21ST NOVEMBER 2019 RESULTING IN A SERIOUS INJURY SUSTAINED BY OFFICER CADET [redacted], ROYAL MILITARY ACADEMY SANDHURST

APSG/SI/2019/RMAS/MANSV

4 MAY 2023

COVERING NOTE

1. The Service Inquiry (SI) assembled at Army Headquarters on 15 May 20, by order of General Officer Commanding Army Recruiting and Initial Training Command[1] (GOC ARITC). The SI investigated the circumstances surrounding the 6-Tonne MAN SV Troop Carrying Vehicle fitted with Enhanced Seating (TCVES) Road Traffic Collision (RTC) at Hohenfels Training Area, Germany, on 21 Nov 19 during Royal Military Academy Sandhurst (RMAS) Exercise DYNAMIC VICTORY (Ex DV); and the subsequent Serious Injury sustained by Officer Cadet (OCdt) [redacted].

2. The following papers are enclosed:

Section 1: Executive summary

Section 2: Background and Narrative of events

Section 3: Analysis

Section 4: Conclusions: Findings, Recommendations and Observations

Section 5: Convening Authority comments

Section 6: Reviewing Authority comments

Annexes:

A. Methodology

B. RMAS Welfare Organisation

C. Medical Automated Significant Event Report (ASER)

D. Direction to Convene, Convening Order and Terms of Reference

E. Glossary

[Signature]

Major [redacted]
Army Personnel Services Group
President

[Signature]

Major [redacted]
Army Personnel Services Group
Member

[Signature]

Warrant Officer Class 1 [redacted]
Headquarters 3rd (United Kingdom) Division
Member

[1] Hd APSG transferred the Convening Authority to Comdt RMAS on 7 May 21 and back to GOC ARITC on 17 Mar 23.

SECTION 1: EXECUTIVE SUMMARY

What happened

1.1 On the morning of 21 Nov 19, the second-to-last day of Ex DV, a 6-Tonne MAN SV fitted with TCVES, carrying 11 RMAS OCdts, was travelling in a convoy of two on a military road on Hohenfels Training Area (HTA), Germany. It was involved in a serious Road Traffic Collision (RTC). The vehicle pitched into a three-quarter rollover, resulting in four OCdts being injured, including one who was Seriously Injured (SI)[2]. This OCdt [redacted] which required surgery at a civilian hospital in Germany. He was evacuated by air to Queen Elizabeth Hospital (QEH) for further treatment, and later transferred to other facilities for rehabilitation. He completed his commissioning course, graduated and continues to serve.

1.2 The vehicle was significantly damaged. The cost of repair was £77,503.36 and the vehicle was subsequently written-off. The vehicle replacement vehicle cost (including TCVES and fittings) is approximately £242,000. The driver was subject to Court-Martial proceedings, [redacted]. The Secretary of State has accepted responsibility and a claim for damages is pending.

Examination and inquiry into the incident

1.3 An immediate Defence Accident Investigation Branch (DAIB) 'triage investigation' was conducted into the RTC and produced a Deployment Record. The Defence Safety Authority (DSA) declined to convene a Service Inquiry (SI). The Deputy Chief of General Staff (DCGS) directed the Single-Service Inquiry Coordinator (Army) (SSIC (A)), Head APSG (Hd APSG) that an Army SI be convened, to further examine unit and personnel related issues. An Interim SI Report made in Oct 22 indicated a need for further analysis; a Final SI Report was submitted in Mar 23.

1.4 Protection as outlined in Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008 was afforded to five potentially affected persons (PAP).

Key findings of this Inquiry

1.5 **Causal factor**. The causal factor leading to the unforced single-vehicle accident was that the Driver, largely through inexperience, drove in a manner unsuited to the conditions.

1.6 **Contributory factors**. The inquiry into the RTC exposed several matters beyond the specifics of the vehicle accident, of which the most significant were:

a. Failings in **command and control** (including the lack of Permanent Staff (PS) supervision of OCdts, lack of communications and failure to report the incident correctly);

b. Failings in **personnel management** (including sub-optimal support to the injured OCdt and his family); and

c. Failings in **medical support** (including medical planning and execution prior to, during and after the incident).

[2] He was classed as 'UL' at the time, amended to 'SI' after he was reviewed following his admission to QEH.

1.7 **Findings**. The inquiry made the following key findings:

a. **Failure to provide supervision**. The lack of PS supervision of OCdts during the exercise's administrative task was a serious breach of the Safe System of Training (SST) and the principal contributory factor in this incident.

b. **Failure in command and control**. Sending OCdts on a task, with no means of communicating with Exercise Control (EXCON) either routinely or in an emergency, was a further serious breach of the SST. Flawed decision making also directly contributed to the consequences which arose from the incident. A combination of these failings resulted in it taking 65 minutes for appropriate first responders to arrive on the accident scene, despite the Medical Officer and EXCON being only seven kilometers away.

c. **Failures in medical support**. Medical planning was inadequate, and key elements of the medical plan were not fully rehearsed, understood nor implemented. Incorrect casualty medical classification and imprecise information-sharing contributed to faulty liaison with next of kin (NoK) and prevented the OCdt's family from initially accessing the welfare support to which they were entitled.

d. **Failure to report the incident to the Royal Military Police (RMP)**. A two-month delay in reporting the accident to the RMP led to a delay in legal proceedings being brought against the driver. This avoidable delay attracted criticism by the Judge Advocate when sentencing the driver.

e. **Trauma Risk Management (TRiM) failings**. There were multiple breaches of TRiM policy.

f. **Failure to consider competency and experience for employment.** The driver's inexperience was not identified and therefore not mitigated against. The driver was employed beyond his competency and experience.

1.8 **Recommendations and observations**. Section 4 of this report is a summary of the 18 Army recommendations made to mitigate or prevent future recurrence. 16 of these recommendations have been resolved and by 30 Jun 2023 **none will be outstanding or remain open**.

Major [redacted]
Army Personnel Services Group
President

SECTION 2: BACKGROUND AND NARRATIVE OF EVENTS

BACKGROUND

Context

2.1 This SI examines the RTC of a 6-Tonne MAN SV fitted with TCVES during the final term of Regular Commissioning Course (CC) 191. The accident occurred during Ex DV in Nov 19 and involved OCdts from 16 Pl/Ypres Coy (16 Platoon/Ypres Company). Ypres Company and the exercise were under the direction and responsibility of Commander New College (Comd NC).

2.2 The incident was initially examined by a DAIB team, who deployed immediately to the accident site and produced a Deployment Record. DCGS through Hd APSG then determined that an Army SI should be convened, since the issues which required further examination were largely unit and personnel related.

Conduct of the Inquiry

2.3 The SI commenced in May 20. It was adversely affected by the impact of COVID lockdowns, restrictions on assembling witnesses and taking evidence, and personnel turbulence. .The SI was directed to be paused during the Driver's Court Martial, recommencing in Apr 21. Evidence included analysis of the DAIB Deployment Record, the RMAS NC Learning Account (LA) and the APSG LA Review. Oral testimony on oath was taken from 16 witnesses and concluded in Jul 22. The SI reported to the Convening Authority (CA) in Oct 22. Although the SI had been conducted well and appropriate analysis done and recommendations drawn, the report was poorly drafted by the SI President. Consequently, the SSIC(A) directed that it was re-written by a freshly appointed President and a Final Report was submitted in May 23 incorporating relevant Regulation 18 Witness comment. During the SI the CA was transferred from GOC ARITC to Comdt RMAS and then finally, on 17 Mar 23, back to GOC ARITC for his review.

2.4 In this Report, RMAS instructors and unit staff regardless of their role are referred to as Permanent Staff (PS) to distinguish them from OCdt trainees.

2.5 Four Potentially Affected Persons (PAP) were identified and afforded protection as outlined in Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008. The same protection was afforded to a fifth PAP, who was identified in Mar 23 after further analysis during the rewrite of the Draft Report.

RMAS

2.6 RMAS is the British Army's residential basic officer training establishment for Regular, Reserve and Professionally Qualified officers, selected foreign and Commonwealth officers, and the University Officer Training Corps. At the time of the incident RMAS was under the command of GOC ARITC. RMAS trains and develops OCdts to the level required of an Army Officer on first appointment and hence is a Basic Training (BT) establishment. The Commissioning Course lasts for 44 weeks and is conducted in three terms. The first two focus on basic military skills, fitness and decision making, with additional academic and leadership components introduced in the second term. The final term practises the OCdts' new skills during complex and demanding training exercises in the UK and overseas. After successfully completing the CC the OCdts cease being a 'Trainee' and become Commissioned Officers in the rank of Second Lieutenant (2Lt). They leave RMAS and commence Initial Trade Training (ITT) in their chosen Arm or Service.

2.7 **New College (NC).** NC is responsible for training OCdts in their intermediate and final terms. NC does not equate in size and capability to a typical Army unit. It has an extremely small HQ, headed by a Lt Col who holds dual appointments as both College Commander and Staff Officer Grade 1 (SO1) Training[3]. Comd NC is supported by an Adjutant (Adjt), Regimental Sergeant-Major (RSM) and a small instructional and exercise planning staff. Sub-units (such as Ypres Coy) are led by a Major/Company Commander (Maj/Coy Comd), supported by a Company Sergeant-Major (CSM). Each company has three platoons (Pl), each led by a Captain (Capt) Pl Comd, supported by a Colour Sergeant/Staff Sergeant (CSgt/SSgt) Instructor. It is these experienced and high-quality PS who are the primary interface with the OCdts. NC does not have organic logistics, communications, medical, welfare and pastoral departments. Instead, it is supported by the Sandhurst Support Unit (SSU) which provides enabling support across the whole of the Sandhurst site. The Panel sensed a degree of tension between the Colleges and RMAS HQ, influenced by what the Colleges are required to deliver versus what they are resourced for, and where the boundary lay between College, RMAS HQ and elements of the SSU. **(F1-T7) (F1-T8) (T1-T9) (F1-T11) (F-T14)**

2.8 **Wounded Injured and Sick (WIS).** Adjts are the WIS Manager for their Colleges. CO SSU has overall responsibility for the management of WIS across the site.

2.9 **Medical and rehabilitation support.** As well as normal medical facilities, RMAS has a rehabilitation platoon, Lucknow Pl, whose remit is to rehabilitate then return injured OCdts to training safely and as promptly as is possible. **(F1-T9) (F1-T7)**

2.10 **Welfare and pastoral support.** Welfare support is provided through the Unit Welfare Officer (UWO), aided by the Royal Voluntary Service and other charitable organisations. Pastoral Support is provided by the Senior and College Padres. **(F1-T7) (F1-T8) (F1-T9)**

2.11 **Other welfare support.** The Defence Medical Welfare Service (DMWS) is a charity which helps Service Persons (SP) and their immediate family while in hospital. DMWS also provide access to Fisher House, accommodation for military patients and their families whilst

[3] With effect the Jul 22 Command Board, RMAS College Commander is now a 'Command appointment.'

SP are being treated at military wards in QEH. Families can stay in a secure and supportive environment at Fisher House for as long as required, without charge. This eliminates the stress of finding somewhere to stay and reduces the financial burden as well as the pressure of travel to and from QEH.

2.12 **Logistic support.** 44 Support Squadron Royal Logistic Corps (44 Sqn RLC) is a sub-unit of RMAS, providing support to all training activity. 44 Sqn provide drivers and vehicles, signallers and communications equipment, equipment support and logistic and other enabling support.

MAN SV fitted with TCVES

2.13 The 6-Tonne MAN SV is a flat-bed cargo lorry with an enclosed cab for the driver and two passengers. An open rear cargo area with removal side panels and tailgate is covered with a tarpaulin under a tubular metal frame. This frame is not a safety feature but is designed simply to support the tarpaulin, which affords a degree of protection from weather. When fitted with the enhanced seating safety system (hence the designation TCVES), the MAN SV can carry troops seated in two modules (one with six and one with eight seats) secured to the vehicle platform. This provides a total of 14 passenger seats, each with separate protective features, designed to ensure safety to seated occupants.

MAN SV TCV

MAN SV TCV part fitted with TCVES (rear section)

2.14 There may be a Vehicle Commander, who must be a LCpl or higher rank. If travelling with rear seated passengers, a Rear Passenger Supervisor is required.

Ex DV

2.15 Ex DV is a two-week field exercise and is the final training event for each CC. The activity is directed by the Academy HQ but planned and delivered by NC. Ex DV runs to a standard format three times a year. Since 2009, other than for a brief period during COVID restrictions, Ex DV has been conducted at the Joint Multinational Training Centre (JMTC), on the Grafenwöhr Training Area (GTA) and Hohenfels Training Area (HTA) in Germany. This single-vehicle RTC incident occurred on the second to last day of the Ex. **(F1-T11) (F1-T12) (F1-D23) (F1-D26)**

2.16 The Nov 19 iteration of Ex DV ran from 3-23 Nov 19 in two distinct phases. The first, Live Firing, was delivered in GTA. The second, Company-level rural and urban activities culminating in a battalion attack on the final day, were conducted at HTA. The table below shows the key dates during Ex DV, noting that ground deployment of vehicles, equipment and support staff to/from Germany occurred before and after the air deployment dates shown.

Date	Event
3 Nov 19	OCdts and PS fly to Munich, Germany via Royal Air Force Brize Norton (RAF BZN)
3-13 Nov 19	Live firing training activities at GTA
14 Nov 19	Move from GTA to HTA
14-20 Nov 19	Field training exercises at coy level at HTA
21 Nov 19	Final Phase of Ex DV begins
22 Nov 19	Final battalion attack followed by the 'Beret Ceremony'
23 Nov 19	OCdts and Exercise Control (EXCON) Staff return to RMAS

2.17 **Preparation**. Approximately six weeks prior to each Ex DV, a confirmatory planning/coordination conference is held, chaired by the RMAS NC Chief Instructor (CI) who is also the Ex DV Exercising Officer (EXO). The EXO is accountable to the Comd NC who, as Ex Director, is responsible for the Exercise. **(F1-T11)**

2.18 **Participation**. Approximately 550 personnel deployed on Ex DV 19. 225 personnel were OCdts under training. A further 325 personnel served as Safety and Directing Staff (DS), EXCON staff and as drivers, medical and communication specialists and other support staff. **(F1-T10) (F1-T11) (F1-T12)**

2.19 **Medical**. The Medical Plan was produced by the ARITC Competent Medical Authority (CMA).

2.20 **Supply to Experimentation and Training (SET)**. RMAS is not resourced to run all exercises from within its own staff and so is reliant on additional personnel and equipment provided via the SET process. SET designates support from Field Army (Fd Army) workforce and resources; these are effectively 'loaned' by the providing unit for the duration of Ex DV and then released back to their parent unit once the exercise has concluded.

