Ministry of Defence

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D/MSU/4/7/1

14th September 2015

Dear Mrs Hunt,

Thank you for your letter of 20 July in which you enclosed a copy of your Regulation 28 Report following the Inquest into the deaths of Corporal James Dunsby, Lance Corporal Craig Roberts and Lance Corporal Edward Maher.

As you will be aware, my Department takes very seriously its relationship with HM Coroners and we fully recognise how important it is that we learn all possible lessons to ensure that deaths under similar circumstances in the future can be prevented. We are also committed to supporting our servicemen and their families and we recognise fully that it is unacceptable to lose three soldiers in such circumstances. In your report you have raised concerns about a number of issues which I will address in the paragraphs below.

1. *A new tracker system has been introduced recently. The new system's slow man/static function does not work. It is therefore still the case that those running the exercise have no means to identify static or slow moving soldiers.*

The new tracker system was introduced in to service in November 2014 and first used on an exercise in January 2015. The system functions correctly in that it provides alerts if any beacon breaches the slow moving parameters. However there are challenges in how this is interpreted by those using it, as the system can not identify the cause (e.g. an individual taking a break or stopping to fill water bottles) which can overload the operators making it difficult to identify those at risk.

In addition there are issues with the system's ability to cope with the volume of data it receives when in continuous contact with a large number of beacons, as this was not how it was designed. This will be rectified in an upgrade scheduled to take place before the end of this calendar year. In order to overcome the issues with interpretation of the slow man/static function in the intervening period, the following mitigation measures have been put in place:

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HM Senior Coroner the City of Birmingham and Solihull
Coroner's Court
50 Newton Street
Birmingham
BN4 6NE

- Each candidate's beacon is visually monitored by Directing Staff to ensure they are on track. If their position is not updating automatically the indicator on screen changes colour, alerting Directing Staff that there may be a problem.

- The rate of refresh of the system has been reduced to once every 5 minutes, which overcomes some of the issues with both overload on Directing Staff and the system itself, as brief stops (e.g. to check navigation) are less likely to be detected.

- Directing Staff at Check Points will alert the Command Vehicle if a candidate does not arrive at the expected time.

- Where a candidate's pace or location raises cause for concern a quick reaction force (QRF) is immediately sent to their last known location. In addition to the QRF (e.g. if they are addressing another issues) one of the directing staff is able to move from the closest check point to their last known location to investigate as necessary.

- The system allows text messaging between candidate and Directing Staff and is used to check candidates' status and location.

- No candidates are allowed to commence or continue the exercise until the Directing Staff have confirmation from the system that their beacon is working. Spare beacons are available at checkpoints and any delays while these are allocated and checked does not impact on candidate exercise times.

2. *Those in a senior commanding position were unaware that the new tracker system's slow man/static function did not work until the inquest- this came to light as I asked for a demonstration of the new system which was undertaken on the Malvern's on Sunday 21 June 2015. I was informed the slow man/static function did not work. I heard no evidence that any steps have been taken to address this problem and no interim measures have been put in place to mitigate the risk.*

All commanders on the exercise now have a full understanding of the new tracker system, its capabilities and limitations. Representatives from the company who produce the system attended the last exercise (and will attend future iterations) to update on any issues and better understand the concerns of the Directing Staff. In addition the company are contracted to provide direct support to exercises as well as 24/7 remote advice as required.

Upgrades outlined under Point 1 should address remaining concerns, however to ensure all matters raised during the inquest and in the various investigations are being addressed, a meeting will take place in October between the delivery authorities (Defence Equipment and Support) and the Directing Staff. The timing of this meeting will ensure all requirements are captured and either addressed or alternative mitigations put in place before the next planned selection exercise.

3. Witnesses at the inquest confirmed that before this tragedy they were unaware of the main guidance for heat illness namely JSP539-joint service code of practice-climatic illness and injury in the armed forces Version 2:1 November 2012. Some witnesses in a very senior position –AA and SR44- claimed, retrospectively, that this guidance was not applicable to this endurance exercise. Others [redacted] and [redacted] confirmed it was the current guidance and no separate guidance had been issued for exercises with this specialist group. I am concerned that the MOD still do not have a clear plan and guidance for the detection of Heat illness in this type of exercise and have failed to instruct commanders of the importance of adhering to JSP539 for this type of activity.

