

RECORD OF CROWN CENSURE OF MOD (ROYAL NAVY) FOLLOWING
THE FATAL ACCIDENT TO RECRUIT MARINE ALAN WAYNE RICHARDS
ON 31 MARCH 2000

AGREED MINUTES OF MEETING HELD AT HSE OFFICES ON 19
JANUARY 2005

ATTENDEES

HSE

Max Walker, Head of Operations South West (Chair)
Paula Johnson, HM Principal Inspector of Health and Safety
Dawn Lawrence, HM Inspector of Health and Safety

MOD

Brigadier G S Robison, Commandant, Commando Training Centre Royal
Marines
Major < > Case Officer
Warrant Officer 1 < >
< > CESO (RN)
< > DCESOI (MOD)

Lt Col < > MOD Communications

OBSERVERS

Malcolm McDowall, HM Inspector of Health and Safety, Crown Sector
Keith Derrick, Administration Team Leader
MSS Stutt, GNN

< >

< >

INTRODUCTION (Max Walker)

As Chairman I would like to open the proceedings by outlining the purpose of the Crown censure procedure in which we are engaged.

'Crown censure' is the term given to the formal recording of a decision by HSE that, but for Crown immunity, the evidence of a Crown body's failure to comply with health and safety law would have been sufficient to provide a realistic prospect of conviction in the courts as specified by the Code for Crown Prosecutors. The Crown Censure procedure is set out in Personnel Information Notice 45 and so available to all Crown Bodies.

Broadly speaking, the Crown, as an employer, is bound by the duties imposed by health and safety law, but is not subject to the provisions relating to statutory enforcement because of Crown immunity.

Alternative administrative arrangements have been established, known as Crown censure, to enable effective enforcement of these statutory duties in order to maintain the confidence of Crown employees and the public in the regulation of Crown bodies. These arrangements include ensuring that health

and safety issues identified in Crown bodies receive the same priority as they would in private concerns.

Under Crown censure procedure, HSE notifies the relevant department or agency at a senior level of any circumstances where, but for Crown immunity, criminal prosecution would have been appropriate. All such decisions are taken in accordance with the Health and Safety Commission's published enforcement policy statement and with the Code for Crown Prosecutors.

The censure procedure involves a formal meeting (or 'hearing') between a Senior HSE inspector and representatives of the senior management of the organisation involved. This is such a meeting.

The purpose of today's proceedings is to seek acknowledgement of the offence and the deficiencies that led to the tragic death of Alan Wayne Richards and to obtain an undertaking that the necessary steps have been taken to prevent a reoccurrence.

We will hear from Dawn Lawrence, the investigating inspector who will explain the circumstances giving rise to this censure.

Then Brigadier Robison will respond and make any representations by way of mitigation, as well as setting out the steps that have been taken as a result of the events which are at the centre of this censure.

If the hearing confirms HSE's view that the evidence would be sufficient to provide a realistic prospect of conviction in the civilian courts, HSE will formally notify the headquarters of the Ministry of Defence who must prepare an agreed briefing for Ministers. The censure will become a matter of public record and brief details will be placed on the HSE enforcement database and web site. An agreed press release will be prepared.

We will now hear from Dawn Lawrence who will explain the findings of her investigation and the relevant legal requirements.

HSE INVESTIGATION FINDINGS AND LEGAL REQUIREMENTS (Dawn Lawrence)

The charge

It is HSE's view that the MOD Royal Navy, being an employer within the meaning of the Health and Safety at Work etc Act 1974, failed to discharge a duty imposed by section 2(1) of the said Act, in that they failed to ensure, so far as was reasonably practicable, the safety at work of all their employees, including Alan Wayne Richards, during recruit training on 31 March 2000 at Woodbury Common, near Lymington, Devon, whereby it is alleged they are guilty of an offence contrary to Section 33(1)(a) of the Act.

We believe that this failing is one for which, but for Crown immunity, HSE would have pursued a criminal prosecution in the courts and secured a conviction.

I will first describe the background to this case, then the particular circumstances leading to the accident, and finally summarise the organisational failings identified.

Introduction

This Crown Censure arises from the investigation of the fatal shooting of Recruit Marine Alan Wayne Richards, which occurred at Woodbury Common, near Lympstone on 31 March 2000. Blank ammunition used as part of a training exercise was contaminated by live ammunition taken on to the exercise as part of Armed Sentry Procedures for Woodbury Common. A number of live rounds were mistakenly discharged by one of the instructors, two of which struck and fatally wounded RctM Richards.