Key individuals

2.21 Key individuals relevant to this inquiry include:

a. **Comd NC**. A Lt Col who arrived in [redacted] from command of a regular combat arm unit. As Ex Director, he was accountable for the conduct and execution of Ex DV. **(F1-T10)**

b. **CI/EXO**. A Maj who arrived at RMAS in [redacted] from sub-unit command. Initially a Coy Comd, he took over as CI in [redacted] and was responsible for the planning and execution of Ex DV. **(F1-T11)**

c. **Academy Chaplain**. An Army Chaplain for over 16 years with extensive operational experience. Started at RMAS in [redacted] and was the 'team lead' for chaplaincy services at the Academy. **(F1-T9)**

d. **SO3 Plans/Assistant CI**. A Capt who served as RSM of a regular Battalion. Arrived at RMAS in [redacted]. Had previously served at RMAS as a CSgt PI Instructor and as a CSM. His post involves all aspects of coordinating training support. **(F1-T12)**

e. **Adjt NC**. A Capt who arrived in [redacted] from an attachment as a Royal Marines Coy 2IC. Attended the All-Arms Adjutant Course prior to joining RMAS. **(F1-T14)**

f. **RSM NC**. A Warrant Officer Class 1 who arrived at RMAS on promotion. Previously served at RMAS as a CSgt PI Instructor. **(F1-T16)**

g. **Ypres Coy Comd**. A Maj who arrived at RMAS in [redacted] from a staff appointment. He took over as Ypres Coy Comd in [redacted] **(F1-T4)**

h. **16 PI Comd**. A Capt who arrived at RMAS in [redacted] from Regimental Duty. **(F1-T6)**

i. **Medical Officer [redacted] (MO[redacted])**. The assigned MO for Ex DV. Drawn from SET. MO[redacted] was an Army Reservist with [redacted] years' military service. He qualified as a civilian Doctor in [redacted], then trained as a [redacted]. He has 5 years' postgraduate experience and was in his third year of specialist training (known as ST3). In the previous two years he had deployed as a General Duties Medical Officer (GDMO) on exercises to Kenya and Belize, and on operations to Kabul for 4 ½ months. MO[redacted] arrived the weekend that NC departed for Germany. He did not attend the exercise coordination conference and was not involved in developing the Medical Plan. **(F1-T13)**

j. **Medical Officer [redacted] (MO[redacted])**. Unusually for Ex DV, and not reflected in the Medical Plan, a second (non-SET) MO also deployed on the Ex. MO[redacted] was a Regular posted to RMAS and was also in his ST3. He was assigned by the Senior Medical Officer (SMO) [redacted] to join Ex DV to gain experience. [redacted]. At the time of the RTC MO[redacted] was dealing with another, unrelated, medical incident. MO2 subsequently visited the OCdt in the German hospital and coordinated with the Aeromedical Evacuation Control Centre. The two MOs were at similar stages of their professional medical development, both being ST3. The Panel was unable to determine which MO had primacy; both could 'reach-back' to UK-based MOs, including SMO RMAS, for advice.

k. **College Padre**. Normally the Old College (OC) Chaplain, he was covering for his NC colleague on Ex DV. A Chaplain for six years, including service with an Infantry Battalion and an operational tour, he started at RMAS in [redacted] **(F1-T9)**

l. **Academy (Ac) Welfare Officer**. A Civil Servant and the first incumbent of the post, created because of an OFSTED report into RMAS. Had attended the Unit Welfare Officer's (UWO) Course and started at RMAS as UWO in [redacted]. **(F1-T7)**

m. **SO2 Personnel, Regimental Headquarters (RHQ) RLC**. A Maj who heads RLC Recruiting and Liaison, responsible for all RLC engagement with RMAS. Knew the OCdt prior to and during his time at RMAS. **(F1-T5)**

n. **OCdts (where they are relevant to the inquiry) and Driver**. Seating plan below:

Front Cab		
OCdt [redacted], Exercise PI Sgt	OCdt [redacted], Exercise PI Comd	Vehicle Driver (SET troops)
Rear Seating		
Left		**Right**
OCdt [redacted]		OCdt [redacted]
OCdt [redacted]		OCdt [redacted]
Empty		OCdt [redacted]
Empty		OCdt [redacted]
Empty		OCdt [redacted]
Empty		OCdt [redacted] – Injured
Empty		OCdt [redacted] – Seriously Injured

o. **The Driver**. A Regular Private ([redacted] year-old male), the Driver was a SET augmentee from an infantry battalion. He reported to 44 Sqn at RMAS at short notice on [redacted] to drive a MAN SV from Sandhurst to Germany and then on Ex DV. He replaced an earlier nominee who had been withdrawn by his unit[4]. The driver held in-date and appropriate MAN SV and troop-carrying qualifications. He had held a driving license for [redacted] car and had very little driving experience. He qualified to drive the MAN SV in [redacted] but had driven the vehicle infrequently, as driving was not his primary trade. Prior to this exercise he had never driven a MAN SV TCVES with passengers in the back. The Panel determined that the driver was not 'Competent' nor 'Current' as articulated in the Army's SST as he lacked recent and relevant experience (**see Section 3, TOR 1**). **(F2-D33)**

p. **OCdt [redacted]. By default, the 'Vehicle Commander'.** A [redacted] year-old OCdt with nearly four years Army Reserve service prior to joining CC 191. A qualified MAN SV driver but had not previously acted as commander of a MAN SV. Filling the exercise appointment of PI Comd at the time of the incident, which is why the OCdt 'commanded' the task and hence the vehicle. **(F1-T1)**

q. **OCdt [redacted] By default, the 'Rear Passenger Supervisor'.** Filling the exercise appointment of PI Sgt at the time of the incident and provided testimony that the RSM issued directions for the task.

r. **OCdt [redacted]. Injured in the incident.** Admitted to German hospital [redacted] the OCdt returned to the training area but did not rejoin the exercise.

s. **OCdt [redacted] The Seriously Injured OCdt.** A [redacted] year-old OCdt who incurred [redacted] during the incident. Initially treated in a German hospital then evacuated by air to QEH for further surgeries and medical interventions. Medical category updated to 'Seriously Injured' at the QEH. RMAS deemed that that the SP had completed CC 191 and he graduated with his peers on the Sovereign's Parade. Following commissioning he was supported by RHQ [redacted] with a work placement during medical rehabilitation. [redacted] **(F1-T2)**

Narrative – before the incident

2.22 The Ex DV coordination conference took place in Oct 19, chaired by CI NC. This conference is held to confirm arrangements for the upcoming exercise, noting that control and support staff may be new participants. **(F1-T11)**

2.23 Prior to deploying, all 44 Sqn staff received a task-specific briefing. OCdts received a safety brief in accordance with the Ex DV Admin Instruction.

2.24 On the evening of 20 Nov 19, Ypres Coy was conducting administrative tasks in a Forward Operating Base (FOB) known as FOB West in preparation for the final battalion attack phase that would begin on 21 Nov 19 and conclude the morning of 22 Nov 19 **(F1-T1) (F1-T12) (F1-T16) (F1-D27).** This would be followed by the 'Beret Ceremony' and recovery to the UK.

2.25 Each evening an EXCON coordination meeting was held to assign activities and tasks for the following 24 hours. On 20 Nov 19 the meeting was chaired by the EXO;

[4] The vehicle was sourced from another unit.

attendees included the ACI, RSM and other enabling EXCON Staff. The key tasks discussed at the meeting related to relocation of EXCON ahead of the final attack, clear-up and hand-back of the training area on which the OCdts had been training, and the coordination of recovering back to the UK. **(F1-T11) (F1-T12)**

2.26 PS Officers departed that evening for the RMAS-programmed official exercise hosting event in Munich, some 40 minutes' drive from HTA. Alcohol was served at the event, which is a regular component of Ex DV, intended to thank those allied and foreign personnel who support and enable the exercise. Afterwards, some Officers stayed overnight in Munich rather than returning to HTA. As there was no PS booking-in/out system the Panel has been unable to determine how many or who returned to FOB West. **(F-T4) (F1-T6) (F1-T10) (F-T-11)**

2.27 The Warrant Officer/Senior Non-Commissioned Officer (WO/SNCO) PS remained at FOB West during the administrative period. There is testimony from OCdts that some of these PS engaged in informal social activity locally. Again, the absence of a booking-in/out system means the Panel cannot determine which WO/NCO PS remained on the exercise area. The Panel has therefore been unable to establish the degree of formal PS supervision of the OCdts from the evening of 20 Nov 19, when the officers departed to Munich and WOs/SNCOs stood down and possibly socialised, until the early afternoon of 21 Nov 19, when OCdts gave orders and started to deploy for the battalion attack the next morning. On the balance of probability however, it appears that during this 'administrative' period very few if any OCdt-facing PS were specifically working and committed to the exercise other than those running EXCON. **(F1-T15) (F1-T16)**

Narrative – the day of the accident

2.28 Thu 21 Nov 19 was an administrative day. Orders would be delivered in the afternoon by the OCdt exercise Coy and Pl Comds. In the evening the OCdts would deploy to start the final phase of Ex DV, the battalion attack. To support this final phase, part of EXCON was to move from FOB West to be better placed for the final attack on the morning of 22 Nov 19. **(F1-T1) (F1-T11) (F1-T12) (F1-T15) (F1-16) (F1-D24)**

2.29 That morning, PS were either involved in relocating EXCON, assisting with the coordination of recovering back to the UK, at or returning from the previous night's social function, or had been stood down. There is no testimony that any were directly supervising the OCdts. The RSM remained in charge of the OCdts at FOB West. **(F1-T1) (F-T2) (F1-T6) (F1-T12) (F1-T15) (F2-D37)**

2.30 Clearing the training area includes collecting spent ammunition cases, filling in trenches, and collecting litter. This is an administrative task. It cannot be considered a training task, and no training objective is set. There is testimony that the RSM oversaw this activity. The RSM was unable to recall or confirm this, citing the length of time elapsed since the incident. It appears to the Panel that the RSM was the last member of PS who directly interacted with the OCdts that morning and could have influenced the command, control and conduct of the clearance tasks. **(F1-T1) (F1-T12) (F2-D37)**

2.31 Training area clearance was tasked via the OCdt chain of command (OCdts allocated Pl Sgt appointments for the final attack). MAN SVs fitted with TCVES were used to move the OCdts to and from each clearance task. OCdt [redacted] was in an exercise command appointment of [redacted] the OCdt rode in the cab and by default assumed the responsibility of Vehicle Commander. OCdt [redacted] was in the exercise command appointment of [redacted]; this

OCdt also rode in the front of the vehicle. By virtue of their exercise role and indicated by the checks and warnings this OCdt gave to the rear-seated passengers, by default this OCdt assumed the role of Rear Passenger Supervisor.

2.32 Below is a timeline of events on the morning of the accident. **(F1-D17) (F2-D30)**

Time (GMT)	Incident +	Event
0800 hrs	-	RSM allocates areas to be cleared to OCdt Ex Pl Sgts
c. 0840 hrs	-	16 Pl depart FOB West for tasking in two MAN SVs in Convoy
c. 0900 hrs	-	16 Pl arrived at wrong tasking location
c. 0920 hrs	-	16 Pl departs for correct tasking location
c. 0945 hrs	-	16 Pl arrives at correct tasking location
c.1020 hrs	-	16 Pl departs tasking location to return to FOB West
c. 1030 hrs	**Incident**	The unforced single-vehicle RTC occurs
c.1040 hrs	+10 mins	Telephone call by driver of lead (uninvolved) MAN TCV to 44 Sqn, RMAS (in UK) using personal mobile phone
c. 1050 hrs	+20 mins	2nd telephone call by driver of lead MAN TCV to 44 Sqn, RMAS
c.1110 hrs	+40 mins	EXCON becomes aware of RTC. PS, MO[redacted], Combat Medical Technicians (CMTs) and Battlefield Ambulance (BFA) deploy. REME recovery unit arrives at RTC (alerted by EXCON)
c.1135 hrs	+65 mins	EXCON PS and MO[redacted] arrive at the scene of the accident
c.1145 hrs	Incident + 75 mins	OCdts [redacted] and [redacted] transferred by BFA to Rendezvous (RV) point for patient exchange to local German Hospital

2.33 At 0800 hrs the OCdt Pl Sgts received details of the administrative task of 'collecting brass' from the RSM. Each was given a separate location to go to. **(F1-T1) (F1-T2) (F1-T6) (F2-D37)** No groups were accompanied by PS. No communications plan was briefed to the OCdts. They were not provided with any communications equipment, nor did either vehicle contain a first aid kit.

2.34 Under the direction of OCdt [redacted] (because that OCdt was also the exercise [redacted] 16 Pl split into two groups. Some were assigned to the clearance task; some remained in FOB West to continue with preparations for the final attack. Those OCdts who deployed on the clearance task were carrying helmets; their weapons and webbing remained in FOB West. The designated MAN SV drivers had been warned-off to be prepared to depart on the various tasks and were waiting, lined-up with their vehicles. They had not been advised where to go or what route to take; directions were to be given to them by those OCdts navigating alongside the driver in the front cab. **(F1-T1)**

2.35 At approximately 0840 hrs 16 Pl left FOB West in a convoy of two MAN SV fitted with TCVES headed to an area to the Northwest of HTA, approximately seven km away. It is reported that it rained the night before, and that the road surfaces were damp but fine to drive. Off-road formed tracks were well-maintained and drivable. It was daylight with good visibility. The speed limit on the training area was 40kmh/25mph.

2.36 16 Pl got lost. The OCdts then navigated to the correct location and began the administrative task. OCdts were not under any pressure. When the clearance task was finished the OCdts boarded the vehicles to return to FOB West. Those in the back assumed rear seats randomly during each of the moves and the only seating plan of relevance to this Inquiry is the seating plan for the last journey (**see para 2.21n**). **(F1-T1)**

2.37 During the earlier moves that day, OCdts had become concerned about the standard of driving of the vehicle in the incident. OCdt [redacted], in the appointment of Ex Pl Sgt and default Rear Safety Supervisor, gave direction to all OCdts to wear the fitted TCVES safety harness for the return trip to FOB West. This safety practice had not been enforced when OCdts had been moving in MAN SV fitted with TCVES prior to this. **(F1-T1)**

2.38 The two vehicles began the return journey, back to FOB West, at approximately 1020 hrs. OCdts testified that the standard of the driving (of the vehicle in the incident, the rearmost of the two) began to noticeably deteriorate. The driver was skidding or drifting around corners before dropping back to leave an extended gap between the two vehicles in the convoy, before accelerating again to catch up. There is testimony that the rear driver was deliberately 'power sliding' around corners (the front vehicle driver was not).

2.39 OCdt [redacted], the Vehicle Commander (Veh Comd), asked the driver to drive more carefully. This was a request and not an order as the OCdt did not feel they had the authority to 'order' a trained soldier. By his actions, the driver disregarded the request. The driver began to lose control of the vehicle as the back end of the vehicle started to fish-tail. The driver appears then to have over-corrected. The vehicle veered off the road and up the side of an embankment. The near-side front of the vehicle struck a rock and the vehicle pivoted violently at 90 degrees to the direction of travel. Forward momentum combined with rapid deceleration pitched the vehicle into a three-quarter roll and it came to an eventual halt on its side, approximately 50 meters further down the road from first impact. The photo below shows the crashed vehicle at rest, with a graphic showing the seating location of OCdt [redacted]. **(F1-T1) (F1-T3)**

2.40 The lead vehicle had stopped at a T-junction for a navigation check. The rear passengers of that vehicle saw the crash, managed to alert their driver, and ran back up the road to provide aid at the crash scene. **(F1-T1) (F1-T3)**

2.41 The following injuries were sustained:

OCdt	Injury
[redacted]	[redacted] Received surgery the same day in a local German hospital. Medical category of Unlisted (UL). Evacuated by air to QEH, with a series of medical interventions after. Medical category after review of Seriously Injured (SI). Further treated at Defence Medical Rehabilitation Centre.
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Narrative – immediately after the accident

2.42 Uninjured OCdts from both vehicles provided first aid and assistance to the injured. Despite being injured ([redacted]), OCdt [redacted] took charge at the scene. This OCdt coordinated action by fellow OCdts, triage of the injured and sent OCdts to look for potential helicopter landing sites for CASEVAC by helicopter. **(F1-T1) (F-T3) (F2-D37)**

2.43 With no means of communication and no PS present, the OCdts had no way to contact EXCON. Fortuitously, the driver of the lead MAN SV was a 44 Sqn RLC driver with a personal mobile phone. This driver used his personal phone to contact 44 Sqn back in the UK to request that a message be relayed to the Ex DV EXCON in Germany. He made a second call shortly after, to hasten a response. The OCdts continued to care for the four injured OCdts. One injured OCdt [redacted], [redacted] Meanwhile, OCdt [redacted] also cared for the uninjured but shaken driver of the crashed vehicle. **(F1-T1) (F1-T3)**

2.44 The DAIB Deployment Record states that:

> 'The first responders to arrive at the accident site, some 40 mins after the accident, were from the REME detachment, with the medical responders not arriving until 66 mins after the accident. This was because they were transiting to a new location in preparation for the final exercise. Additionally, as no medical packs could be located on the vehicles involved in the incident and as the OCdts had left their webbing and equipment in FOB West there was limited medical equipment available to treat the casualties during the first hour after the accident. This could have led to a catastrophic outcome had there been more serious injuries.'

2.45 MO [redacted] and EXCON PS arrived 66 minutes after the incident. MO [redacted] testified to having concerns [redacted] The full extent of the injury was not known at this time. MO [redacted] oversaw the move by BFA of the two injured SPs (OCdts [redacted] and OCdt [redacted]) to an RV point on the edge of the training area and conducted a patient exchange to a waiting civilian German ambulance. MO [redacted] did not accompany the OCdts to the Hospital as he was content the OCdts were safe in the hands of the German ambulance crew, and he wished to review the other patients who were now at the RAP. They were visited later that day by MO [redacted]. **(F1-T13)**

2.46 OCdt [redacted] and OCdt [redacted] received medical assistance in the local German Hospital. OCdt [redacted] was discharged from hospital (DFH) on the same day and returned to the exercise but did not take an active part in the final attack. OCdt [redacted] was admitted to hospital and

received surgery [redacted] that same day. During a phone call to OCdts [redacted] family, Comd NC inadvertently incorrectly told them that the [redacted]. Post-operation, it was the OCdt himself who informed the family of the nature of the surgery received in the German hospital, which he described to them as '[redacted]. **(F1-T6) (F1-T13)**

2.47 **British Forces Germany Host Nation Patient Support Officer (BFG HN PSO).** Aspects of the medical plan were followed, including: the 'blue light' plan (medical team reaction to an incident); transfer of a casualty to a German civil ambulance; and subsequent contact with the aero-medical evacuation (AEROMED) team. However, a critical aspect of the medical plan **was not followed**. No contact was made with the BFG HN PSO when the casualties were admitted to the German hospital. The medical plan includes the following advice, which was not complied with:

> '**Admission to German Hospitals.** British Forces Germany has secured an extension to the existing HN contract until Sep 20, therefore existing arrangements within Germany will remain extant until this date. BFG has a Hospital Hotline to give support to entitled personnel attending A&E or admitted as in-patients to Designated German Provider hospitals. This telephone service is provided by BFG HN PSOs whose role is to assist BFG patients with language problems. They are also familiar with procedures and practices within German hospitals. The PSO can also obtain consent from the patient for the release of information to the medical/dental centre, Unit and as appropriate to the welfare services. This will ensure that translation of discharge documents, follow up appointments at the medical centre or hospital, payment of the hospital bill, Notification of Casualty (NOTICAS) and other administrative procedures are initiated quickly by the relevant agencies.'