JSP 539 provides the principles which should be applied by all UK Armed Forces in order to minimise the risk of climatic injuries. To ensure all commanders are aware of the importance of adhering to JSP 539, the Defence Safety Authority recently issued an Urgent Safety Advice notice on Climatic Illness and Injury Awareness and Prevention. This advice reminds Armed Forces personnel of the sources of information and risk assessments to be undertaken in order to try and prevent and treat heat illness (and cold injury).

The Medical Plan for the exercise was completely revised in advance of the most recent iteration (June 2015). Prior to all future exercises this plan must be reviewed and signed off by the Senior Medical Officer and Chief Instructor of the Lead Regular Unit (see response to Point 7 for further detail). Oversight is provided by medical staff in HQ Specialist Military Units. The revised Medical Plan requires that a comprehensive training package on climatic illness and injury and JSP539 is established. This has improved knowledge and awareness of the JSP and climatic illness and injury. In addition, the Medical Plan has introduced a requirement for all professional medics on the exercise to conduct virtual exercises and rehearsals prior to future exercises.

4. Senior commanders had received no training before this tragedy on JSP539. There was no clear system for disseminating information to different regiments and no means to check those commanding this type of exercise had the requisite knowledge and training.

Commanders of Specialist Military Units are all now briefed on JSP 539 as part of their pre-appointment training. All specialist units will now receive appropriate training packages on JSP 539, heat illness and its treatment. If a requirement to operate outside the parameters of JSP 539 is identified by the Directing Staff, then a formal waiver must be issued by Director Specialist Military Units. This approval requires an explanation of the measures in place to justify such a deviation as well as the operational necessity for them.

The Medical Plan for the exercise provides for training of all Directing Staff in JSP 539 and is signed off by the Training Officer of the Specialist Military Unit responsible. Furthermore, all students are required to sign declarations that they have read and understood Standard Operating Instructions (which include JSP 539), which ensures they are aware of all relevant procedures.

5. Senior commanders were unaware that the staff who completed the risk assessment for this exercise and who conducted the exercise had not been trained in the preparation of risk assessments. The risk assessment used simply adopted a risk assessment that had been prepared by the lead regular unit.

Training in the conduct of Risk Assessments was addressed in the immediate aftermath of the incident in 2013 and following the improvement notice issued by the HSE. In addition to this, work is being conducted to review how the organisation can improve training in this area and HQ specialist military units is reviewing and rewriting its Training Governance and Assurance Policy which will lead to further changes in the policy and procedures of subordinate units. The revised Training Governance and Assurance Policy was completed in August and changes by the subordinate units will be in place before the end of the calendar year, prior to the next iteration of the exercise.

6. Senior commanders were unaware that the staff who conducted this exercise were unaware of climatic guidance in JSP539 and therefore did not understand the implications of the weather forecast and the importance of heat illness and its treatment.

As explained under point 4 above, all specialist units will now receive appropriate training packages on JSP 539, heat illness and its treatment.

7. Senior commanders were unaware that the reservist units had a different build up to test week. The reservists had a military skills week the week before test week whereas the signals regiment had build up marches. None of the signals regiment students suffered heat illness.

The overall command of the exercise, including the preparatory training immediately preceding it, now rests with the Commanding Officer of the Lead Regular Unit. This has simplified the reporting chains and command responsibilities and ensured that information can be provided to a single command chain which has the authority to make changes to the exercise in light of this information as appropriate.

In consultation with the HSE the preparatory training undertaken by Reserve Units was reviewed following the incident. Following this Reserves were included in the build up marches undertaken by Regulars in the week preceding the exercise. A further review was undertaken at the end of June 2015 which concluded that this had failed to fully mitigate the risk. A further change was made prior to the most recent exercise with Reserves now undertaking instructor-led marches (at controlled pace) before moving on to the more demanding build up marches undertaken by Regulars.