The Exercise

RctM Richards was assigned to 780 Troop, and was in week 9 of his training at the time of the accident. In week 9 the Troop was to take part in a practical training exercise, Hunters Moon. A written exercise instruction was provided to guide the training team, but it did not specify exactly what activities were to be carried out or how, and left much to their discretion. It did not require the training or practice of a no-notice move, but it was decided to include one. The conduct of a crash move constituted a change to the planned exercise. No risk assessment existed, either for Exercise Hunters Moon, or a crash move and no suitable and sufficient assessment was made or recorded by this training team.

The instructors

The way CTCRM operated meant that there was frequent rotation of staff at all levels in and out of post at CTCRM and instructors would typically serve only a couple of years there. This meant that at any one time, many instructors might have very little experience of recruit training and current CTC procedures. The make up of the training teams was planned taking this into account where possible, and efforts were made to mix new and experienced staff in a team, but the desirable balance was not always achieved. Initially 780Tp had an experienced sergeant, but he was drafted elsewhere, and at the time of the accident the Troop was without a substantive Sgt. The remainder of the team was very inexperienced in many important practicalities, having been at CTC for a few months at most, and 780 was their first Troop through training. They had limited experience of recruit training and general CTC procedures, conduct of training on Woodbury Common, the Armed Sentry Procedure, and Exercise Hunters Moon. The lack of any suitably experienced instructor on the team was significant as it meant there was no-one who had practical knowledge or experience of the Armed Sentry Procedure. Therefore there was no-one present who recognised Captain < > failure to comply with it.

Captain < > had been sufficiently concerned about the lack of an experienced Sergeant to support his team that he had raised it both with Company Sergeant Major < > and Company Commander Major < > but was told he would have to carry on without.

General information, instruction and training for instructors

Following appointment, each Instructor was required to attend the 2.5 day Instructors Preparatory Course (induction). The course had limited safety content and made only passing reference to the use of armed sentries on Woodbury Common. All except one of 780 Tp's instructors had attended this course at the time of the accident. On joining, the Tp Cmdr was given, and required to sign for receipt of, a set of some relevant orders and instructions including Commando Training Wing Standing Orders and the Troop Commanders Handbook, but **not** the Orders containing the Armed Sentry Procedures.

The Troop Commanders Handbook contained an instruction that the Tp Cmdrs were to conduct training "safely - as defined in the appropriate pamphlet" and a list of pamphlets and orders which were relevant. One of the pamphlets listed was 'Pamphlet 21' (Infantry Training Volume IV - Ranges, Pamphlet 21 Regulations for the Safe Conduct and Supervision of Firing (Infantry Weapons)). This set out procedures to be followed during weapon handling and use, including handover of weaponammunition to another person and procedures for preventing cross contamination of live/blank ammunition when switching from one type to the other. The training team should have complied at all times with the procedures set out in Pamphlet 21.

Armed Sentry Procedure (ASP)

Training on Woodbury Common was subject to special security procedures using an armed sentry to guard against potential terrorist attack. The ASP was set out in a document called 'Orders for the Armed Instructor During Training on Woodbury Common' and contained in one volume of orders. The instructions for general matters pertaining to training on Woodbury Common, namely 'Training Instruction B13 'Orders for the Use of Woodbury Common for Training' were found in a separate volume. Training Instruction B13 mentioned the need for Armed Sentries but it did not contain any reference or signpost to the detailed Armed Sentry Procedures in the other volume. Therefore it was possible for someone to read about the requirement to have an armed sentry without realising that there were more detailed orders about how this was to be done. Copies of the volume of orders containing the ASP were not given to Troop Commanders. They were informed that the volume existed and that it should be read, but no time was allocated for this. No positive checks were made to confirm that the ASP had been read. The organisational arrangements for ensuring that all relevant staff were aware of these safety critical orders were weak and the risks arising from inadequate understanding were significant.

Shortly before the accident it had come to the attention of senior staff that some Troops exercising on the Common were not booking out at the guardroom and were not nominating an armed sentry. The continuing requirement to have an armed sentry was discussed at briefing meetings with Troop Commanders but the detail of the orders was not discussed. On 17 March a written reminder was issued in the form of a Daily Routine Order,

which all staff were supposed to read. This did contain a specific reference to the Pad IV orders.