2.48 A NOTICAS report was raised by Adjt NC as per the guidance and direction in Joint Service Publication 751, Joint Casualty and Compassionate Policy and Procedures (JSP 751). MO[redacted] and the Adjt both testify to having difficulty in determining the correct casualty category to use for the injury listing in the NOTICAS. The JSP states that medical authorities (in this instance MO[redacted]) are responsible for identifying the medical category for each type of casualty[5]. There is testimony that the MO did use the term '[redacted] to the Adjt. However, the advice from MO1 was interpreted by the Adjt such that he completed the NOTICAS as an UNLISTED (UL) category to describe the medical category of the OCdt. **(F1-T2) (F1-T13) (F1-T14)**

2.49 The relevant casualty categories that were available to the Adjt and MO[redacted] for the NOTICAS are defined in JSP 751 Ch 2 para 3.3 as:

Code	Definition
VSI	Very Seriously Injured (injury is of such severity that life is imminently endangered).
SI	Seriously Injured (injury is of such severity that there is cause for immediate concern but there is no imminent danger to life).
III	Incapacitating Injury (injury does not warrant classification of VSI/SI but renders casualty physically and/or mentally incapacitated).
UL	Unlisted (injury requiring hospitalisation but which does not warrant classification of VSI/SI/III).

2.50 A summary of the Notification of Casualty reports filed with the Joint Care and Compassionate Centre (JCCC) lists the following relating to OCdt [redacted]:

[5] JSP 751, V21 Nov 19, Ch 3 para 3.2.

Date	Type	Med Category	Submitted by	Event
Thu 21 Nov 19	Initial Report	UL	NC Adjt	Accident
Sun 24 Nov 19	Update	Remains UL	Royal College of Defence Medicine (RCDM)	Morning after arrival at QEH
Tue 26 Nov 19	Update	SI (Previously UL)	RCDM	QEH
Tue 3 Dec 19	Update	Remains SI	RCDM	QEH
Wed 11 Dec 19	Update	Remains SI	RCDM	QEH
Mon 16 Dec 19	Final Report	DFH (Previously SI)	RCDM	DFH

2.51 On balance the Panel deems the Initial NOTICAS casualty category of UL to have been incorrect. This had the following consequences:

a. Firstly, it precluded a level of welfare support (known as 'DILFOR'[6]) that should have been immediately extended to the OCdt's family. This would automatically have been facilitated by JCCC had the casualty category been classed as SI rather than UL.

b. Secondly, it had the effect of misinforming the RMAS chain of command, whose honest but incorrect understanding from then on was that the OCdt's injury was less significant than it really was.

c. Thirdly, it placed the responsibility for informing NoK/Emergency Contact with NC rather than through JCCC, which is why Comd NC phoned the OCdt's family on the evening of the incident with what transpired was incorrect information about the nature of OCdt [redacted] injury.

2.52 At around 1800 hrs on 21 Nov 19 two CSgt/SSgt PS provided group 'Trauma and Risk Management' (TRiM – a post-incident counselling and support procedure) to 16 PI/Ypres Coy once they had returned to FOB West. TRiM is discussed in Section 3 of this report.

2.53 OCdts testified that they were not given an option whether to continue with the Ex and the final battalion attack. They continued with the Ex. The Padres testify to being surprised that the Ex continued as scheduled and hint at some unhappiness and disagreement, although this may not have been expressed at the time. The command view, taken after consultation with multiple parties, was to continue with the exercise. **(F1-T1) (F1-T2) (F1-T8) (F1-T9)**

Recovery to and treatment in the UK

2.54 The same RAF aircraft which returned the RMAS exercise to the UK was used to AEROMED the casualty. The reconfiguration of the RAF aircraft for AEROMED rather than wholly for able-bodied passengers required that a small number of those scheduled to return on 23 Nov 19 had to take a second, later flight the next day. It appears inexplicable to the Panel that one of those 'bumped' from the AEROMED flight was the PS 16 PI Comd, who consequently arrived back in the UK on Sun 24 Nov 19. 16 PI Comd was the first member of RMAS to meet with the OCdt and family at the QEH, on Tue 26 Nov 19, followed by the Padre on Wed 27 Nov 19. Subsequently, a visit programme was established, coordinated by 16 PI Comd, that included OCdts as well as PI and Coy staff and the Padre, ensuring

[6] **Dangerously Ill Forwarding of Relatives.** The policy for the provision of travel and accommodation at public expense for relatives and friends to visit sick and injured service personnel in hospital is termed DILFOR.

daily contact with the casualty and his family. But, critically, there was no contact on those first two days back in the UK, nor did RMAS escort the casualty to QEH, and these failings are commented on by the family. Had the PI Comd not been 'bumped' to a flight the next day, the Panel is confident that the PI Comd would have ensured that better and more personal contact with the OCdt and his family would have occurred earlier. **(F1-T4) (F1-T6) (F1-T9)**

2.55 The OCdt was transferred to the QEH from BZN on the evening of Sat 23 Nov 19. He was transferred without his kit, which was shipped to RMAS, having been cached at FOB West. The OCdt was not reunited with any personal items while at QEH. The result was that he was hospitalised initially with no personal items (until his family provided some from home), which he understandably found unsettling and frustrating.

2.56 RMAS did not communicate effectively with the family of the OCdt during his transfer to QEH. The result was that the family made their own, independent, plans to visit him at QEH the day after he arrived, and arranged their own accommodation at Fisher House. If RMAS had categorised the casualty as SI as opposed to UL, the family (through DILFOR) would have received direct support from the Army earlier; and RMAS (HQ including UWO) are more likely to have viewed the incident in a more serious light.

2.57 Adjt NC was the WIS Manager for NC, reporting to CO SSU for WIS and not to Comd NC. The 'welfare' function for RMAS sat with the Unit Welfare Officer, [redacted] Responsibility for welfare bypasses College Commanders and is executed centrally. At the time of the incident, the job description of Comd NC did not include welfare as a responsibility and he had no dedicated welfare resources. Despite 'welfare' being a command function, College Commander posts were not at the time classed as command appointments and college HQ staff establishments did not reflect those of a field army unit. Welfare responsibility was subsequently added post-incident and numbers of welfare personnel significantly increased (Annex B).

2.58 The UWO referenced an alleged dysfunctional relationship between the Welfare office and NC during post-incident case management. They felt excluded from meetings related to the OCdt. The impact of this was that the UWO was not aware of all actions being taken, some of which were or might have been welfare related. To a lesser extent the Padres report a similar experience. **(F1-T7) (F1-T8) (F1-T9)**

2.59 The Coy Comd and PI Comd continued to take the lead in RMAS liaison and communications with the family. While this may be good practice (in that the Coy Comd and PI Comd knew the OCdt well and their involvement provided a welcome and clearly beneficial personal touch), they are not 'welfare experts'. The lack of involvement by the UWO, for whatever reason, complicated matters as it was unclear who in RMAS had executive agency in the case. **(F1-T4) (F1-T6) (F1-T7) (F1-T14)**

2.60 The table below lists contact by telephone, text message or in person, from the time of the accident until first face to face contact with the family by RMAS on 26 Nov 19:

Date	Time	Event
Thu 21 Nov	c.1030 hrs	Accident
	1700 hrs	Comd NC phoned family, advising that the OCdt had broken ankle
	2020 hrs	Post-surgery OCdt [redacted], using PS PI Comd's phone, advises parents of the state of his injury
	2023 hrs	Family telephone PS PI Comd, who confirms diagnosis and relays a prognosis which was unclear as:

Date	Time	Event
		a. No-one in the UK element attending the hospital spoke German b. Even if they had, the failure to inform the BFG HN PSO hospital liaison staff, one of whose roles is to provide appropriate translation services, meant that 'medical German' could not be understood
Fri 22 Nov	0927 hrs – 1501 hrs	a. Series of SMS text messages between family and PI Comd. Family eventually advised about the OCdt's AEROMED to QEH. b. OCdt [redacted] contacts family using his own phone, repeating his understanding of the German Doctor stating it was a [redacted] c. Family receives photos of the crash scene and injuries
Sat 23 Nov	1107 hrs	PI Comd advises flight details returning to BZN but no QEH details
	2113 hrs	Family of OCdt [redacted] advise PI Comd of Ward at QEH
Sun 24 Nov	0900 hrs	Parents of OCdt [redacted] arrive QEH. The family contacted Fisher House direct for accommodation
Mon 25 Nov	-	a. Parents contact PI Comd requesting update. b. Complain of no official communication from RMAS and no welfare support including that DMWS have not been involved
Tue 26 Nov	-	PI Comd Visits QEH
Wed 27 Nov	-	Padre visits QEH

2.61 While welfare visits were conducted in accordance with policy, the family perception of their effectiveness was uncomplimentary, as revealed in a statement to the Inquiry:

> 'The injury was far more severe than first described and indeed potentially career threatening given the images our son had sent. There seemed to be a lack of information regarding repatriation to the UK and no contact by the Joint Services Compassionate Cell. Our son arrived in Birmingham (QEH), wasn't met by any Military staff and, as far as we know, wasn't given any wash kit or change of clothing. We feel that a weak initial listing delayed our son leaving Germany, delayed expert medical care to him on arrival at QEH and delayed any direct support to his family. Any potentially bad news, like the news given to our son early on Monday morning, should have been done when he had support around him and not just before surgery when he was obviously nervous and alone.' **(F1-D4)**

2.62 The family's upset at what they saw as poor case management, lack of coordination and poor communication by RMAS is summed up as follows:

> 'We felt isolated and quite forgotten about by the Army, extremely angry and resentful that the incident had happened in the first place. Information was being received from multiple sources with nothing coming from the official channels.' **(F1-D4)**

2.63 The OCdt had been due to commission into the [redacted]. RMAS, in collaboration with [redacted] RHQ, agreed that he would not be transferred to the Lucknow Rehabilitation Platoon, but instead would Commission with the rest of CC 191. **(F1-T4) (F1-T5) (F1-T6)**

2.64 QEH consented for OCdt [redacted] to attend the Commissioning Parade. He was to depart the hospital at 0500hrs and travel to RMAS in a taxi that was wheelchair-enabled. The taxi was booked by UWO RMAS. The taxi was cancelled following incorrect advice from Adjt NC that the visit to attend the Parade had been called off. Subsequently, Adjt NC clarified to the UWO that the instruction to stand down was wrong and that the OCdt would still be attending the Commissioning Parade. But nobody re-booked the cancelled taxi. When no taxi showed up at QEH the OCdt's mother drove him in her own car. **(F1-T7) (F2-D38)**

2.65 The family was understandably upset at what they perceived to be another failing in the welfare and care of the OCdt. They arrived at the Parade significantly inconvenienced and later than planned. **(F1-T6)** At the end of the Commissioning Parade ceremony his platoon lifted the OCdt in his wheelchair up the Old College steps and symbolically over the threshold. He then returned to QEH. The OCdt was discharged from QEH to home on 16 Dec 19 and was subsequently taken on strength by RHQ [redacted] during his further rehabilitation. **(F1-T2) (F1-T5)**

Reporting the incident

2.66 An Incident Report (INCREP) was submitted, in accordance with Army General Administrative Instructions (AGAI) Volume 2 Chapter 62. **(F1-D18) (F1-D20)** However, the RTC was not reported at the time, either to local Royal Military Police (RMP) or to the Central RMP Duty Office at MOD Southwick Park. RMP became aware of the vehicle accident on 22 Jan 20, over two months later. This failure to report is contrary to direction in **AGAI 62, para 62.034** which states:

> '**Involvement of Service Police...when a discipline incident occurs**. Where offences are committed, or serious incidents occur in the Army or on the MOD Estate, they are to be reported to the appropriate Police agency. The CO is under a legal duty to ensure that the Service Police, as soon as is reasonably practicable, are aware of an offence or a suspected offence under Schedule 2 of the **AFA 06** or of the existence of prescribed circumstances.'

2.67 Failure to promptly refer the matter to RMP had at least two negative consequences:

a. When the RMP became aware of the incident on 22 Jan 20 they started an investigation. Their Initial Report dated 29 Jan 20 **(F2-D34)** alleged that there were failings by the OCdt 'vehicle commander'. This line of investigation stopped on 20 Mar 20 following acceptance by the RMP of the argument made in a statement from 44 Squadron that:

'JSP 800 states that a vehicle commander should be a JNCO and above (...) as (OCdts) are still in training, an OCdt at week 50 of training would (still) not officially be JNCO or above.' **(F1-D9) (F2-D35)**

Until it was corrected and retracted, the suggestion in the RMP investigation that the OCdt (now a 2Lt) who was acting as 'vehicle commander' could be in part responsible for the RTC [redacted] OCdt was now a commissioned officer at the start of their career. [redacted] OCdt subsequently withdrew from Initial Trade Training at the Infantry Battle School [redacted] **(F1-T1)**

b. On 1 Mar 21, in his pre-sentencing summing up during the Driver's Court-Martial, the Judge Advocate (JA) criticised the Army for the delay in bringing the Driver to trial.

'I just comment briefly on the subject of delay, and this is really for a wider audience; some 15 months or so have elapsed since this incident. Some of that can be attributed to COVID and although we have not been told the precise underlying reason why, it

seems clear to me the rate of investigating this incident, which is in fact quite a straightforward road traffic accident, has been lamentably slow. Those responsible for carrying out the investigation, be they internal or otherwise, have to be conscious of the fact that every week, every month of delay can have major repercussions for those who are accused and those who complain. It can also affect the quality of evidence, and the pursuit of fairness and attention to detail, whilst commendable, must be balanced against the impact of a judicial process and the effect on the participants within that process.' **(F2-D32)**

SECTION 3: ANALYSIS

TOR 1: Present the facts surrounding the accident on 21 Nov 19 identifying potential causal, contributory and/or aggravating factors

Introduction

3.1 **Duty of Care**. Army Health and Safety management is based upon the principle of Duty of Care. Army Command Standing Order (ACSO) 1200, Army Safety and Environmental Management System, Ch 2 para 8, is clear in its direction and guidance:

> 'The Army has a legal and moral Duty of Care obligation for the health, safety and welfare of all its personnel and those who might be affected by its acts or omissions. This obligation is universal (applied to all activities), and responsibility is vested in every individual. However, more is expected of commanders who direct and supervise activity to manage the risks they create and/or are confronted by. This is done by understanding the risks, making a judgement on whether the risk (potential adverse outcome) is worth the potential benefit and putting controls in place to reduce the risks to as low as is reasonably possible. The Safe System of Work/Training (SSW/T) is a useful framework and will, in most cases, reduce risk to as low as is reasonably possible and ensure Duty of Care obligations are being met.' **(F1-T10)**

3.2 **Assessment of factors.**

a. **Framework**. The SST provides a suitable framework with which to assess the factors surrounding the incident. SST requires that training be conducted in a manner which meets the Army's Duty of Care in terms of Safe Person, Safe Equipment, Safe

Practice and Safe Environment[7].

b. **Causal chains**. An explanation of the probabilistic terminology used ('very likely' etc.) in addressing causal factors is at Annex A. If an issue was identified by the Panel as being at least 'very likely' on the balance of probability to have been part of a casual chain, it was deemed necessary by the Panel that a recommendation be made to mitigate it. Otherwise, the issue was noted as an 'observation'.

Safe person

3.3 **Definition**. JSP 375 defines 'safe person' as those who have been given the appropriate information, instruction, training, and supervision to enable them to carry out a specific activity as a competent person with the appropriate qualification, currency maturity and experience. The SET Driver and the OCdts are considered in this category; the MOs are discussed under 'safe practice' as part of the analysis of medical aspects of the incident.

The SET Driver

3.4 The driver had held a current and valid UK driving license [redacted] and was appropriately qualified to drive the vehicle. However, the driver had only qualified as a MAN SV driver in [redacted], and had never, before this incident, driven a MAN SV with passengers in the rear. The driver's 'experience' did not make him a Suitably Qualified and Experienced Person (SQEP). His lack of SQEP was not identified by RMAS. Other driver duties existed that did not involve transporting passengers. Had RMAS assessed his SQEP and realised his shortcomings, the driver could have driven kit and equipment rather than people; or been provided with coaching and on the job training to raise his level of experience. The Panel concludes that the driver should have been assessed and given a driving task more suited to his level of SQEP. **(F1-T12)**

3.5 **Causal factor**. The Driver pleaded guilty at Court Martial on 1 Mar 21 to 'failing to maintain proper control' of the MAN SV fitted with TCVES by 'driving at excessive speed and therefore in a manner unsuitable for this type of road.' The JA deemed this to be 'unprofessional, reckless behaviour.' **(F2-D32)** The arrival brief given by the CI also covered the specific conditions, the dangers, the rules and the approach that was to be taken. The driver's actions directly contravened this direction.

a. **Finding.** Driver action was the **causal factor** in his losing control of the vehicle, which resulted in the accident. His lack of experience in not driving to the conditions at an appropriate speed was a **contributory factor** to the accident.

b. **Recommendation 1**. RMAS SET drivers should be required to report to 44 Sqn 48 hours before the start of the SET duty, in order that they may be assessed to ensure that they are assigned tasks appropriate to their SQEP.