As explained below, I have also directed that a non-statutory inquiry be conducted to look at, amongst other issues, the requirement of the Reserve Units to undertake this exercise and the exact training requirement dictated by their role.

8. The general system for reporting heat illness cases is disjointed and results in cases being missed and therefore not reported. Inaccurate data impedes the ability of the MOD to assess the true incidence of heat illness during exercises and to put in place any plan that's required to mitigate ongoing risks of heat illness.

I acknowledge that there have been failings in the accurate recording of cases of heat illness historically. The Defence People Health Board's Heat Illness Working Group, in collaboration with the Defence Safety Authority, is working to improve the process for reporting of heat illness and injury. Progress will be reported to the Defence People Health Board in October and I will write to you in November with an update on this important work. The revised Medical Plan for the specialist exercise requires prompt and accurate reporting of all climatic injuries, so as to enable an accurate capture of the required data.

At the time of the incident there was no mechanism to record Reserve medical information on the Defence Medical Information Capability Programme (DMICP). There was a system for Medical Reporting of cases of heat illness but this relied on the use of paper forms which may have contributed to failings in their recording. Medical information relating to Reservists is now being loaded on to DMICP, thus statistics relating to climatic injuries sustained by both Regular and Reserve personnel will show up in health audits by Defence Statistics. This has been reflected in the exercise Medical Plan.

9. The tracker system used at the time was known to be unfit for purpose in that the slow man/static function did not work effectively. No commander at any level addressed this deficiency in any directions to staff or further risk assessments.

I accept that there were issues with the tracker system in place at the time, which was not designed to provide the slow man/static functionality being developed in the new system. I also accept that these issues were not appropriately mitigated by other means. Our actions to address these issues are outlined at Point 1.

10. A previous fatality, Soldier G see LAIT report October 2012, had identified that treatment for casualties should be within the "golden hour". In addition following Private Poole's death in 2009 it was identified that the tracker was not fit for purpose and standard operating procedures were issues dated January 2011. None of these recommendations were implemented by those involved in this exercise. I am concerned that lessons had not been learnt from these previous events. There appears to be no clear pathway for communicating this sort of information.

There is a formal process in place for the capturing of lessons learnt/identified (Land Forces Standing Order (LFSO) 1118 – Learning Lessons in the Land Environment). Lessons are managed through the Defence Lessons Implementation and Management System (DLIMS) process which provides for a comprehensive way in which to consider that appropriate lessons are learnt, and that all appropriate steps are taken to prevent or minimise a recurrence. There is a clear and well established process, which is now being reinforced through the Training and Governance Policy review referred to under

Point 5 which will formalise the DLIMS process as a core part of the biannual review of normal training, including exercises such as this.

The lessons identified in the two incidents you refer to were captured by this process. The 'Golden Hour' is normally applicable to circumstances where patients have suffered from major trauma or severe injury and need to access definitive emergency treatment in that time frame. It is not always relevant to environmental injury/illness which should be judged on a case by case basis. In cases of heat stroke, the immediate and most pressing medical and first aid action (after attending to airway, breathing and circulation) is to cool the patient as quickly as possible. The cooling can often be initiated in the field fairly quickly and, in some circumstances, this can be done more effectively in the pre-hospital environment.

In the case of the issues with the tracker in use at the time of Marine Poole's death; work was undertaken to enhance its capability and improvements were introduced in December 2010. It was subsequently identified that there was a need to replace the system and this led to revised set of 'User Requirements' which included statements taken from the Lessons Identified. The time it took to implement the new system was not a result of a failure to identify the lessons, but a result of the complexity of procuring such a piece of equipment. I accept that further mitigation should have been put in place to address the gap in capability while the systems were being upgraded and replaced, these issues have now been addressed through the improvements in training and the conduct of risk assessments and improved awareness throughout the command chain of the capabilities of the system.

11. There is no system in place to ensure that WBGT readings obtained at Sennybridge camp are communicated to exercise commanders in the area during the day.