The ASP required the deployment of an armed sentry with each Troop training on Wloodbury Common, up to a maximum of 6 sentries deployed at any one time. The sentry was to be armed with a personally zeroed weapon and 50 rounds of live ammunition, carried as 25 rounds in each of 2 magazines. Instructions required the magazines to be painted red, taped over and together, not loaded onto the weapon and kept in the possession of the designated sentry. The sentry was required to be briefed on his orders, carry a copy of relevant orders and wear an orange armband.

The orders required the armed sentry duty to be performed by a member of the training team. Instructors, including those who had been the nominated armed sentry in possession of live ammunition, could and did regularly participate in weapon handling and blank firing on exercises. In merging the training role, which might foreseeably involve the need to handle blank ammunition, and the armed sentry role, which involved handling live ammunition, the ASP introduced a significant hazard - that of contamination of blank ammunition with live.

The orders prohibited a person from being in possession of live and blank ammunition at the same time. In practice the teams found various ways to manage the overlapping role of sentry and instructor, including leaving the weapon, live ammunition and sentry in the team tent away from the training, leaving the weapon and live ammunition in or around the team tent under general supervision, or handing the duty over to another instructor.

The orders allowed the duty and weapon to be handed over to another person of suitable rank and required such a transfer to be signed for. However, there was no procedure for this or any form on which a signature could be recorded. The orders did not refer to or emphasise the importance of following normal safety precautions and proper procedures for live to blank transition. This permitted handover introduced a further potential problem, namely that the weapon would only be zeroed to the original duty holder and not to the recipient.

The designated armed sentry was required to attend the guardroom before deploying to be given and to sign for receipt of rounds and other equipment. The signature was made on a log which contained a declaration that he had received all relevant equipment and had read the orders. The orders required the armed sentry to be briefed on his orders but did not say who would conduct this briefing and it was not done.

The live ammunition and all other equipment required by the armed sentry (apart from the weapon) was held by the guardroom at CTC. By implication, the guardroom staff were responsible for maintaining adequate stores of equipment required by the ASP, although that was not specified in writing, nor had the job been allocated to anyone specific within the guardroom. No-one in the line management chain for the guardroom had checked the logbook,

carried out any monitoring of the provision of stores or of compliance with the armed sentry procedures in respect of the guardroom functions. The responsibility for doing this was not specified or allocated to anyone. The lack of stores on the day of the accident was not a one-off occurrence and had been a problem over a long period.

There was complete absence of any structured proactive monitoring of whether the controls in the ASP were being applied or complied with, or that they were adequate to control the significant risk introduced. The ASP did not specify any arrangements for monitoring compliance on the common, nor was this specified anywhere else. Although various staff had cause to visit an exercise in progress, ostensibly for 'monitoring training' this was directed at quality of training delivery and progress of recruits. Nothing was specified about monitoring the ASP despite the high risk associated with it. Even simple checks of documentation that did exist (e.g. Guardroom logs annotated with comments about inadequate stores), or which should have but didn't (eg. duty handover records, Pamphlet 21 signed declarations) could have been done, but were not. It was clear that different teams and individuals had different ways of delivering the Armed Sentry role and there was widespread non-compliance with the detail of the ASP and Pamphlet 21. If effective monitoring had revealed this picture then the organisation could have taken remedial action in advance of this incident.

Some staff had raised concerns about the risks arising from the armed sentry procedure with senior officers prior to this accident. There is no evidence that these concerns were properly investigated. Had this been done, it would have provided an opportunity to identify non-compliance with orders or risks not adequately controlled by orders, and remedial action could have been taken.

The ASP had been in place for many years and although a review of sorts had taken place this was not comprehensive and did not take account of matters such as the effectiveness of the procedure in countering the perceived threat and whether the risks outweighed the benefits.

Circumstances leading to accident

780 Troop planned to do Exercise Hunters Moon on 27-31 March 2000 and were to remain on the common for the duration of the exercise. Capt [REDACTED] Troop Commander, initially assumed the role of the armed sentry. He visited the armory and booked out an SA80 rifle, which had not been zeroed for him. He later visited the guardroom and booked out the live ammunition. There was no tape available in the guardroom that day and the live magazines were not taped over or together either then or later. There were no orange armbands and no copies of the Armed Sentry Orders or Rules of Engagement. Capt [REDACTED] was not briefed on the orders by anybody that morning. He took the ammunition and signed the Armed Sentry booking out log in the guardroom on 2713100 despite not receiving tape, armband or copies of orders or having read the orders.