The OCdts

3.6 **Definition**. OCdts are 'trainees' as defined in Defence Direction and Guidance for Training and Education, JSP 822.[8]

[7] ACSO 1200: Army Safety and Environmental Management System.
[8] The term 'trainee' encompasses all those in receipt of training, for both individual and collective training, and encompasses such terms as...'Officer Cadet'

3.7 **Vehicle commander (veh comd) training**. Veh Comd training is conducted at ITT establishments. As a BT establishment, RMAS would not be expected to conduct such training.

3.8 **Supervision**. The Coy Comds and CSMs remained at FOB West to directly supervise those OCdts preparing for the final attack. Apart from those involved in relocating EXCON for the final attack, other PS had been stood down to attend an RMAS-sponsored hosting event. The Panel identified a general assumption within those RMAS NC PS who provided testimony that OCdts, at this stage of the course, were sufficiently trained to operate unsupervised[9]. This subjective view is contrary to SST policy and the definition above. RMAS NC has since changed its practice and OCdts, who **by policy are trainees**, will be supervised by PS throughout. **(F1-T10) (F1-T11) (F1-T16) (F1-T1) (F1-T2) (F1-T3) (F1-T11) (F1-P3)**

a. **Finding.** The decision to consider the OCdts as trained and competent was flawed. Combined with the practice of providing no PS supervision during this task, this is **almost certainly the major contributory factor** in this incident. Had a member of PS been in either vehicle, it is **extremely unlikely** that the driver would have driven in the manner that they did. **(F1-T1) (F1-T2) (F1- T6) (F1-T12)**

b. **Recommendation 2.** RMAS must ensure that the appropriate level of training is provided for all SPs, including OCdts, who are going to be employed as Vehicle Commander and Rear Passenger Supervisor; and, where appropriate, that PS supervision is provided.

c. **Recommendation 3.** RMAS must ensure that OCdts are supervised, in accordance with Safe System principles found in ACSO 1200. Furthermore, the safe and policy complaint delivery of Ex DV must henceforth be the priority over Defence Engagement and thanking the exercise's facilitators or Host Nation supporting staff.

d. **Observation 1**. 44 Sqn now trains all OCdts in relation to the duties of a Vehicle Commander and a Rear Passenger Supervisor, and in the correct use of all safety equipment on the MAN SV fitted with TCVES. **(F11-D19)**

Safe equipment

3.9 **Definition**. JSP 375 states that it is the unit Commander's responsibility to ensure that their subordinates have available, and make proper use of, the correct equipment to carry out an activity, and that only Competent Persons or those under training who are being provided with the appropriate supervision are allowed to operate and service the equipment.

3.10 **The vehicle itself**. The DAIB report found that:

'The vehicle and TCVES were recorded as Fully Fit on JAMES. The vehicle had been inspected (Mandatory Equipment Inspection) on 31 Jul 19 and had been monthly serviced on 28 Oct 19. All applicable modifications had been embodied, and there were no outstanding non-task worthy (NT) or Limited Role (LR) faults on the vehicle. Therefore, the serviceability of the vehicle was not considered to have been a factor in this accident. The TCVES is comprised of a 6 and 8 seat module, with the 6-seat

[9] It is important to distinguish between supervision during administrative periods and during training. For example, on the final attack a CSgt was placed with each platoon in a hypothetical 'MFC appointment' to ensure supervision. This was also the case on all transport moves to and from the final attack.

module installed closest to the front of the vehicle. Both the 6-seat module (ERM ESK000254) and the 8-seat module (ERM ESK001049) were fitted on 2 Oct 17 and had been inspected on 31 Jul 19. A monthly inspection of both modules was carried out on 28 Oct 19 and there were no NT or LR faults recorded.'

Finding. The vehicle **did** perform within the safety design and the serviceability of the vehicle **was not a factor** in this accident.

3.11 **First-aid medical equipment**. No first aid medical pack could be located in either vehicle. The OCdts were in 'belt order' so had no personal first aid kits. The absence of vehicle first aid packs appears to have been caused by the packs being withdrawn in preparation for the return journey back to the UK[10]. **(F1-T1) (F1-T2) (F1-T3)**

a. **Finding**. The absence of the medical first aid packs prior to the end of the exercise, for whatever reason, resulted in neither vehicle having a medical first aid pack. This was a serious safety breach. While it is **not possible to determine** the effect this had on the nature of the care provided by the OCdts prior to the arrival of MO1, it is **very likely** an **aggravating factor** in this incident.

b. **Recommendation 4.** RMAS must ensure that all necessary vehicle safety and first aid kit and equipment is available to all exercise participants, trainees and enabling staff, throughout the entire exercise.

c. **Observation 2.** It is now regulated practice by 44 Sqn to ensure that each vehicle crew comply with the relevant vehicle policies and use the vehicle complete to CES, including a medical first aid pack.

3.12 **Weapons stowage.** The TCVES has a weapon stowage clip system to allow personal weapons (PWs, defined as the SA80 rifle) to be safely secured. JSP 800 directs that PWs must be stored using the clips during transit. At the time of this incident, PWs were not being carried. However, OCdts admitted to a routine practice during the exercise of not using the weapon stowage clips and carrying PW across their bodies. OCdts also testified to an absence of compliance safety checks by PS. The Panel also found that not all weapon configurations can be stored in the safety clips (**see Section 3, TOR 5**). **(F1-T1) (F1-T2) (F1-T3)**

a. **Finding**. Had the OCdts been carrying their PWs, and if, as evidence suggests, they had not been correctly secured, it is **very likely** that injuries would have been sustained during a serious accident such as this violent three-quarter roll.

b. **Recommendation 5**. RMAS must ensure compliance with the safety direction in JSP 800, that PWs are always stowed correctly during transit using the safety clips.

3.13 **Seat belts/safety harnesses**. JSP 800 mandates the use of seat belts and rear safety harnesses when travelling in TCVES. OCdts testified that they routinely did not use seat belts or the safety harnesses for the TCVES. OCdts testified that no compliance checks were made by PS to ensure that passengers were wearing seat belts or TCVES safety harnesses. It is impossible to confirm this, although this was not the first journey they had had in the back of a MAN SV fitted with TCVES during their year at RMAS, nor on the

[10] The MAN SVs were to be driven back to RMAS on civilian roads and vehicle medical first aid packs would have been mandatory for such travel to be legally conducted. The only satisfactory explanation is that the medical packs were being accounted for centrally that morning, before being placed back in the vehicles. It is impossible, given the passage of time, to verify this.

exercise[11]. OCdts testified that immediately before the journey that led to this accident, they decided to wear the seat belts correctly. **(F1-T1) (F1-T2) (F1-T3)**

a. **Finding**. OCdts testified that PS were not conducting rear vehicle safety checks. Not doing so is contrary to SST and Duty of Care, but **it is not possible to determine** the frequency or extent to which PS may not have been enforcing these safety measures before the incident. Had the OCdts not been wearing seat belts, or not using the TCVES safety harness, it is **very likely** that more casualties and more severe injuries would have been incurred during this accident. **(F1-T1) (F1-T2) (F1-T3)**

b. **Recommendation 6**. RMAS must ensure that PS conduct routine and regular compliance safety checks to confirm that OCdts are operating safely and correctly when using the TCVES.

c. **Observation 3**. Training to use the TCVES safety features including the seatbelts has already been addressed; it is now being provided by 44 Sqn.

d. **Observation 4**. The Panel is obliged to make the above recommendation but is concerned by an apparent avoidance of personal responsibility for their own safety by OCdts. OCdts might reasonably be expected to know of and thus comply with both law and policy regarding the wearing of seatbelts and use of vehicle safety features.

3.14 **Foot placement**. JSP 800 states that TCVES passengers are not to place their feet on the vehicle side, but are to put them vertically down, under the seated position. **(F1-T3)**

Finding. The Panel found no evidence that OCdts were seated improperly.

3.15 **Communication within the vehicle**. The MAN SV was not designed with any built-in method of communication between the front cab and the rear passengers, such as a basic sliding hatch. The rear passengers of the lead convoy vehicle, who had witnessed the accident looking out of the rear of their vehicle, were thus unable to gain their driver or commander's attention until they stopped at a junction. This is **very likely** to have contributed to a delay in the front vehicle assisting the accident vehicle. **(F1-T2)**

a. **Recommendation 7**. RMAS should ensure that a method of communication is provided between the MAN SV cab and rear passengers. The solution must exclude mobile phones as a signal cannot be guaranteed.

b. **Observation 5**. RMAS NC SOPs now state that Personal Role Radios are to be issued for use when carrying rear passengers in MAN SV.

Safe practice

3.16 JSP 375 defines safe practice as the safe conduct of any activity, including those arising from the use of equipment, in a specific location, by competent persons.

Command and control

3.17 The OCdts, who were still trainees at the time, were dispatched on the task without

[11] The implication is that the OCdts either routinely and knowingly did not adhere to safety procedures; or that they had, indeed, not been briefed and were genuinely ignorant of them.

a communication plan or communication equipment. No PS accompanied them, presumably because they were unavailable as they were either returning from Munich or had been stood down. They therefore had no means of communicating to EXCON for guidance or in an emergency (and vice versa). Nor could they be recalled or re-tasked. The exercise had an overall Risk Assessment (RA) which included communications matters and the activity on the day of the incident was technically covered by that RA. However, there was no dynamic reassessment made at the time the OCdts were dispatched as to whether these generic arrangements were valid and extant given the specific circumstances of the task. The Panel's view is that they were not. The effect of the inadequate command and control arrangements for this tasking was that independent groups of RMAS vehicles were deployed on the training area on multiple tasks at multiple locations, with no PS present or supervising and with EXCON having no awareness of where they were, who had deployed, and when they might be expected back. Nor had either of the MOs been told that OCdts were active on the training area. The OCdts having had their phones taken off them at the start of the exercise, it was entirely fortuitous that one of the Drivers had a personal mobile phone with reception and was able to call 44 Sqn back in the UK, who then alerted the MT Sgt at EXCON of the RTC.

3.18 The OCdts were unable to communicate to EXCON and hence were uncontrolled and uncontrollable. This represents a **serious failure in command and control**. The task on which the OCdts were dispatched was thus unsafe and breached the SST[12]. **(F1-T1)**

a. **Finding**. The command and control failure by RMAS to consider a communication plan for the task, nor provide communications equipment, nor supervise using PS was cumulatively **almost certainly a contributory factor** to the delay in first responders arriving on the scene of the incident, some 65 minutes after it happened.

b. **Finding**. Medical professionals (MO1 and two CMTs) arrived at the accident scene 66 minutes after the RTC occurred. Whilst this is outside the 'Golden Hour', it is **not possible to determine** whether this delay in receiving professional medical attention was an **aggravating factor** to the OCdt's injuries.

c. **Finding**. Command decisions regarding the location, timing, conduct and attendance at the RMAS-sponsored hosting event meant that PS were unavailable for supervisory duty. Remaining PS had been stood down by the NC chain of command the night before and the morning of the task and were also unavailable. These decisions established the overall command and control culture at this point in Ex DV, which the Panel judges to be deficient. The absence of supervision has already been established as being a **contributory factor**.

d. **Finding**. The RSM directed the clearance task and was **more likely than not** the last person who could have averted the command and control failure; either by ensuring that the OCdts were accompanied by PS or that they had communications equipment of their own. **(F1-T1) (F1-T12) (F1-D37)**

e. **Recommendation 8**. RMAS must ensure that OCdts are accompanied on all tasks by PS with safety communications to EXCON.

[12] It may also have been contrary to US Range Orders for troops to have been on the training area without communications via EXCON.

f. **Observation 6**. The Panel believes that while the RSM **very likely** dispatched the OCdts on the task without supervision or communications, mitigation applies including:

(1) **Absence of PS**. PS were unavailable. They had been stood down by the NC chain of command the night before and the morning of the task. This appears to the Panel to have been established practice on Ex DV.

(2) **Normalisation of behaviour through precedent**. Conducting the range clearance task in this manner also appeared to be established practice from one Ex DV to the next. Hence any inherent lack of policy compliance, laxity or failure to do due diligence had effectively already been 'normalised' through precedent.

(3) **Collective responsibility**. The decisions leading up to the incident reflect general organisational omissions which led to a failing in duty of care.

Medical planning and execution

The MOs

3.19 The designated exercise MO, MO[redacted], was an Army Reservist drawn from SET. After MO[redacted] was assigned to fill the SET MO post it appears that MO[redacted] a Regular [redacted] prior to assuming his first independent Regimental Medical Officer (RMO) post, was made available, to deploy. MO[redacted] was not stood down, with the effect that two MOs deployed. MO[redacted] evidence suggests that he viewed himself and MO[redacted] as equals, with neither being in overall charge but instead both deferring to supervisors (MO[redacted] to his training lead, a [redacted]; MO[redacted] to the SMO [redacted] a [redacted] if they required advice. **(F1-T13)**

3.20 Both MOs were at similar stages of their careers. One can surmise that MO[redacted] who was a Regular, had more exposure to RMAS culture and knew the NC chain of command. Certainly, SMO [redacted] appears to have viewed MO[redacted] as being 'assisted' by MO[redacted]. Conversely MO[redacted] a Reservist, had significant military and operational experience and considered he and his colleague to be clinical equals. Both were able to seek advice from other, more experienced MOs, via planned 'reach-back' to the MOs at RMAS.

a. **Finding**. Neither MO[redacted] nor MO[redacted] was designated the medical lead for the exercise. Neither MO, nor their supervisors, nor Comd NC, appear to have viewed this as an issue or problem. The Panel considers it to be a failing that the Ex DV medical plan was not amended when it was known that there would be two MOs deploying, so that there was one single, agreed, medical lead. While it may **not be possible to determine** the extent to which this affected the provision of medical support to Ex DV19, it is considered **likely** to be a **contributory factor** to what may be seen to be the lack of ownership of the medical plan by the MOs. **(F1-T13)**

b. **Observation 7**. The Finding that neither MO[redacted] nor MO[redacted] was designated the Lead MO and that they therefore lacked ownership of the medical plan reinforces Recommendation 9.

Medical – planning

3.21 **Ex DV Medical Plan**. The Competent Medical Authority (CMA) ARITC drafted and

approved the Ex DV Medical Plan. The plan includes direction in instances in which SP require admission to a local German hospital. The Ex DV planning conference included the medical plan on its agenda. However, any medical-related discussions focused only on provision of emergency treatment and delivery of an injured party from the training area to hospital, as referenced in para 1.3.88 of the plan. Analysis, discussion or 'wargaming' of other complex medical contingencies did not occur either at the time of the coordination conference or later. **(F1-T11)** This critical omission was noted in two previous SIs, involving the recent deaths of a SSgt and a Guardsman, which made recommendations to prevent reoccurrence.

3.22 **MO involvement in medical planning and ownership of the medical plan.** An MO should have attended the Ex DV 19 Coordination Conference. However, MO[redacted] was sourced from SET, was nominated after the conference, and hence did not attend. MO[redacted] an [redacted] MO, had not at that stage been nominated so did not attend. Thus, neither deploying MO was involved in the exercise planning process or conference[13]. No other RMAS MO or the SMO attended. MO[redacted] testified that he was provided with a copy of the medical plan before deployment. **(F1-T11) (F1-T13)**

a. **Finding**. Medical planning was inadequate in that RMAS NC failed to fully plan for an event that might include hospitalisation; nor to plan for other potentially serious medical events; nor to focus on areas post-injury which might require subsequent attention. The medical plan was not tested against these eventualities. This is **very likely** an **aggravating factor** in the later breakdown in communications and lack of timely provision of welfare to the injured OCdt and family.

b. **Finding**. No other available RMAS-assigned MO took responsibility for the medical plan by attending the Ex DV Coordination Conference in that capacity. It is **very likely** that this was a **contributory factor** in the medical plan not being properly handed over to nor adequately understood by MO[redacted] or MO[redacted].[14]

c. **Finding**. MO[redacted] and MO[redacted] were 'familiar' with the medical plan in that they had read it and had tested elements of the plan during the exercise. However, neither fully engaged to take ownership of the plan. The absence of a designated 'Lead MO' compounded this. The Panel's view is that, since neither took the lead, **they shared responsibility** for fully understanding, engaging with and testing the medical plan. For example, neither MO nor any member of the NC chain of command appear to have been aware of the BFG HNS PSO nor of how to use them. Consequently, medical risk had not been reduced to as low as reasonably possible and this was **very likely** a **contributory factor** in the delay in determining a correct medical understanding of the OCdt's injuries. It was also **very likely** a **contributory factor** in the difficulty in determining an appropriate medical classification, which had later malign ramifications in terms of providing DILFOR for the OCdt's family. **(F1-T13) (F1-E12)**

d. **Recommendation 9**. RMAS NC must ensure that:

(1) The Ex DV coordination conference includes detailed discussion, testing and 'wargaming' of the medical plan.