I accept that the lack of a system to obtain and monitor WBGT readings from Sennybridge Camp was a failing. Having reviewed this it has been concluded that obtaining readings from Sennybridge Camp would be of limited value in determining the climatic risks in the training area, which is some distance from and of different terrain to the camp area. WBGT readings are now taken at the command vehicle (located in the exercise area) and at the highest point in order to understand the range of conditions out on the course being used. They are continuously monitored throughout the exercise and any changes in the readings are recorded in the communications log and all check points notified of these and any control measures required as a result.

In order to improve on this and to provide as accurate information as possible, a scoping exercise is currently being conducted to look at establishing further WBGT meters across the routes used. This will allow geographical variations to be better taken into account and Dynamic Risk Assessments to be conducted to inform route planning and overall timings and/or objectives in light of the prevailing conditions. This work will be completed in time to allow any changes to be implemented in advance of the next iteration of the exercise.

12. There was no involvement of a doctor experienced in heat illness detection and treatment when devising the medical plan for this exercise; the medical plan was prepared by a junior combat medical technician.

The revised Medical Plan, outlined at point 3, put in place for the most recent and all future exercises is to be reviewed (and signed) by the Senior Medical Officer and Chief Instructor of the Training Squadron from the Lead Regular Unit, following consultation with the medical team in the higher headquarters. The Senior Medical Officer is trained in and has experience of heat illness detection as well as wider medical risks with exercises of this type. They are also able to draw on the expertise within the organisation and across the Defence medical community. The revised Medical Plan also requires that a professional medic (who would be experienced in heat illness detection and treatment), reviews the Medical Plan each day, prior to the start of exercises, taking account of the prevailing and forecast climatic conditions, route changes, availability of support assets and any students who are considered to be 'at risk'. Any changes to the Medical Plan must be made in consultation with the Senior Medical Officer and Chief Instructor from the Lead Regular Unit.

13. There was no prior liaison with the NHS and Mountain rescue before this exercise about what their involvement might be in the case of any injuries or illness.

Local Commanders now liaise with local Police and Mountain Rescue prior to the start of every exercise. In addition, communications are established with the closest Search and Rescue location to confirm the communications plan and Medical Staff are required to liaise with local hospitals. The Medical Plan directs that rehearsals and virtual exercises be undertaken to consider the response, including likely timelines, to medical emergencies.

In addressing your concerns I have sought assurances from the Royal Navy, Army, Royal Air Force and Joint Forces Command as to whether any wider lessons from your recommendations apply to their activities. I have received assurances that activities are conducted in line with the appropriate MOD policies, for example on risk assessments, climatic illness and injury. This work has identified a number of improvements; most notably the Royal Navy identified lessons in three of its training activities all of which have been addressed or will be addressed by March 2016 with mitigation in place until that time.

We continue to work with the Health and Safety Executive to take forward their recommendations and seek their advice on implementing improved processes. I have directed that two further inquiries be conducted by the Ministry of Defence. Firstly, a Service Inquiry will look at the events of 13 July 2013 to try and ensure that all safety-related lessons, including those identified in your Regulation 28 report, are learnt for endurance training across the whole of Defence. This will be conducted by a Service Inquiry Panel, convened by the Director General Defence Safety Authority, which will provide an independent, thorough and objective review outside of the chain of command. In order to ensure all relevant issues are captured and considered by the Service Inquiry, I have also written to the Director of Specialist Military Units,

Commander Joint Forces Command and the Chief of the General Staff directing that they identify areas of arduous activity that may be relevant to the Service Inquiry and make these known to the Service Inquiry panel.

Secondly, a non-statutory inquiry will look at the care and support provided to the bereaved families in this case and to those members of the MOD who were closely involved in the incident; and review the training needs analysis for the reserve units involved in this incident in light of their current role.

I hope that this response helps to address your specific concerns regarding the tragic deaths of Corporal Dunsby, Lance Corporal Roberts Lance Corporal Maher. I am content for you to copy this response to the Chief Coroner and other Interested Persons. I have also undertaken to place a copy of this response in the Library of the House of Commons. I will do so when Parliament returns from the conference recess in October, as per your request for a slight delay to rightly afford the bereaved families time to consider my reply.

Yours ever,

[redacted]

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