Instructors attention had been drawn to the ASPs shortly before the accident in Routine Daily Orders. Therefore all Training Team members should have been familiar with it. However, since none had been told in advance by Captain t h a t they would be required to carry out the duty none had taken note of the detail. Since Capt ██████ had not obtained a copy of the orders booklet when booking out from the guardroom, there was no copy available to staff on the exercise who didn't know what the duty required of them. They relied on instructions from Capt ██████ who also did not know the correct procedure.

The Troop deployed to Woodbury Common for the exercise. During the exercise the nominated sentry changed several times, with various members of the training team taking over the responsibility for the duty at some time. There was no formal handover, no signatures obtained to confirm transfer, and the precise details of who had the weapon/magazines and when cannot be confirmed. There is no evidence that normal safety precautions or live-blank transition procedures were followed at any time. At some point the sentry duty was transferred from Capt ██████ to Cpl ██████. One magazine was loaded onto the weapon and ██████ stated that he put the other into one of ██████ pouches. ██████ stated he drew ██████ attention to this, ██████ stated that he was unaware of the existence of the second magazine. The sentry weapon and attached magazine were later transferred to another person and at the time of the accident were known to have been in the team tent. The second magazine was forgotten and remained in ██████ possession. It was this magazine that he later mistook for blanks and loaded and discharged during the crash move, fatally wounding RctM Richards. If the ASP had been followed, this live magazine would have been taped over and taped to the other magazine and would not have been in a position or state whereby it was capable of being accidentally loaded onto a weapon.

On Thursday night the recruits set up overnight camp in a wooded copse, with sentries on duty. Captain < > had decided that the Troop was to be subject to a simulated enemy attack by the training team and to be required to immediately pack up camp and move location - a crash move. The instructors were to act as enemy and attack the camp. Not all instructors had brought weapons to the exercise so some borrowed weapons from sick/injured recruits who would not be taking part. They also took quantities of blank ammunition and pyrotechnics. At approximately 5am, whilst it was still dark, the training team mounted their attack. They approached quietly from different directions until challenged by a sentry and then they commenced a noisy attack, firing blanks and discharging pyrotechnics (thunderflashes). Corporal ██████ approached, firing his rifle, which was set on automatic, towards the camp. It was dark and his line of vision into the camp was obscured by vegetation so he would have had limited, if any, view of the recruits. Although not firing deliberately at any individual, it is apparent that he was firing in their general direction. He discharged a magazine of blanks, extracted a second magazine from a pouch on his webbing, loaded it onto his weapon and continued firing. The magazine contained 25 live rounds. 13 were discharged, dislodging the blank firing attachment fitted, before he

realised what had happened and stopped. 2 of the rounds struck Rct Richards who was some 15 metres away, almost directly in front of him

Summary

MOD Royal Navy (Royal Marines) did not take all reasonably practicable steps to ensure the health and safety of employees.

Significant organisational failings have been identified and can be summarised as including

- ◆ Inadequate risk controls built into the high hazard Armed Sentry Procedure (ASP), especially for prevention of contamination of blank training ammunition with live ASP ammunition.
- ◆ Complex voluminous documentation separated and obscured crucial Woodbury Common security information and ASP.
- ◆ Failure to effectively communicate ASP to all instructors expected to undertake duty.
- ◆ Failure to properly investigate staff concerns about the ASP (re risks of ammunition contamination/mix-up) raised prior to the accident
- ◆ Failure to achieve suitable skill and experience mix within 780 Troop training team
- ◆ Failure to maintain adequate stores of relevant ASP equipment in guardroom.
- ◆ Failure to devise or implement suitable systems or allocate responsibilities to monitor compliance with or adequacy of risk controls in the ASP, either in the guardroom or on the common.
- ◆ Failure to carry out adequate review of the need to continue with ASP.
- ◆ Failure to ensure that suitable and sufficient risk assessments were carried out for Exercise Hunters Moon and the conduct of crash moves.

We contend that these failures constitute a breach of section 2(1) of the Health and Safety at Work etc Act 1974. As a result of these failures, employees were exposed to significant risks to their health and safety.

HSE accepts that there were failings on behalf of individuals and acknowledges the Court Martial proceedings against Captain [REDACTED]. However in some respects it is easy to focus on those individuals closest to and most directly linked to the immediate circumstances of the incident. If the fullest lessons are to be learned from incidents like this it is important that the role of all the duty holders is examined and that is why we are here today. Each of the organisational failings I have outlined represents an opportunity to have done things differently - a chance to have broken the chain of events which eventually led to Wayne's tragic and unnecessary death. Just because some of those chances are remote from the accident in time or place does not make them any less significant in terms of their potential ability to have altered the course of events. Therefore it is crucial that the organisation accepts and acts to remedy these wider failings if it is to succeed in preventing further incidents.