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[13] The Panel were advised that in the absence of a nominated MO in the planning stages for Ex DV, the Medical Centre SNCO attended the planning conferences.

[14] The RMAS SMO and DSMO were responsible for drafting the Med Plan and gaining CMA approval. There were plenty of opportunities for MO[redacted] and MO[redacted] to be briefed on the Med Plan by those that drafted it.

(2) An MO attends the Ex DV coordination conference to advise on the medical plan. Where possible this should be the deploying MO. Where this is not possible, Comd NC must ensure that the deploying MO understands the medical plan and any adjustments made.

(3) If more than one MO is deployed that a designated lead MO is identified and formally appointed.

Medical – execution

3.23 **Faulty execution of the plan – unacceptable delay**. Professional medical responders arrived at the scene of the accident approximately 66 minutes after it happened. If the nature of the SP's injuries had been such that he had suffered internal or external bleeding, the unit might have been dealing with a death. As it was, the precise nature of the OCdt's injuries was not known until he reached hospital. The unacceptable delay has already been identified as a breach of the 'Golden Hour', but it is more than this. The goal should surely be for the medical first responders to arrive as quickly as practicable and to **deliver medical effect as soon as possible**. The Panel contend that execution of the medical plan failed under moderate stress.

3.24 **Effective transfer of the casualty from training area to hospital**. The 'blue light emergency' part of the medical plan worked. The OCdt was safely transported off the training area and to the local German hospital for treatment. **(F1-T13)** However, the Panel finds it concerning that no MO, CMT or RMAS PS accompanied the OCdt to hospital.

3.25 **Not engaging BFG HN PSO**. Neither MO appeared to have considered contacting the BFG HN PSO. Doing so would have overcome communication issues with German medical practitioners and health officials, enabling faster passage of correct information. It is possible that this assistance might also have prevented the first miscommunication with the family, by informing Comd NC as to the true state of the injury before he spoke to them. The Panel therefore concludes that aspects of the medical plan were not followed in full. Had the medical plan been consulted, an MO would have contacted the PSO who would have provided linguistic support with the hospital and been involved in liaising with RCDM. This would have helped improve several aspects of information-sharing, including a more precisely worded INCREP and better understanding by MOs, OCdt and family. Engaging with the BFG HN PSO would also have correctly identified the casualty category, namely Seriously Injured and not Unlisted. Being listed as Seriously Injured on the NOTICAS would have triggered an appropriate level of welfare support to the family, as detailed in the Dangerously Ill Forwarding of Relatives (DILFOR) policy. It would also have better informed RMAS (both deployed and at Sandhurst) as to the true severity of the OCdt's injury.

3.26 **Medical lead for the incident**. MO[redacted] attended the scene of the incident. MO[redacted] was engaged with another medical case and did engage with the hospitalised OCdt and with the AEROMED team, but the Panel assesses that MO[redacted] remained the lead MO throughout this incident. The Panel judges that it was therefore MO[redacted] responsibility to determine the correct medical category and to keep the chain of command informed as to the state of the SP's medical injury. MO[redacted] failure to correctly do so complicated the management of this case. **(F1-T13) (F1-P2)**

3.27 **Incorrect casualty classification**. The MO is responsible for selecting the casualty category to inform formal notification (NOTICAS) and reporting (INCREP). Completing and submitting both the NOTICAS and INCREP is the responsibility of the Adjt. The Adjt

incorrectly listing the OCdt as UL on MO[redacted] advice had negative consequences, such as impacting on the entitlement for DILFOR, which would not have occurred if MO[redacted] been better informed as to the true state of the injury. A relatively experienced MO, MO[redacted] attended the scene of the RTC, supervised the CMTs treating the injury and monitored the case himself; yet he was not able to determine that the injury warranted classification as SI. He used the term '[redacted] when discussing the case with the Adjt, yet either didn't know that this (on the balance of probability) placed the injury firmly in the SI bracket or, if unclear, was unable to or did not consult JSP 751 and correctly interpret its guidance[15]. The Panel finds this lapse concerning and it speaks to a serious training deficiency. **(F1-T10) (F1-T13) (F1-T14) (F1-P2)**

a. **Finding**. MO[redacted] did not follow the guidance in the medical plan to engage the PSO when a UK SP is admitted to a German civil hospital. This is **extremely likely** to have been a **contributory factor** to the suboptimal information-sharing and poor communication which is a consistent feature of medical aspects of this incident.

b. **Finding**. MO[redacted] advice to list the OCdt as UL, based on a lack of information regarding the true severity of the injury, is **extremely likely** to have been a **causal factor** in misinforming Comd NC ahead of his conversation with the family. This added to the family's distress when they later became aware of the true nature of the injury.

c. **Finding**. MO[redacted] advice to list the OCdt as UL, based on a lack of information regarding the true severity of the injury, is **extremely likely** to have been a **causal factor** in the incorrect NOTICAS listing. This also had the effect later of delaying the DILFOR welfare support to which the family was entitled.

d. **Finding**. MO[redacted] flawed advice on the medical category was made without a full understanding of the medical facts, which could have been gleaned via the PSO if he had been consulted. The error was compounded by MO[redacted] not then seeking guidance via 'reach-back' and instead choosing to provide what transpired to be bad advice to the Adjt. Notwithstanding the absence of accurate translated clinical advice from the German medical practitioners, MO[redacted] apparent unfamiliarity with Army medical processes is **extremely likely** to have been a **contributory factor** in him being unable to determine the appropriate medical classification for the OCdt from an examination of JSP 751 (see paras 2.50 and 2.51 above). The Panel have taken advice and find it compelling that, because his injury was such that the OCdt was subject to relatively major surgery under general anesthetic, a medical category of SI would have been appropriate. This should have been apparent to MO[redacted] (and to the Adjt) either at the time or at the very latest that evening following the OCdt's surgery, and the Panel are concerned that it was not.

e. **Recommendation 10**. RMAS must develop a mechanism to ensure that any MO assigned to an exercise overseas understands how and in what manner to comply with protocols for medical support from the host nation.

f. **Recommendation 11**. RMAS must develop a mechanism to ensure that, for all exercises, casualty classification procedures are understood by the Adjt, MO and any others who have agency in issuing NOTICAS and INCREP.

[15] The Panel notes that the information used to guide the med category decision was initially very scant and slowly trickled in over the next few days. However, the SP's med category could and should have been updated to SI as soon as the operative findings were known, or the day after, and certainly not until 5 days later at QEH.

g. **Recommendation 12**. Army HQ (Senior Health Advisor (Army)) (SHA (A)) is requested to provide reassurance to Hd APSG that there is a mechanism to ensure that any MOs tasked through the SET process are qualified and competent to advise on medical classifications.

3.28 **Defence Medical Service (DMS) direction on pre-surgery communication with RCDM**. After the OCdt's admission to QEH, DMS raised an Automated Significant Event Report (ASER) in response to the incident. ASER is a DMS system which facilitates a consistent, systematic approach to reporting serious incidents and near-misses that is evidence based, encouraging learning from both good practice and adverse events. DMS HQ Corporate Governance UK Strategic Command[16] reviewed the ASER. They alluded to a resulting change of process such that:

'The MED PLAN must indicate that no surgery on British Military personnel (is to occur) unless discussed with the RCDM consultant.'

a. **Finding**. There are strong arguments against the proposed change requiring consultation with RCDM before surgery overseas; time may be of the essence, and it may be contended that standards of emergency and surgical care are as high in German hospitals as in the NHS, if not higher. This issue is discussed further at Annex C.

b. **Observation 8**. SHA (A) may wish to clarify with DMS the policy implications of the DMS proposal that no surgery be performed on British Military personnel unless discussed with a RCDM consultant (save for life, limb or eyesight-saving surgery). Any resultant Recommendation should be developed by APSG Lessons Fusion Cell (LFC) in conjunction with SHA (A), outside the scope of this Inquiry.

Safe environment

3.29 **Definition**. JSP 375 notes that it is the correct application of the assessment of risk process that makes an environment or place safe.

3.30 **Training area risk**. The operating environment in GTA and HTA on EX DV was safe. The training area is well maintained and well managed by the US. Range roads are of similar or better quality that those on UK training areas and are safe for the designated speed. The lead vehicle in the convoy drove the route without issue. Once engaged, the medical facilities on the training area were accessed without issue as was the local hospital.

a. **Finding**. It is the Panel's opinion that the training area in which the activity was conducted was a safe place in which to operate and is **not a factor** in this incident. Driver actions and the absence of direct PS supervision were what rendered the environment unsafe.

b. **Observation 9**. The operating environment in which the incident was set was safe. The Driver pleaded Guilty at Court-Martial [redacted]. This admission of fault reinforces that it was the actions of an individual that placed the OCdts at risk. That risk **could have been mitigated by proper supervision at the appropriate level**.

[16] [redacted]

TOR 2 – Establish the adequacy and sufficiency of planning, preparation and supervisory support to Exercise DYNAMIC VICTORY

Suitability of SET

3.31 The Panel is satisfied that the SET process is, in principle, effective. A unit has a requirement, writes the specification, the need/priority is assessed, and personnel and resources are allocated to match. However, the Panel observes that MAN SV Drivers present a competency risk owing to the different types of cargo that a MAN SV may be required to be transport; kit and equipment versus people. In this incident the driver was qualified and current and therefore considered competent. In the Panel's opinion, the driver **could not** be considered experienced, however.

3.32 One option to improve the suitability of such 'fills' would be for RMAS to write a more stringent SET requirement. This would have the effect of narrowing the pool of 'fills'; hence it might be self-defeating in that no 'fill' might be available because the SQEP bar was set too high. It would also be contrary to SET policy, which requires the 'net' to be as wide as possible. To mitigate this issue of SET 'fill', RMAS have instituted a policy such that SET drivers attached to 44 Sqn are assessed for competency and assigned tasks appropriate to their level of experience when they arrive at RMAS prior to being tasked. This is discussed in TOR 1 and not considered further here.

Exercise planning and preparation

3.33 Ex DV repeats to a similar format three times per year. The exercise is run by the same team within a single RMAS college, which enhances continuity among the key staff who plan and deliver the exercise. The Panel received testimony that the complex organisation and taut establishment of RMAS meant that formal ownership of the exercise was never adequately confirmed, and this may have been a contributing factor to a number of the issues that arose. The primary weakness appears to be in ensuring any key participants from outside RMAS are brought into the planning process at an early opportunity. This is most likely to affect the MO when they are filled by SET and, as in this case, are unable to attend the confirmatory planning conference six weeks before deployment.

Supervision of OCdts

3.34 RMAS is a BT establishment. Trainees, in this case OCdts, are not considered trained until they complete the CC. The Panel found that NC had adopted an unwritten cultural practice of allowing OCdts to operate without supervision. This was justified on the basis that the OCdts were near to commissioning and should, at that stage of their career, be capable of performing without supervision.[17] **(F1-T10) (F1-T11) (F1-T12) (F1-T13) (F1-T16)**

3.35 The Panel heard testimony to the effect that not allowing OCdts freedom and responsibility without PS supervision would risk delivering a sub-standard product to the Army. There is a view that the simple classification of RMAS as a BT establishment does not allow for the complexities and fundamental differences between the models of initial soldier and officer training in the British Army, and the responsibilities that the trainees must

[17] For balance and clarity, OCdts **were** supervised by Safety Staff during Ex DV when required. However, supervision was reduced or removed during the 'white space' in between training activities, when OCdts were expected to operate and administer without PS direction.

adopt on completion of their course. However, no policy reflecting any bespoke RMAS perspective could be provided which might show whether an OCdt could be considered as 'trained' at some point other than on completion of the CC. HQ RMAS G1 confirms that OCdts are **not** considered 'trained' until at the point of commissioning, at the end of the Sovereign's Parade.

a. **Finding**. The action towards the end of Ex DV to stand down supervisory PS for the better part of a day, including overnight 18/19 Nov 22, on the basis that OCdts are considered trained and can complete administrative tasks such as range clearances without supervision, was a command decision. Removing this supervision was not based on policy. It **almost certainly** contributed to what the Panel considers to be a command and control failure which had malign effects. This is discussed at para 3.18 above. In the absence of any policy that articulates some other point at which an OCdt may be considered 'trained', RMAS NC should ensure that PS supervision is maintained throughout Ex DV (and other exercises).

b. **Observation 10**. RMAS NC has already ceased the practice of allowing OCdts to operate unsupervised. They are now supervised throughout Ex DV and all other exercises.

TOR 3 – Establish and assess RMAS understanding and compliance with relevant policy

WIS procedures

3.36 Management and recording of WIS by RMAS was compliant with policy but could have been better executed.

3.37 The OCdt was transferred to the QEH from BZN on the evening of Sat 24 Nov 19 in an ambulance with accompanying medical staff. Nobody from RMAS went with him. The NoK and family received no DILFOR or official support as the OCdt was at that time still classed UL. The family eventually arrived at the QEH unassisted by RMAS. The family received no communication from RMAS for some days[18].

a. **Finding**. Although WIS was technically conducted in accordance with policy overall, it is the Panel's opinion that opportunities were **almost certainly** missed to communicate with the family, especially in the period immediately after returning from Germany. This contributed to the family's feeling of abandonment, as detailed in their statement, as well as their anger on behalf of their son at the incident itself.

b. **Recommendation 13**. In the event of a Serious Injury or Very Serious Injury, or where the circumstances are emotive or may involve adverse public or media interest, RMAS should ensure that any injured/hospitalised OCdt is accompanied by an appropriate member of RMAS PS who is empowered to arrange for the smooth arrival and support of the family.

Welfare

3.38 With a garrison strength of around 3,000, RMAS has a significant welfare dependency. Testimony generally agreed that the welfare function was under-resourced. **(F1-T7) (F1-T8) (F1-T9)**

3.39 The Welfare Officer cited an unfortunate dysfunctional relationship between Welfare and NC, and that they felt excluded from meetings. Coordination of visits and welfare for the OCdt appeared to fall to the Pl Comd, supported by the Coy Comd and Padre, who collectively assumed the unofficial position of family liaison. **(F1-T6) (F1-T7) (F1-T9)**

3.40 At the time of the incident the welfare capability was the responsibility of one individual, the Welfare Officer. Rectifying this was given a high priority and there has been an uplift in personnel responsible for Welfare since the incident. Comd NC's Job Description (JD) did not contain Welfare in the responsibilities. As part of a series of reforms Welfare was subsequently added to the College Comd JDs in May 20.

a. **Finding**. The provision of Welfare WO2s at College level, and other enhancements (Annex B) should **very likely** provide for better command and control and awareness of welfare matters, rather than the UWO having to deal straight to Coy and Pl Comds with limited support and oversight. **(F1-T7) (F1-T10)**

[18] In RMAS' defence we should note this as a consequence of the incorrect medical listing. As far as the RMAS chain of command were concerned the OCdt was UL, and consequently would require a relatively low level of support.

b. **Recommendation 14**. RMAS should ensure that the planned changes to Welfare organisation (Annex B) have been fully implemented.

Trauma management

3.41 Army TRiM policy is detailed in Land Forces Standing Order (LFSO 3217). This is focused on operations rather than training and the policy requires refreshing, but it does provide coherent and effective guidance on post-trauma management. On the evening of the day of the RTC all personnel who were involved in it were given TRiM as a group by practitioners from within the unit. This does not comply with the policy in LFSO 3217 which states that:

> 'The period immediately after an incident, particularly when there are casualties, is often difficult. Whilst it is important to provide support to those involved, TRiM risk assessments must not be conducted until 72 hours after the incident. This allows time for those involved to make some sense of what took place.'

3.42 Whilst it is commendable that support was provided so soon after the RTC, RMAS should also have complied with the 72-hr TRiM rule. This was identified by RMAS in their Learning Account.

3.43 RMAS NC's TRiM administration and execution was flawed in other ways. No records of planning or decisions were made available to the Panel. Policy deviations were noted:

a. RMAS used non-Army TRiM documentation. **(F1-D21) (F1-D22)**

b. The TRiM Coordinator listed is a Chaplain who was not on the exercise nor in Germany at the time.

c. The TRiM documents were not signed.

d. No month-one follow-up was made. The Panel is unclear how month-three follow on-reports were populated, when month-one reports were not completed.

e. The TRiM records were entered onto JPA, but the OCdts' subsequent ITT units were not notified, for further action if necessary after they left RMAS.

