REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Rt. Hon. Mark Francois MP** Minister of State for the Armed Forces Ministry of Defence Floor 5, Zone A Main Building Whitehall London SW1A 2HB
1.	**CORONER** I am **David Ridley** Senior Coroner, for the coroner area of Wiltshire & Swindon
2.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 12 May 2014 I resumed the Inquest into the deaths of both Private Robert WOOD and Private Dean HUTCHINSON ("Rob & Dean") at my Court here in Salisbury, Wiltshire. The Inquest concluded on the 22 May 2014. I found that both Rob and Dean had died from:- 1a) Inhalation of products of combustion and severe burns. In relation to the conclusion I handed down a narrative conclusion, a generic version of which is attached to this report marked "A".
4	**CIRCUMSTANCES OF THE DEATH** These are clearly set out in my narrative conclusion attached to this report.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The final day of evidence looked closely at the various processes undertaken by the Ministry of Defence to learn from the tragic deaths of both Rob and Dean, on the 14 February 2011 and I am aware that a significant number of changes have already been introduced. Concerns numbered 1 and 3 focus in the main on the Fire Risk Assessment document and the Fire Diary. Item 4 is a general concern and is self evident. The **MATTERS OF CONCERN** are as follows. – (1) In evidence from [redacted] from the Defence Fire Risk Management Organisation, I looked at the modification to the Fire Diary on the subject of fire risk assessments. I have attached a copy of the relevant extract marked "B" and the relevant section is already highlighted. It talks of a review of the fire risk assessment where there has been or there is planned to be a change in use or structure alteration.

In evidence a number of witnesses, in particular, [redacted] who carries out fire risk assessments, agreed that advice should be sought ideally before any change of use or structural alteration. I appreciate that there will be incidences whereby a change of use can take place extremely quickly however I considered that this section did not weight a preference in favour of a review prior to a change of use or any structural alteration taking place. It is my view that the current version gives equal weighting to the 2 options available when the evidence I heard was in favour of advice being sought before a change of use was carried out or any structural alteration taking place. In this particular case the alterations were phased alterations over a period of time and whilst I formed the view that it was speculative on the facts of this particular case that such a review before the change would have made a difference that cannot be said for future incidences. As the evidence I heard supports a preference for such reviews to be undertaken before a change of use or structural alteration takes place I would ask that this be reviewed insofar as the wording is concerned.

(2) Instruction and training is now given specifically to Junior Fire NCOs as regards recognising the possibility of overloading in relation to electrical appliances. In my decision I found that the absence of such training was a systemic failure contributing to the deaths of both Rob and Dean. In evidence from Captain Hamilton from the Royal Engineers he explained insofar as the chiller cabinet that was used inside the Transport Troop tent was concerned that whilst that may have a specific amperage in relation to the draw of current, he commented that at the start of a cycle when the compressor becomes activated that figure can be multiplied by a factor of between 6 to 10. For example a 2 amp appliance suddenly draws a current of between 12 and 20 amps. He commented that in order to recognise such an issue that this required quite specific training and knowledge attributable to the qualifications of an electrician. As the Fire Diary is the guide to any Junior Fire NCO I would be grateful if you could please confirm that this document includes guidance to relevant Fire NCO's as regards who to contact if they have a concern as regard overloading in order to seek expert advice on the matter.

What became very clear during the course of the Inquest is that such matters sometimes have to be explained in very clear terms and levelled so as to be understood at the lowest level of service men/women.

(3) A copy of the fire risk assessment is, of course, given to the relevant Fire NCO and, of course, the sleeping issue is very much highlighted to all fire risk assessment assessors. In the actual fire risk assessment of the General Support Squadron area that was undertaken on the 3 December 2010 it was not picked up by the relevant fire NCO who, of course, subsequently received a copy of the document stating that sleeping was not taking place.

I would be grateful if you could please review the matter in relation to the risk assessment document with a view to considering whether it would be sensible to put a note possibly in bold and/or even capitals on the subject of the declaration in relation to **sleeping in office accommodation** to act as a reminder to the Fire NCO to check the point. Whilst [redacted] referred to the guidance, referring to the use of cots/beds, soldiers of course are resourceful and will sleep at a desk or even on the floor.

(4) It may seem a matter of common sense but in relation to the issue of random checks ("*silent hours checks*"), what was happening insofar as the Transport Troop tent was concerned in relation to satisfying the obligation to carry out checks between the hours of 2300 hours to 0500 hours the following day was that those responsible if they happened to worked late beyond 2300 hours say until 0000 would regard that as sufficient. More senior officers who gave evidence recognised that such checks to be effective needed to be random. I found this to be failure at individual levels and I would be grateful if the matter could be considered to be used as a training example to reinforce the point to Junior Officers and NCOs on the subject of random checks. I found that had random checks been undertaken that it more likely than not would have acted as a deterrent and stopped the practice of all sleeping on duty at night.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 July 2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] Kellogg Brown & Root Ltd. Messrs. Hilary Meredith, Solicitors for the family of Robert Wood. Messrs. Hogan Lovells International LLP Solicitors for the family of Dean Hutchinson. Treasury Solicitor representing the MOD. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**3 June 2014** **David Ridley CORONER**