REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Rt Hon. Ben Wallace MP, Secretary of State for Defence**
1	**CORONER** I am Sir Ernest Ryder, nominated Judge Coroner.
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 26 November 2018 the Senior Coroner for Dorset commenced an investigation into the death of **BENJAMIN DAVID MCQUEEN**, aged 26. The investigation concluded at the end of the inquest held by me as nominated Judge Coroner from 10 to 28 July 2023. The conclusion of the inquest was as follows: **Medical Cause of Death** 1a Drowning **How, when, and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death.** On 14 November 2018, Benjamin McQueen drowned during a military diving exercise in Portland Harbour, Dorset. He experienced complications during the dive. He carried out one or more authorised emergency drills which would have rapidly depleted the supply from his breathing apparatus. He was recovered from the sea bed from a depth of about 18 metres, but despite appropriate attempts at Cardio Pulmonary Resuscitation he could not be revived and his death was declared at 19.17. **Conclusion of the Coroner as to the death** **Short form conclusion: Accident** during arduous military training for operations with an elite unit. **Additional narrative conclusion**: Ben's Unit collectively took diver safety seriously and conscientiously. However, his death was contributed to by the following failures: (1) Not topping up breathable gas levels between the two dives; (2) The lack of a training requirement for all signals to be acknowledged; (3) Inadequate risk assessment for the combined use of the equipment on the exercise which failed to identify mitigating measures for the risks arising (insistence on careful progression; shallower water and ensuring breathable gas was topped up); (4) A marked and inappropriate increase in the rate of training progression in the second phase of the exercise; (5) Insufficiently firm instruction on when student divers should surface.

	It is also possible (but cannot be said to be probable) that his death was contributed to by: (1) Limitations in training in the Emergency Ascent Drill, including the lack of reference to the use of the Buoyancy Control Jacket to ascend; (2) Not specifically training dive students to check their cylinder pressure after the trouble drill and not specifically warning about the use of breathable gas it could use up; (3) Inadequate consideration of the risk of a lost diver in selecting the most appropriate cylinder for the stand-by diver; (4) Failing to ensure a full and rapid de-brief of all of the surviving divers who surfaced in choosing where to deploy the stand-by diver; (5) The lack of formal authorisation from Headquarters for some of the equipment to be used on the exercise because following the correct procedure may have highlighted the deficiencies in the risk assessments; (6) The resource limitations leading to a relative lack of proactive engagement in the Chain of Command between the levels of the Dive Cell Co-ordinator and the head of the training department.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are briefly summarised in the text above. Detailed factual findings in Security Sensitive form are held by MOD and I request that you should have regard to the full Security Sensitive factual findings.
5	**CORONER'S CONCERNS** I have been greatly assisted by detailed evidence from MOD on the changes made to the relevant aspects of military diving training since Ben's death. From that evidence it is very clear that there has been a comprehensive and far-reaching review of policies, practices and organisational structures which will have very significantly reduced the risk of future fatalities. In several areas, the changes made go beyond those recommended by the Defence Safety Authority, and in nearly all other cases the recommendations have been adequately addressed. There are a few areas where there remains technological limitations to the response to the earlier DSA recommendations, but I am satisfied on the evidence I have heard that appropriate technological advances are being rapidly sought, with the risks in the meantime being mitigated by other means. Among over thirty recommendations arising from earlier investigations where extensive action has already been taken, there are four discrete areas in relation to which I assess that the Statutory threshold for me to make a Report to Prevent Future Deaths is met. Accordingly, it is still the case that during the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (1) **A stand-by diver was present at the dive exercise and he was deployed to try to find and rescue Ben. However, the stand-by diver had to surface having run out of breathable gas before Ben was found. A spare breathing apparatus cylinder was not carried in the safety boat for the stand-by diver (or other divers) to use in the event that the stand-by diver's main cylinder ran out.** (2) **The progression of the dive training in which Ben was engaged was safety–critical. The progression of training was accelerated for several reasons, one of which was a visit by a high-ranking naval officer. The concern of the instructing staff was to polish the drills ahead of that visit and to take the pressure off the dive students by allowing them to practise the dive with relevant equipment ahead of the visit. This acceleration of safety-critical training in part because of such a visit was not appropriate.**

	(3) **Ben was lifted unconscious from the sea bed and Cardio Pulmonary Resuscitation was immediately started. A defibrillator was also applied, but this was only available because it was carried by a Harbour Patrol vessel which came to assist. I am concerned that in such safety-critical military diving training, the dive support staff did not have available to them a defibrillator of their own either on the supporting safety boats or on land. This did not cause or contribute to Ben's death but could lead to future fatalities.** (4) **There is an inconsistency regarding the minimum safety pressure level for the relevant diver's breathing apparatus as between the maintenance manual for which DE&S is responsible and all other policy and safety guidance.**
6	**ACTION SHOULD BE TAKEN** (1) As to carrying a spare breathing apparatus cylinder in safety boats in addition to that carried by the stand-by diver where this is practicable, I am reassured that this appears to be happening in practice in Ben's former unit. But I have a concern that this does not yet appear in policy guidance and it is a safety concern that may need to be more widely shared in defence. (2) As to avoiding visits by senior ranking Officers or VIP visitors to training courses leading to an acceleration of safety-critical training, I am reassured that action has been taken in Ben's former unit such that this should not recur in relation to the relevant diving training. But I have a concern as to whether this has been shared more widely amongst other military units. (3) As to the availability of defibrillators, I was informed that they are present at some, but not all, dive sites used by Ben's former Unit. The risk assessment suggesting that defibrillators are not required because of the age/health profile of those attending the diving training appears to focus upon the risk of myocardial infarction (or similar) from a natural cause or routine exercise, rather than the risk of cardiac arrest / heart arrythmias caused by traumatic injury when carrying out arduous military diving. (4) As to the inconsistency regarding the minimum safety pressure level for the relevant diver's breathing apparatus, I was informed that the relevant operators would not need to consult the detailed maintenance manual such that confusion should not occur. Nevertheless, I consider that in the sphere of safety-critical dive training, there is an unnecessary residual risk in different figures being given for the minimum safety pressure level for a type of diver's breathing apparatus. In relation to each of these areas, in my opinion action should be taken to prevent future deaths and I believe that you as the responsible Minister for the Ministry of Defence 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 Friday 22 September 2023. 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: • Ben's family; • The Health and Safety Executive. 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	**28 July 2023**	**[SIGNED BY CORONER]**