3.44 The evidence strongly suggests that NC paid scant regard to the TRiM process, viewing it as a 'box-ticking' exercise.

a. **Finding**. The Panel considers it **extremely likely** that elements of the TRiM process were truncated, or not completed.

b. **Recommendation 15**. RMAS must comply with TRiM Policy as mandated in LFSO 3217.

Incident reporting

3.45 Reporting of accidents is covered by AGAI Vol 2 Chapter 62. The RMP became aware of the incident on Wed 22 Jan 20, over two months after the incident, after ARITC queried RMAS as to why the RMP had not been contacted.

3.46 Direction in AGAI 62 as to when a CO must report driving incidents to the RMP is ambiguous and open to interpretation. In this instance the vehicle was recovered; the OCdts, less those sent for medical treatment, re-commenced preparations to continue for the final attack of the Ex; and RMAS NC viewed the incident as relatively minor. On reflection, when giving testimony, the NC Chain of Command accepted that it was in fact a major incident but that it was not viewed as such at the time. The RTC location was not treated as a crime scene and not reported to the RMP. Given that the incident was immediately investigated by a DAIB Team, the Panel finds this surprising.

a. **Finding**. It is the Panel's opinion that the incident was not treated as serious, and it is **extremely likely** that this, combined with a lack of clarity in the AGAI 62 policy, is why it was not reported to the RMP. **(F1-T6) (F1-T9) (F1-10) (F1-T11)**

b. **Recommendation 16**. SO1 Discipline APSG, in conjunction with Pers Pol and Provost Marshall (Army) (PM(A)), should consider whether AGAI 62 should be updated to provide specific direction to notify the RMP in the event of all RTCs.

c. **Finding**. RMAS 'Book 14'[19] directs RMAS staff on reporting/referral following an incident and contains many pathways and signposts. However, no reference to reporting to the RMP is made in the instance of RTCs. It is **extremely likely** that if more precise guidance were also included in this manual, the incident would have been promptly reported to RMP. **(F1-T10) (F1-T11)**

d. **Recommendation 17**. RMAS should update 'Book 14' to include clear direction on when and in what circumstances the RMP must be advised.

e. **Observation 11**. The failure by RMAS NC to report the accident to the RMP at the time of the incident, and the failure to treat it as a serious incident, was a **contributory factor** leading to a chain of [redacted]. OCdt [redacted] was a victim of crime and had acted commendably in the post incident aftermath but was placed in a vulnerable position by RMP's initial (incorrect) decision to consider them culpable.

[19] An internal RMAS Instruction providing direction on Incident reporting.

TOR 4 – Ascertain the value of loss/damage because of the incident

3.47 **Finding**. The cost of repairing the damage to the MAN SV in question is £77,503.36. The replacement vehicle cost when fitted with TCVES is approximately £242,000. The TCVES system cannot be re-used as it is classed as 'compromised' following the accident. **(F1-E36)**

3.48 There is also a non-financial opportunity cost to the SET donor unit, who lost the use of this vehicle until it was replaced.

TOR 5 – Consider any other matters relevant to the SI

3.49 **MAN SV Safety Note**. The Panel is aware of a **Safety Note** related to the use of MAN SV fitted with TCVES that was issued after the incident. It includes direction on the following:

a. Minimum and maximum height restrictions,

b. Maximum driving time that the vehicle can be driven,

c. That white fleet should be considered for journeys that exceed the maximum driving time permitted, and

d. That the rear two seats of TCVES are now **not to be used**.

Observation 12. The OCdt who was Seriously Injured was occupying one of the rearmost TCVES seats which are now designated not be used.

3.50 **Inability to stow all weapon configurations**. Following testimony by OCdts that weapons could not always stowed securely in the safety clips designed on the TCVES, the Panel made further investigation. This revealed that the design of the safety clips does not keep up with weapon developments and enhancements. A **Safety Note** was drafted by the SI President on behalf of APSG in Jun 20 to address this. **(F1-E66)**

a. **Finding.** Not all PWs in all configurations are capable of being stowed in the weapon clips. **(F1-T1) (F1-T2) (F1-T3)** This issue is **not a factor** in this inquiry.

b. **Recommendation 18**. Army Safety Centre is requested to review/promulgate the APSG/DAIB MAN SV TCVES Weapon Stowage Safety Clip Failure Safety Note.

SECTION 4: CONCLUSIONS

FINDINGS, RECOMMENDATIONS AND OBSERVATIONS

Findings

Para 3.5. Driver action was the **causal factor** in his losing control of the vehicle, which resulted in the accident. His lack of experience in not driving to the conditions at an appropriate speed was a **contributory factor** to the accident.

Para 3.8. The decision to consider the OCdts as trained and competent was flawed. Combined with the practice of providing no PS supervision during this task, this is **almost certainly the major contributory factor** in this incident. Had a member of PS been in either vehicle, it is **extremely unlikely** that the driver would have driven in the manner that they did.

Para 3.10. The vehicle **did** perform within the safety design and the serviceability of the vehicle **was not a factor** in this accident.

Para 3.11. The absence of the medical first aid packs prior to the end of the exercise, for whatever reason, resulted in neither vehicle having a medical first aid pack. This was a serious safety breach. While it is **not possible to determine** the effect this had on the nature of the care provided by the OCdts prior to the arrival of MO[redacted], it is **very likely** an **aggravating factor** in this incident.

Para 3.12. Had the OCdts been carrying their PWs, and if, as evidence suggests, they had not been correctly secured, it is **very likely** that injuries would have been sustained during a serious accident such as this violent three-quarter roll.

Para 3.13. OCdts testified that PS were not conducting rear vehicle safety checks. Not doing so is contrary to SST and Duty of Care, but **it is not possible to determine** the frequency or extent to which PS may not have been enforcing these safety measures before the incident. Had the OCdts not been wearing seat belts, or not using the TCVES safety harness, it is **very likely** that more casualties and more severe injuries would have been incurred during this accident.

Para 3.14. The Panel found **no evidence** that OCdts were seated improperly.

Para 3.18. **The task on which the OCdts were dispatched breached the SST**.

a. The command and control failure by RMAS to consider a communication plan for the task, nor provide communications equipment, nor supervise using PS was cumulatively **almost certainly a contributory factor** to the delay in first responders arriving on the scene of the incident, some 65 minutes after it happened.

b. Medical professionals (MO[redacted] and two CMTs) arrived at the accident scene 66 minutes after the RTC occurred. Whilst this is outside the 'Golden Hour', it is **not possible to determine** whether this delay in receiving professional medical attention was an **aggravating factor** to the OCdt's injuries.

c. Command decisions regarding the location, timing, conduct and attendance at the RMAS-sponsored hosting event meant that PS were unavailable for supervisory duty. Remaining PS had been stood down by the NC chain of command the night before and the morning of the task and were also unavailable. These decisions established the overall command and control culture at this point in Ex DV, which the Panel judges to be deficient. The absence of supervision has already been established as being a **contributory factor**.

d. The RSM directed the clearance task and was **more likely than not** the last person who could have averted the command and control failure; either by ensuring

that the OCdts were accompanied by PS or that they had communications equipment of their own.

Para 3.20. Medical lead for the exercise. Neither MO[redacted] nor MO[redacted] was designated the medical lead for the exercise. Neither MO, nor their supervisors, nor Comd NC, appear to have viewed this as an issue or problem. The Panel considers it to be a failing that the Ex DV medical plan was not amended when it was known that there would be two MOs deploying, so that there was one single, agreed, medical lead. While it may **not be possible to determine** the extent to which this affected the provision of medical support to Ex DV19, it is considered **likely** to be a **contributory factor** to what may be seen to be the lack of ownership of the medical plan by the MOs.

Para 3.22. MO involvement in medical planning and ownership of the medical plan.

a. Medical planning was inadequate in that RMAS NC failed to fully plan for an event that might include hospitalisation; nor to plan for other potentially serious medical events; nor to focus on areas post-injury which might require subsequent attention. The medical plan was not tested against these eventualities. This is **very likely** an **aggravating factor** in the later breakdown in communications and lack of timely provision of welfare to the injured OCdt and family.

b. No other available RMAS-assigned MO took responsibility for the medical plan by attending the Ex DV Coordination Conference in that capacity. It is **very likely** that this was a **contributory factor** in the medical plan not being properly handed over to nor adequately understood by MO[redacted] or MO[redacted] The RMAS SMO and DSMO were responsible for drafting the Med Plan and gaining CMA approval. There were plenty of opportunities for MO[redacted] and MO[redacted] to be briefed on the Med Plan by those who drafted it.

c. MO[redacted] and MO[redacted] were 'familiar' with the medical plan in that they had read it and had tested elements of the plan during the exercise. However, neither fully engaged to take ownership of the plan. The absence of a designated 'Lead MO' compounded this. The Panel's view is that, since neither took the lead, **they shared responsibility** for fully understanding, engaging with and testing the medical plan. For example, neither MO nor any member of the NC chain of command appear to have been aware of the BFG HNS PSO nor of how to use them. Consequently, medical risk had not been reduced to as low as reasonably possible and this was **very likely** a **contributory factor** in the delay in determining a correct medical understanding of the OCdt's injuries. It was also **very likely** a **contributory factor** in the difficulty in determining an appropriate medical classification, which had later malign ramifications in terms of providing DILFOR for the OCdt's family.

Para 3.27. Incorrect casualty classification.

a. MO[redacted] did not follow the guidance in the medical plan to engage the PSO when a UK SP is admitted to a German civil hospital. This is **extremely likely** to have been a **contributory factor** to the suboptimal information-sharing and poor communication which is a consistent feature of medical aspects of this incident.

b. MO[redacted]'s advice to list the OCdt as UL, based on a lack of information regarding the true severity of the injury, is **extremely likely** to have been a **causal factor** in misinforming Comd NC ahead of his conversation with the family. This added to the family's distress when they later became aware of the true nature of the injury.

c. MO[redacted] advice to list the OCdt as UL, based on a lack of information regarding the true severity of the injury, is **extremely likely** to have been a **causal factor** in the incorrect NOTICAS listing. This also had the effect later of delaying the DILFOR welfare support to which the family was entitled.

d. MO[redacted] flawed advice on the medical category was made without a full understanding of the medical facts, which could have been gleaned via the BFG HNS PSO if he had been consulted. The error was compounded by MO[redacted] not then seeking guidance via 'reach-back' and instead choosing to provide what transpired to be bad advice to the Adjt. Notwithstanding the absence of accurate translated clinical advice from the German medical practitioners, MO1's apparent unfamiliarity with Army medical processes is **extremely likely** to have been a **contributory factor** in him being unable to determine the appropriate medical classification for the OCdt from an examination of JSP 751 (see paras 2.50 and 2.51 above). The Panel have taken advice and find it compelling that, because his injury was such that the OCdt was subject to relatively major surgery under general anesthetic, a medical category of SI would have been appropriate. This should have been apparent to MO[redacted] (and to the Adjt) either at the time or at the very latest that evening following the OCdt's surgery, and the Panel are concerned that it was not.

Para 3.28. DMS direction on pre-surgery communication with RCDM. There are strong arguments against the proposed change requiring consultation with RCDM before surgery overseas; time may be of the essence, and it may be contended that standards of emergency and surgical care are as high in German hospitals as in the NHS, if not higher. This issue is discussed further at Annex C.

Para 3.30. It is the Panel's opinion that the training area in which the activity was conducted was a safe place in which to operate and is **not a factor** in this incident. Driver actions and the absence of direct PS supervision were what rendered the environment unsafe.

Para 3.35. The action towards the end of Ex DV to stand down supervisory PS for the better part of a day, including overnight 18/19 Nov 22, on the basis that OCdts are considered trained and can complete administrative tasks such as range clearances without supervision, was a command decision. Removing this duty of care supervision was not based on policy. It **almost certainly** contributed to what the Panel considers to be a command and control failure which had malign effects. This is discussed at para 3.18 above. In the absence of any policy that articulates some other point at which an OCdt may be considered 'trained', RMAS NC should ensure that PS supervision is maintained throughout Ex DV (and other exercises).

Para 3.37. Although WIS was technically conducted in accordance with policy overall, it is the Panel's opinion that opportunities were **almost certainly** missed to communicate with the family, especially in the period immediately after returning from Germany. This contributed to the family's feeling of abandonment, as detailed in their statement, as well as their anger on behalf of their son at the incident itself.

Para 3.40. The provision of Welfare WO2s at College level, and other enhancements (Annex B) should **very likely** provide for better command and control and awareness of welfare matters, rather than the UWO having to deal straight to Coy and Pl Comds with limited support and oversight.

Para 3.44. The Panel considers it **extremely likely** that elements of the TRiM process were truncated, or not completed.

Para 3.46. Incident reporting.

a. It is the Panel's opinion that the incident was not treated as serious, and it is **extremely likely** that this, combined with a lack of clarity in the AGAI 62 policy, is why it was not reported to the RMP.

b. RMAS 'Book 14'[20] directs RMAS staff on reporting/referral following an incident and contains many pathways and signposts. However, no reference to reporting to the RMP is made in the instance of RTCs. It is **extremely likely** that if more precise guidance were also included in this manual, the incident would have been promptly reported to RMP.

Para 3.47. The cost of repairing the damage to the MAN SV in question is £77,503.36. The replacement vehicle cost when fitted with TCVES is approximately £242,000. The TCVES system cannot be re-used as it is classed as 'compromised' following the accident.

Para 3.50. Not all PWs in all configurations are capable of being stowed in the weapon clips. This issue is **not a factor** in this inquiry.

[20] An internal RMAS Instruction providing direction on Incident reporting.

Recommendations. Of the 18 recommendations arising from this Inquiry, 16 have been **actioned** and **closed** on DLIMS by APSG Lessons Fusion Cell. 2 remain open and will be closed by 30 Jun 2023.

Recm and para	Content	SPA[21]	Completion
	Command and control		
3 Para 3.8	RMAS must ensure that OCdts are supervised, in accordance with Safe System principles found in ACSO 1200. Furthermore, the safe and policy complaint delivery of Ex DV must henceforth be the priority over Defence Engagement and thanking the exercise's facilitators or Host Nation supporting staff.	COS RMAS	Completed and closed
7 Para 3.15	RMAS must ensure that a method of communication is provided between the MAN TCVES cab and rear passengers. The solution must exclude mobile phones as a signal cannot be guaranteed.	COS RMAS	Completed and closed
8 Para 3.18	RMAS must ensure that OCdts are accompanied on all tasks by PS with safety communications to EXCON.	COS RMAS	Completed and closed
16 Para 3.46	SO1 Discipline APSG, in conjunction with PM(A), should consider whether AGAI 62 should be updated to provide specific direction to notify the RMP in the event of all Road Traffic Accidents or Road Traffic Incidents.	DACOS Pers Svcs APSG	Category 2 Recommendation, requires follow-up
17 Para 3.46	RMAS should update Book 14 to include clear direction on when and in what circumstances the RMP must be advised.	COS RMAS	Completed and closed
	Safety		
1 Para 3.5	RMAS SET drivers should be required to report to 44 Sqn 48 hours before the start of the SET duty, in order that they may be assessed to ensure that they are assigned tasks appropriate to their SQEP.	COS RMAS	Completed and closed
2 Para 3.8	RMAS should ensure that the appropriate level of training is provided for all SPs, including OCdts, who are going to be employed as Vehicle Commander and Rear Passenger Supervisor; and, where appropriate, that PS supervision is provided.	COS RMAS	Completed and closed
4 Para 3.11	RMAS must ensure that all necessary vehicle safety and first aid kit and equipment is available to all exercise participants, trainees and enabling staff, throughout the entire exercise.	COS RMAS	Completed and closed
5 Para 3.12	RMAS must ensure compliance with the safety direction in JSP 800, that PWs are always stowed correctly during transit using the safety clips.	COS RMAS	Completed and closed

[21] ACSO 1118 Senior Point of Authority (SPA). The SPA is the individual (minimum Band B/OF5 grade/rank) held accountable for implementing the required action.