MOD RESPONSE (Brigadier Robison)

Firstly, and very importantly, I would like to say on behalf of the Commander in Chief Fleet and the Ministry of Defence how very sorry we are that we failed in our duty to ensure the safety of Wayne Richards and that this young man tragically died during Exercise Hunter's Moon at the end of March 2000. Our deepest sympathies go to Wayne's family and friends for the distress and sadness that this bereavement has caused them.

_____ and will seek to demonstrate to them as well as HSE, that measures we have put in place, and the precautions we will henceforth apply, should ensure that such events will not happen again.

Secondly, I would like to state quite clearly that it is the MoD'S policy to comply at all times with the Health and Safety at Work Act 1974 (henceforth referred to in what I intend to say as the Act) and its subordinate legislation. We would not knowingly allow a disregard for the safety procedures that led to this death. Having said that, we fully accept that we did not conduct the procedures on the day of the incident in a way that ensured, so far as was reasonably practicable, that MoD personnel undergoing and providing training, including Wayne Richards, were not exposed to risks to their health and safety. We admit, therefore, that we were in breach of section 2(1) and 7 of the Act, as HSE has set out in its Crown Censure Case Summary. On behalf of the MoD I fully accept the specific findings that they have detailed and hope that my presence at this hearing today demonstrates how seriously the Department as a whole regards the failings identified by HSE.

For the sake of absolute clarity, I should like to describe my own role and responsibilities for health and safety at the Commando Training Centre Royal Marines Lympstone (CTCRM). I am the 1 Star senior officer responsible for all training activities carried out at CTC and it is my responsibility, as it would have been for my predecessor at the time of this incident, to ensure compliance with the Act and with MoD policy for health and safety, as promulgated by the Secretary of State for Defence. I have a health and safety adviser on my staff to assist with these responsibilities and can seek independent advice and scrutiny from the Chief Environment and Safety Officer (Royal Navy).

The MoD has undertaken a number of formal and rigorous processes in order to identify the cause of this tragic death: chiefly through a Board of Inquiry, an investigation by the Army's Land Accident Investigation Team, and an investigation by the Special Investigation Branch of the Royal Military Police. These investigations concluded that the single most important cause of this incident was the disregard by the Troop Commander for an established Armed Sentry Procedure, which resulted in the inadvertent firing of live rounds, leading to the fatal wounding of Wayne Richards, whilst exercising on Woodbury Common. However, the MoD also recognises that this incident revealed serious safety management shortfalls.

The Devon and Cornwall Constabulary conducted an independent investigation, following which the Crown Prosecution Service found insufficient evidence to bring criminal charges against the Troop Commander. However, the MoD did take disciplinary action against this officer under the jurisdiction of the Army Act 1955 for his disregard of the Armed Sentry Procedure. At a Court Martial in December 2003 the officer concerned pleaded guilty to two charges of disobedience to standing orders contrary to Section 36(1) of the 1955 Act. He was fined, reprimanded and deprived of seniority at his rank.

Board of Inquiry

The Board of Inquiry, subsequently convened in April 2004, made the following specific recommendations concerning the use and conduct of the Armed Sentry Procedure:

- a. That where guarding by armed sentries is required during training serials that either armed MoD police or dedicated armed military sentries, wholly separate from the training team, are to be used.
- b. That, whenever Armed Sentry Procedure is required, active safety briefing, rather than reliance on passive communication, will be undertaken.
- c. That the Commandant of the Commando Training Centre will ensure that the lessons learned from this incident concerning the safe use of armed sentries are communicated effectively to his successor as part of the formal handover of duties.
- d. That the security threat to personnel training on Woodbury Common Training Area will be reviewed regularly and the level of protection scaled accordingly.

Specific concerns of the HSE

Turning now to the specific concerns expressed by the HSE, I would like to offer the following responses and describe the measures that have been put in place to address them.