Recm and para	Content	SPA[21]	Completion
6 Para 3.13	RMAS must ensure that PS conduct routine and regular compliance safety checks to confirm that OCdts are operating safely and correctly when using the MAN TCVES.	COS RMAS	Completed and closed
18 Para 3.50	Army Safety Centre is requested to review and promulgate the APSG/ DAIB MAN SV TCVES Weapon Stowage Safety Clip Failure Safety Note.	AH ASCen	Completed and closed
	Medical		
9 Para 3.22	Comd NC must ensure that: (1) The Ex DV coordination conference includes detailed discussion, testing and 'wargaming' of the medical plan. (2) An MO attends the Ex DV coordination conference to advise on the medical plan. Where possible this should be the deploying MO. Where this is not possible, Comd NC must ensure that the deploying MO understands the medical plan and any adjustments made. (3) If more than one MO is deployed that a designated lead MO is identified and formally appointed.	COS RMAS	Completed and closed
10 Para 3.27	RMAS must develop a mechanism to ensure that any MO assigned to an exercise overseas understands how and in what manner to comply with protocols for medical support from the host nation.	COS RMAS	Completed and closed
11 Para 3.27	RMAS must develop a mechanism to ensure that, for all exercises, casualty classification procedures are understood by the Adjt, MO and any others who have agency in issuing NOTICAS and INCREP.	COS RMAS	Completed and closed
12 Para 3.27	Army HQ Pers Army is requested to provide reassurance to Hd APSG that there is a mechanism to ensure that any MOs tasked through the SET process are qualified and competent to advise on medical classifications.	SHA (A)	Category 2 Recommendation, requires follow-up
	Personnel management		
13 Para 3.37	In the event of a Serious Injury or Very Serious Injury, or where the circumstances are emotive or may involve adverse public or media interest, RMAS should ensure that any injured/hospitalised OCdt is accompanied by an appropriate member of RMAS PS who is empowered to arrange for the smooth arrival and support of the family.	COS RMAS	Completed and closed
14 Para 3.40	RMAS should ensure that the planned changes to welfare organisation, as detailed in Annex B, have been fully implemented.	COS RMAS	Completed and closed
15 Para 3.44	RMAS must comply with TRiM Policy as mandated in LFSO 3217.	COS RMAS	Completed and closed

Observations. The Panel made the following 12 observations.

Para	Observation
3.8d	**Observation 1**. 44 Sqn now trains all OCdts in relation to the duties of a Vehicle Commander and a Rear Passenger Supervisor, and in the correct use of all safety equipment on the MAN SV fitted with TCVES.
3.11c	**Observation 2**. It is now regulated practice by 44 Sqn to ensure that each vehicle crew comply with the relevant vehicle policies and use the vehicle complete to CES, including a medical first aid pack.
3.13c	**Observation 3**. Training to use the TCVES safety features including the seatbelts has already been addressed; it is now being provided by 44 Sqn.
3.13d	**Observation 4**. The Panel is … concerned by an apparent avoidance of personal responsibility for their own safety by OCdts. OCdts might reasonably be expected to know of and thus comply with both law and policy regarding the wearing of seatbelts and use of vehicle safety features.
3.15b	**Observation 5**. Following the incident RMAS NC SOPs now state that Personal Role Radios are to be issued for use when carrying rear passengers in MAN SV.
3.18f	**Observation 6**. The Panel believes that while the RSM **very likely** dispatched the OCdts on the task without supervision or communications, mitigation applies including: (1) **Absence of PS**. PS were unavailable. They had been stood down by the NC chain of command the night before and the morning of the task. This appears to the Panel to have been established practice on Ex DV. (2) **Normalisation of bad behaviour through precedent**. Conducting the range clearance task in this manner also appeared to be established practice from one Ex DV to the next. Hence any inherent lack of policy compliance, laxity or failure to do due diligence had effectively already been 'normalised' through precedent. (3) **Collective responsibility**. The decisions leading up to the incident reflect general organisational omissions which led to a failing in duty of care.
3.20b	**Observation 7**. The Finding that neither MO[redacted] nor MO[redacted] was designated the Lead MO and that they therefore lacked ownership of the medical plan reinforces Recommendation 9.
3.28b	**Observation 8**. SHA (A) may wish to clarify with DMS the policy implications of the DMS proposal that no surgery be performed on British Military personnel unless discussed with a RCDM consultant (save for life, limb or eyesight-saving surgery). Any resultant Recommendation should be developed by APSG Lessons Fusion Cell (LFC) in conjunction with SHA (A), outside the scope of this Inquiry.

Para	Observation
3.30	**Observation 9**. The operating environment in which the incident was set was safe. The Driver pleaded Guilty at Court-Martial [redacted] This admission of fault reinforces that it was the actions of an individual that placed the OCdts at risk. That risk **could have been mitigated by proper supervision at the appropriate level**.
3.35b	**Observation 10**. RMAS NC has already ceased the practice of allowing OCdts to operate unsupervised. They are now supervised throughout Ex DV and all other exercises.
3.46e	**Observation 11**. The failure by RMAS NC to report the accident to the RMP at the time of the incident, and the failure to treat it as a serious incident, was a **contributory factor** leading to a chain of events that further damaged the mental health and well-being of OCdt [redacted]. OCdt [redacted] was a victim of crime and had acted commendably in the post incident aftermath but was placed in a vulnerable position by RMP's initial (incorrect) decision to consider them culpable.
3.49	**Observation 12**. The OCdt who was Seriously Injured was occupying one of the rearmost TCVES seats which are now designated not be used.

SECTION 5: CONVENING AUTHORITY COMMENTS

5.1 As the Convening Authority (CA) for this SI, I am grateful to the Panel for the thoroughness of the Report in meeting their Terms of Reference.

5.2 I have reviewed fully the SI Report APSG/SI/2019/RMAS/MANSV. I am content with the outcome of the findings along with the recommendations made in relation to TORs at Annex A to the Convening Order dated 8 June 2020.

Timeline

5.3 The SI was directed and formally convened by GOC ARITC on 8 Jun 20. The SI Report was provided to me for CA comment on 27 Mar 23, comment added, and the Report submitted to APSG for Review on 31 Mar 23. It should be noted that the conduct of this SI Report was adversely affected by the impact of COVID lockdowns, restrictions on assembling witnesses and taking evidence, as well as personnel turbulence. This SI was further delayed as progress had to be stayed during the police investigation and subsequent Court Martial of the Driver, recommencing in Apr 21.

Conduct of the Panel

5.4 I find that the SI has been conducted properly and that the Panel has complied with The Armed Forces (Service Inquiries) Regulations 2008, as well as ACSO 3027 policy on the conduct of SIs. The President and the panel have investigated the workings of the RMAS systems and processes that were in place both prior to and post incident. The panel have also reported on the subsequent changes made by RMAS and other relevant stakeholders because of their findings. Having considered the contents of the report I find that the SI has met its TOR.

Findings of the Inquiry

5.5 The SI had 5 broad TORs. Having considered the Provisional Report, I believe the accident, post-incident reporting and case management, and application of supervisory/duty of care provisions (including adherence to policy) have been fully investigated, and that no further inquiries are required.

5.6 The findings of the inquiry identify failures of RMAS as an employer to correctly take reasonable care of their own and other people's safety. More specifically there were failures in RMAS' ability to meet the requirements defined within Joint Service Policy to deliver against the SST, Supervisory Care, and Casualty and Compassionate policy and procedures. There were also significant failings in the execution of the medical plan, some of which appears to reflect on individuals.

5.7 The main contributing factor to the accident itself was the driver's inappropriate speed; consideration ought to have been provided as to the driver's overall level of experience prior to deployment on the exercise. The driver has had appropriate action taken against them through the Service Justice system. However, I agree with the SI panel that the most significant aggravating factor leading to this incident was the assumption by the PS that OCdts at that stage of training were sufficiently trained to be trusted to operate unsupervised; especially as they had not been provided with the right level of training and equipment to support the delivery of the task. Whilst it is understood that the OCdts were close to the end of the commissioning course and soon to commission into the Regular Army, this did not absolve the staff of their responsibility to continue to provide an

appropriate level of supervisory care within the training environment. Had the OCdt fulfilling the role of PI Sgt not taken the decision to direct that all OCdts must wear the fitted TCVES safety harness on the final leg of the journey the outcome could have been much worse. I commend the actions of the uninjured OCdts in the immediate aftermath of the incident, in particular those of OCdt [redacted], the PI Comd.

5.8 A failure to ensure that either of the MOs who deployed in support of the exercise were involved in any of the exercise planning or final planning conference led to a lack of familiarity with the medical plan and the direction therein. This led to a critical aspect of the medical plan not being followed, the lack of engagement with the BFG HN PSO in the event of a casualty being admitted to a German hospital. This omission, coupled with a lack of understanding of casualty categories subsequently led to the denial of the appropriate initial level of welfare support being provided to OCdt [redacted] family and a misunderstanding as to the overall severity of the injury that had been sustained. The dysfunctional acceptance of ownership and responsibility for the delivery of welfare support within RMAS only served to further compound matters during the SP's movement to the QEH and post incident case-management. This left OCdt [redacted] family without any direct support or official communication, and with a sense of helplessness and a feeling of abandonment.

Potentially Affected Persons (PAP)

5.9 The Service Inquiry panel afforded Regulation 18 status to five individuals. I am satisfied that this was appropriate and that these individuals were treated in accordance with the requirements of Joint Service Publication 832.

Recommendations of the Inquiry

5.10 The Panel has made 18 recommendations, across all aspects of the SI and based upon comprehensive analysis of the findings and requiring implementation by either RMAS (15), Pers pol Svcs (one), SHA (A) (one) and Army Futures (one). I consider all of them to be appropriate and commend them to APSG. No additional recommendations are required. The recommendations focus on:

a. Ensuring adherence to and understanding of the policies surrounding the supervision of trainees in accordance with the SST principles. This includes the provision of a robust communication plan and risk assessments to support all training activity and serials.

b. That medical staff responsible for supporting the delivery of training activity, prior to and during deployment on exercises, are fully involved in the medical planning process.

c. That appropriate training and regular supervision on safety compliance is provided to all SPs, including OCdts, to confirm that they are operating safely and correctly when transiting on the MAN TCVES and any other vehicles in which they may be travelling.

d. Ensuring adherence to and understanding of the policies surrounding post incident and welfare management, specifically incident reporting, casualty categorisation, handling and reporting of wounded, injured and sick service personnel, the TRiM process, and any other welfare and duty of care associated responsibilities.

5.11 I am satisfied that once all the actions contained within the 18 recommendations have been enacted, the risk of a recurrence of the failures identified within this SI report happening at RMAS in the future will be reduced to as low as reasonably possible.

5.12 This SI has identified several significant failings and I invite the Reviewing Authority and the chain of command to consider whether further action is required against those involved.

Summary

5.13 I endorse the SI findings and the recommendations made therein and submit the report to SSIC (A) as the final report.

5.14 On behalf of the Army, I wish to offer my sincere apologies to OCdt [redacted] and his family for the failure to correctly apply appropriate supervisory measures prior to the accident. The discharge of duty of care requirements both post incident and during the initial post-surgery phase of recovery, that a wounded injured, or sick service person would reasonably expect to have received, were also unacceptable.

{Original signed}

T H BEWICK OBE
Major General
General Officer Commanding
Army Recruiting and Initial Training Command **27 March 2023**

SECTION 6: REVIEWING AUTHORITY COMMENTS

6.1 On 21 November 2019, a MAN SV 9T fitted with TCVES was involved in a serious Road Traffic Collision (RTC) resulting in OCdt [redacted] requiring [redacted] surgery. Other OCdts received minor injuries. This happened on the penultimate day of Ex DYNAMIC VICTORY, the final RMAS exercise prior to commissioning, on Hohenfels Training Area. The RTC was preventable.

Service Inquiry

6.2 On 18 March 2020 the Army's Single Service Inquiries Coordinator (SSIC(A)) directed that a Service Inquiry be convened to investigate the circumstances surrounding the accident involving a MAN SV at Hohenfels Training Area. The purpose was for the Army to identify any lessons that would help prevent a recurrence and to enable any appropriate changes to be made to policy, processes and procedures.

6.3 General Officer Commanding Army Recruiting & Initial Training Command convened the Service Inquiry on 18 March 2020 and subsequently approved the completed report on 27 March 2023.

6.4 The Service Inquiry panel afforded Regulation 18 Status to five 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.

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

RECOMMENDATIONS OF THE SERVICE INQUIRY

6.6 **Recommendations**. The Inquiry made 18 recommendations across four areas:

a. Command and control.

b. Safety.

c. Medical.

d. Personnel management

6.7 **Management of the recommendations.** 16 of the 18 recommendations have been endorsed and closed. Two remain to be actioned. These will be completed by 30 June 2023.

6.8 **Record keeping**. All recommendations and the supporting evidence will be recorded on the Defence Lessons Identified Management System (DLIMS).

SUMMARY

6.9 I am satisfied that this avoidable RTC and the subsequent serious injury to OCdt [redacted] has been comprehensively investigated. The President identified several areas for improvement making 18 recommendations, of which 15 were actioned and closed by RMAS. The remaining 3 recommendations were aligned to Army HQ; one has been

effectively dealt with and closed and two require further action. I anticipate this will occur by 30 June 2023, at which point they also will be closed.

6.10 This was an avoidable accident, and the driver has already been appropriately dealt with by the Service Justice System. However, RMAS have now changed their policies and procedures that have been highlighted as a direct result of this Inquiry. In short, all OCdts will now receive additional training on TCVES and be escorted by Permanent Staff.

6.11 On behalf of the Army, I offer my sincere apologies to OCdt [redacted] and his family for this preventable accident and the way they were treated in the immediate aftermath.

E J R Chamberlain 19 May 2023
Brigadier
Head Army Personnel Service Group and
Single Service Inquiry Coordinator (Army)

METHODOLOGY

Accident factors

1. Identified accident factors are defined as follows:

a. **Causal factor/s.** Those factors which, in isolation or in combination with other causal factors and contextual details, led directly to the accident. If a causal factor were removed from the accident sequence, the accident would not have occurred.

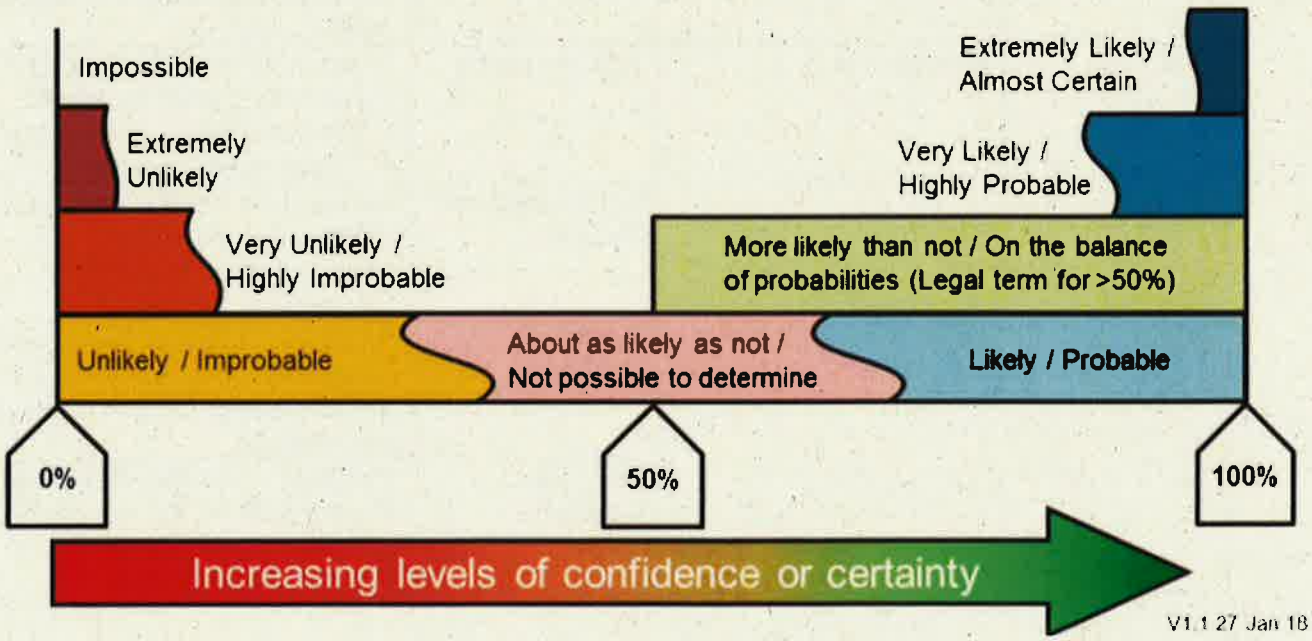
b. **Contributory factor/s.** Those factors which made the accident more likely to happen. They did not directly cause the accident. If a contributory factor was removed from the accident sequence, the accident may still have occurred.

c. **Aggravating factor/s.** Those factors which made the outcome of the accident worse. However, aggravating factors do not cause or contribute to the accident. In the absence of the aggravating factor, the accident would still have occurred.

d. **Observations.** Points or issues identified during the investigation that are worthy of note to improve working practices, but which do not relate to the accident being investigated and which could not contribute to or cause future accidents.

Probabilistic language

2. The probabilistic terminology detailed below describes levels of certainty that an event occurred or a causal link exists. It is commonly used in Army SI Reports[22].



[22] Taken from Australian Transport Safety Bureau paper at https://www.atsb.gov.au/media/27767/ar2007053.pdf

ANNEX B TO RMAS MAN SV SI

RMAS WELFARE ORGANISATION

G1 RMAS Group HQ provided the Panel with intended changes to the Welfare construct; outlined in the following tables. The **As was** table indicates the laydown and corresponding welfare responsibilities at the time of the incident. The **As is** table indicates the changed welfare responsibilities with an uplift of personnel and adjusted responsibilities. The **As will be** table indicates the final phase of welfare responsibilities. This has now been implemented.

'As was' structure			
Specialist	**Responsibilities**	**Generalist**	**Responsibilities**
Welfare Officer (Civ Servant)	Sp to Cadets, Perm Staff and families on site	DCOS RMAS Gp	Principal G1/4 Staff Officer for RMAS Gp. Oversees all Gp units not just RMAS site. 1UP for Welfare Officer and WWO.
Welfare WO	Sp to Cadets, Perm Staff and families on site – as directed by the Welfare Offr	SO2 G1 RMAS Gp	Principal G1 personnel Officer for RMAS Gp. Advises and assures all Gp Units. Overseen by DCOS. Bulk of work is RMAS site (staff and Cadets). Frequent liaison with Adjts on Disc, Welfare Risk and VRM cases.
Padres	Pastoral Care. 1 x Padre per college, 1 x Senior Padre, 1 x Padre for Reserves	SO3 G1 RMAS Gp	G1 Staff Officer working direct to SO2 G1. Due to the amount of Disc across the Gp, SO3 G1 is primarily focused on Disc, Service Complaints and Admin Action cases.
SMO	Medical input	Adjt (Academy)	Academy focused G1 activity; specifically, Cadet facing G1 matters that require escalation 1UP into Academy HQ.
		Adjt (Sandhurst Sp Unit)	Principal G1 Officer for Sandhurst Station. Responsible for G1 oversight of all Perm Staff; Discipline and Welfare.
		Adjt (Old College)	Principal G1 Officer Old College. Responsible for G1 oversight of all Old College Cadets; Discipline and Welfare.
		Adjt (New College)	Principal G1 Officer New College. Responsible for G1 oversight of all New College Cadets; Discipline and Welfare.

'As is' structure			
Specialist	**Responsibilities**	**Generalist**	**Responsibilities**
Welfare Officer (Civil Servant)	Welfare & G1 policy re-write.	DCOS RMAS Gp	Principal G1/4 Staff Officer for RMAS Gp. Oversees all Gp units not just RMAS site. 1UP for Welfare Warrant Officer. Acts as the Welfare Officer for RMAS site.
Welfare WO (site)	Sp to PS and families on site	SO2 G1 RMAS Gp	No change
Specialist	**Responsibilities**	**Generalist**	**Responsibilities**
Welfare WO (OC)	Welfare support to Old College Cadets	SO3 G1 RMAS Gp	No change
Welfare WO (NC)	Welfare support to New College Cadets	Adjt (Academy)	No change
Padres	No change	Adjt (Sandhurst Sp Unit)	Principal G1 Officer for Sandhurst Station. Responsible for G1 oversight of all PS under the SSU
SMO	No change	Adjt (Old College)	Principal G1 Officer Old College. Responsible for G1 oversight of all Old College Staff and Cadets
		Adjt (New College)	Principal G1 Officer New College. Responsible for G1 oversight of all New College Staff and Cadets

'Will be' structure			
Specialist	**Responsibilities**	**Generalist**	**Responsibilities**
Welfare Officer (Mil)	Sp to Perm Staff and families on site.	DCOS RMAS Gp	Principal G1/4 Staff Officer for RMAS Gp. Oversees all Gp units not just RMAS site. 1UP for Welfare WO. Remains closely linked to the Welfare Team as a priority work strand.
Welfare WO	No change	SO2 G1 RMAS Gp	Principal G1 personnel Officer for RMAS Gp. Gives advice and assurance to all Gp Units. Overseen by DCOS. Bulk of work is RMAS site (staff and Cadets). Frequent work with Adjts on case management and G1 Assurance
Welfare WO (Old College)	No change	SO2 G1 Discipline	Proposal: New SO2 post frees-up SO2 G1 for G1 Assurance (Disc, WIS, PAPMIS, Pers Admin).
Welfare WO (New College)	No change	SO3 G1	Proposal: SO3 G1 will focus on G1 Assurance of Gp Units, with specific involvement in UHC, WIS, and PAPMIS assurance.
Padres	No change	Adjt (Academy)	No change
SMO	No change	Adjt (Sandhurst Sp Unit)	No change
		Adjt (Old College)	No change
		Adjt (New College)	No change
		Chief Clerk HQ RMAS	Proposed additional staff support

ANNEX C TO RMAS MAN SV SI

MEDICAL ASER RESULTING FROM THIS INCIDENT

1 After the OCdt's admission to QEH, DMS raised an ASER in response to the incident. ASER is a DMS system which facilitates a consistent, systematic approach to reporting serious incidents and near misses that is evidence based, encouraging learning from both good practice and adverse events.

2. DMS HQ Corporate Governance UK Strategic Command reviewed the ASER. They allude to a change of process because of their review:

> 'The event occurred overseas and was only apparent on transfer back to (RCDM/QEH medical facility). Several contributory factors were identified in the subsequent review and root cause analysis of the ASER event. An operational Learning Account and After-Action Report took place at RMAS by CMA ARITC and a team from RMAS. This identified several learnings and recommendations. Contributory factors appear to be linked to communications, processes, protocols and procedures.
>
> My review shows that one of the key findings was that there was a failure of comms with the RCDM prior to transfer to (from) the German hospital. The learnings have resulted in a change of process so that RCDM consultants are contacted prior to surgery being undertaken in a host nation facility. The MED PLAN must indicate that no surgery on British Military personnel (is to occur) unless discussed with the RCDM consultant. The only exception should be life-saving surgery. Conclusion is that I am assured that the learnings from this event have been learned and corrective actions have been implemented.' **(F2-E53)**

3. The Panel recognises the intent behind this initiative but notes that in this instance neither MO saw it necessary to follow the medical plan and consult DMS/RCDM either on their own initiative, by seeking 'reach-back' advice nor by consulting the BFG HNO PSO.

4. This DMS direction in its present form cannot lead the Inquiry to make recommendations. It requires further clarification because the Panel considers that there will be circumstances in which surgical standards overseas will be comparable to or may exceed those in the UK, and time may be of the essence. The DMS' absolute requirement to consult with a UK specialist seems unnecessarily inflexible. Also, the proposed change in process is not yet reflected in policy and this Inquiry would not wish to make recommendations until this occurs.

5. Therefore, the Inquiry **Observes** (in Section 4, Conclusions) that implementing this DMS direction sits with SHA (A) for further consultation and action as appropriate.

ANNEX D TO RMAS MAN SV SI

DIRECTION TO CONVENE, CONVENING ORDER AND TERMS OF REFERENCE

DIRECTION TO CONVENE

From: Brigadier EJR Chamberlain

Single Service Inquiry Coordinator (Army)
Army Personnel Services Group
Home Command
[redacted]

Telephone: [redacted]
Military:
MODnet: [redacted]

Reference: APSG/SI/[redacted]

Major General TH Bewick OBE
General Officer Commanding
[redacted]

17 March 2023

SERVICE INQUIRY (SI) INTO CIRCUMSTANCES SURROUNDING THE ACCIDENT INVOLVING A 6 TONNE MAN SV TROOP CARRYING VEHICLE (TCV) AT HOHENFELS TRAINING AREA, GERMANY ON 21 NOVEMBER 2019, RESULTING IN A SERIOUS INJURY (SI) SUSTAINED BY [redacted].

1. A Service Inquiry was convened to establish the circumstances surrounding the accident involving a 6 Tonne MAN SV TCV at Hohenfels Training Area, Germany on 21 November 2019, resulting in a lower limb injury sustained by [redacted] OCdt [redacted] categorised as SI.

2. On 18 March 2020 my predecessor directed Major General Paul Nanson CBE to act as the Convening Authority as The Royal Military Academy Sandhurst came under Army Recruiting & Initial Training Command at the time.

3. When the Royal Military Academy Sandhurst became a 2 Star organisation, Major General Capps CBE was directed to act as the Convening Authority on 17 May 2021.

4. The Service Inquiry has now been completed and is ready for final review. As this matter originated with Army Recruiting and Initial Training Command and contains recommendations which may be of relevance to broader training environments, I believe it is appropriate that you should conduct the final review. The President Major [redacted] is available to discuss the report if required.

Copy to:

ARITC - COS
APSG – DACOS Pers Svs
APSG – SO1 SI
APSG – SO2 Legal
File

AMENDMENT 5 CONVENING ORDER FOR A SERVICE INQUIRY
BY ORDER OF MAJOR GENERAL D F CAPPS CBE
COMMANDANT ROYAL MILITARY ACADEMY SANDHURST

1. A Service Inquiry (SI) was convened by Maj Gen Nanson on 18 Mar 2020, in accordance with Section 343 of the Armed Forces Act 2006 (AFA 06), to investigate the circumstances surrounding the accident involving MAN SV TCV at Hohenfels Training Area, Germany on 21 Nov 2019, resulting in an injury sustained by [redacted] categorised as a serious injury.

2. An SI assembled on 15 May 2020 at Andover. The SI is the Panel's priority tasks and takes precedence over other duties.

3. The SI Panel comprises:

   a. President: [redacted] Maj [redacted]

   b. Member: [redacted] Maj [redacted]

   c. Member [redacted] WO1 [redacted]

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

5. The Medical SME is: [redacted] Maj [redacted]

6. The Panel is to investigate and report the circumstances surrounding the incidents, 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.

7. Commandant Royal Military Academy Sandhurst 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.

8. 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 reasonably possible.

9. 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.

10. 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 Service Inquiry immediately and seek legal advice.

11. 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.

12. 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.

13. The President is required to submit monthly progress reports to the Convening Authority and APSG Service Inquiry Branch in accordance with Appendix 4 to Annex G to Chapter 2 of JSP 832.

GENERAL ADMINISTRATION

14. RMAS will be required to cover the administrative costs incurred by the Service Inquiry, including the services of a court recorder. These costs are to be charged to ARITC UIN: [redacted]

D F CAPPS CBE
Commandant
Royal Military Academy Sandhurst

Annex: A Terms of Reference.

Annex A to GOC ARITC
SI Convening Order
Dated as per Direction to Convene

TERMS OF REFERENCE (TOR) FOR THE SERVICE INQUIRY (SI) INTO THE CIRUCMSTANCES SURROUNDING THE ACCIDENT INVOLVING A MAN SV TCV AT HOHENFELS TRAINING AREA, GERMANY ON 21 NOV 2019

1. The Panel is to investigate the circumstances surrounding the MAN SV accident that resulted in 30224218 OCdt Taylor sustaining an injury categorised as Seriously Injured.

2. The purpose of the SI is to:

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

b. Present the facts surrounding the injury sustained by [redacted], categorised as Seriously Injured.

c. Assess fitness for purpose of the relevant extant policies and determine whether they were complied with.

d. Establish if policy and procedures relating to the welfare and care of the Service Person were followed.

e. Establish if there were any cultural or human factor elements that contributed to this occurrence.

f. Determine the status of any relevant equipment including serviceability status, defect or deficiencies.

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

h. If appropriate, identify lessons and recommendations to help prevent further recurrence of this or a similar incident.

3. The Panel is to report on all relevant matters, and, under each TOR, the Panel is to provide observation, discussion, conclusion and, where appropriate, make recommendations. In particular the Panel is to:

a. **TOR 1 – Present the facts surrounding the accident on 21 Nov 2019 identifying potential causal, contributory and/or aggravating factors.**

b. **TOR 2 – Establish the adequacy and sufficiency of planning, preparation and supervisory support to Exercise DYNAMIC VICTORY (Ex DV) (CC191).**

c. **TOR 3 – Establish and assess RMAS understanding and compliance with welfare and discipline policies, namely but not limited to:**

(1) Army General and Administrative Instructions (AGAIs)

a. Volume 2 Chapter 57 (Army Health Committees)

b. Volume 2 Chapter 62 (Discipline Policy)

c. Volume 3 Chapter 81 (Army Welfare Policy)

d. Volume 3 Chapter 99 (Command and Care of Wounded Injured and Sick Service Personnel)

e. Volume 2 Chapter 110 (Army Vulnerability Risk Management (VRM) Policy)

(2) Army Command Standing Orders (ACSOs)

a. 3217 Trauma Risk Management (TRiM)

(3) Joint Service Publication (JSP)

a. JSP 375 Management of Health and Safety in Defence

b. JSP 800 Defence Movement and Transport Policy

c. JSP 822 Defence Direction and Guidance for Training and Education

d. JSP 839 Victims Services

(4) Defence Instructions and Notices (DIN). 2007DIN06-091 – Supervisory Care Policy for Phase 1 Recruits and Phase 2 Trainees

d. **TOR 4 - Ascertain the value of loss/damage to the Service as a result of the incident and determine the status of any relevant equipment including serviceability status, defect or deficiencies**

e. **TOR 5 - Consider any other matters relevant to the SI and, based on the evidence, make such findings and express opinions as are appropriate to support recommendations in order to prevent further incidents in similar circumstances.**

ANNEX E TO RMAS
MAN SV SI

GLOSSARY

Acronym/Abbreviation	Definition
2Lt	Second Lieutenant
44 Sqn LAD	44 Squadron Light Aid Detachment, RMAS
AC	Academy
AEROMED	Aeromedical Evacuation
APSG	Army Personnel Services Group
ARes	Army Reserve
ARITC	Army Recruiting and Initial Training Command
ASER	Automated Significant Event Report
BFA	Battlefield Ambulance
CA	Convening Authority
Capt	Captain
CC	Commissioning Course
CI	Chief Instructor
CMA	Competent Medical Authority
COs	Commanding Officer
CoC	Chain of Command
Comd NC	Commander New College
Comdt	Commandant
COS	Chief of Staff
Coy	Company
CSgt	Colour Sergeant
CSM	Company Sergeant Major
DAIB	Defence Accident Investigation Branch
DCMH	Department of Community Mental Health
DFH	Discharged From Hospital
DILFOR	Dangerously Ill Forwarding of Relatives
DMWS	The Defence Medial Welfare Service
DS	Directing Staff
DV	Dynamic Victory
ECO	Exercise Control Officer
EX	Exercise
EXCON	Exercise Control
EXD	Exercise Director
EXO	Exercise Officer
FOB	Forward Operating Base
G1	HR/Personnel function (Army)
GDMO	General Duties Medical Officer
GOC	General Officer Commanding
Gp	Group
GTA	Grafenwöhr Training Area
HC	Home Command
Hd	Head
HLS	Helicopter Landing Site
HoE	Head of Establishment
HQ	Headquarters
HTA	Hohenfels Training Area
Ill	Illness/Injury
INCREP	Incident Report
JD	Job Description

JSP	Joint Services Publication
LCpl	Lance Corporal
LEGAD	Legal Advisor
LFSO	Land Forces Standing Order
LOC	Land Operations Command
Lt	Lieutenant
Lt Col	Lieutenant Colonel
Maj	Major
MAN SV	Truck vehicle brand name
MEDEVAC	Medical Evacuation
MLD	Medically Limited Deployability
MND	Medically Non-Deployable
MO	Medical Officer
NC	New College
NCO	Non-Commissioned Officer
NOK/NoK	Next of Kin
NOTICAS	Notification of Casualty
Obsn	Observation
OC	Old College
OCdt	Officer Cadet
OCdts	Officer Cadets (Plural)
Ph	Phase
Pl	Platoon
Pl Comd	Platoon Commander
PRR	Personal Role Radios
PS	Permanent Staff
Pte	Private (Soldier)
PW	Personal Weapons
QEH	Queen Elizabeth Hospital (Birmingham)
RAF	Royal Air Force
RCDM	Royal College of Defence Medicine
Recm	Recommendation
REME	Royal Mechanical and Electric Engineers
RHQ	Regimental Headquarters
RLC	Royal Logistic Corps
RMAS	Royal Military Academy
RMP	Royal Military Police
RSM	Regimental Sergeant Major
RTA	Road Traffic Accident
SA-80	Rifle, Personal Weapon, Standard Issue
SCI	Senior Chief Instructor
SET	Support to Experimentation and Training
Sgt	Sergeant
Sgt Maj	Sergeant Major
SSgt	Staff Sergeant
SI	Serious Injury
SIB	Special Investigations Branch
SNCO	Senior Non-Commissioned Officer
SNvE	Safety Notice via Email
SO1	Staff Officer – Lieutenant Colonel
SOI	Standard Operating Instruction
SOP	Standard Operating Procedure
SP	Service Person
SPA	Service Prosecuting Authority
Sqn	Squadron
SQEP	Suitably Qualified and Experienced Person
SSgt	Staff Sergeant

SSIC (A)	Single -Service Inquiry Coordinator (Army)
SST	Safe System of Training
SSW	Safe System of Work
SSU	Sandhurst Support Unit
TCV	Troop Carrying Vehicle
TCVES	Troop Carrying Vehicle Enhanced Seating (System)
TO	Training Objective
TOR/ToR	Term(s) of Reference
Tp	Troop
Tps	Troops
Trg	Training
TRiM	Trauma Risk Incident Management
TY	Training Year
VSI	Very Serious Injury
WIS	Wounded Injured and Sick
WO1	Warrant Officer Class 1
WO2	Warrant Officer Class 2