- a. Risk Assessment. Back in early 2000 a risk assessment was not in place for Exercise Hunter's Moon. Risk assessments are now conducted for all aspects of training at CTCRM, in accordance with MoD Policy.
- b. Requirement for the Troop Sergeant to be experienced in the Armed Sentry Procedure. It is agreed that at the time of the incident neither the Troop Sergeant, nor any of his corporals, were familiar with the Armed Sentry Procedure and had they been their intervention may have corrected the Troop Commander's actions. This lack of familiarity was, however, due in part to the unease felt by some at CTCRM over

the need to perform the Armed Sentry Procedure in addition to their training roles. The separation of training and guarding roles has decisively addressed this point.

c. Provision of Safety Awareness Training. At the time of the incident, the Troop Commanders' Handbook did not contain the Armed Sentry Procedure and the Instructors' Induction Course had limited safety content, making only passing reference to that Procedure. All Troop Commander and instructor safety training now includes specific reference to safety critical procedures performed at CTCRM and reinforces responsibilities for health and safety and the requirement to risk assess all activities. Troop Commanders are also explicitly required to sign a declaration that they have studied all safety critical procedures and understood them.

d. Separation of Armed Sentry and Training Roles. The practice of the ASP in conjunction with the training role, which led to the accident, has been discontinued. Whenever armed sentries are required we will ensure:

(i) Total separation between training and armed sentry duties by the deployment of Armed Ministry of Defence Police or dedicated armed military sentries.

(ii) That the armed sentry procedure is unambiguous and clear, and is reviewed at regular intervals.

(iii) That full training and familiarisation with the armed sentry duties is provided and recorded as having been provided, with specific responsibility for certifying this procedures falling to the Commanding Officer and Adjutant of CTCRM.

(iv) That full and clear verbal and written briefings are given at the point of issue of live ammunition (Guard Room), and that these too will be formally recorded.

(v) That adherence to the procedures is regularly checked and recorded.

(vi) That a second, documented and independent, check on any change in responsibility for live ammunition or changes to armed sentry personnel will be carried out.

(vii) That safety critical instructions are unmistakably highlighted and not subsumed in other less important Establishment Standing Orders.

(viii) That all concerns raised about safety critical procedures are fully documented and investigated by the site Health and

Safety Adviser, and are auditably brought to the attention of the Commanding Officer or Adjutant where necessary.

A revised procedure for armed sentries has been produced to address the above points and is for use whenever armed guarding during training exercises is required.

Concluding Remarks

From what I have described to-day you will see the measures that have been taken to address the safety management shortfalls at CTCRM at the time of this very sad accident. Once this Crown Censure procedure is completed, I will look to the Royal Navy's Chief Environment and Safety Officer to continue to provide me, as the Commandant at CTCRM, with continuing independent review and assurance that my health and safety standards remain as high as is reasonably practicable, and are compliant with the Act and MoD policy. The lessons learnt from this incident will be disseminated to all Commanding Officers and Heads of Establishment.

I would like to conclude by expressing again on behalf of the Ministry of Defence our deep regret and sadness that we failed to ensure the health and safety of Wayne Richards. I sincerely hope that I have provided assurance, to both the HSE and particularly to Wayne's family and friends, that the investigations and remedial work which I have set out for you will continue to eliminate the risk of injury or fatal wounding from live ammunition by armed sentries during training exercises at CTCRM.

CONCLUDING SUMMARY (Max Walker)

Thank you for that clear statement of acceptance of responsibility

First of all I must add to the expression of sympathy to the family of Wayne Richards. These are tragic circumstances and which of us in the room can imagine the anguish of a parent losing a teenage son. These proceedings cannot possibly bring that son back but I hope that there might be some consolation in the fact that changes have and are being made to prevent other people's sons and daughters losing their lives in similar ways in training activities.

Having heard also all the circumstances of the case and representation from the Ministry of Defence I am convinced that the failings that contributed to the tragic death of Wayne Richards were as a result of a failure to:

- a) Ensure suitable and sufficient risk assessments were carried out for Exercise Hunters Moon and the conduct of crash moves
- b) To provide, communicate and maintain safe systems of work for Armed Sentry Procedure
- c) To monitor the effectiveness of risk control measures

and that the MoD consequently did not comply with section 2 of the Health and Safety at Work Act. These failings are such that I am also convinced that the evidence would be sufficient to provide a realistic prospect of conviction in the civilian Courts. HSE has taken the correct action in formally censuring the MOD through this procedure. HSE therefore formally censures the MOD and will notify the headquarters of MOD who must prepare a briefing for ministers.

I note and very much welcome the substantial improvements outlined today with regard to the conduct of training. HSE does not want to interfere with the training and development of individuals or teams within the Armed Services. I hope that we understand how important such training is for the effective performance of the Armed Services under operational conditions. The risks during training are generally more predictable and controllable than in operations. It is important you have the competence and proper instructions and a supportive management framework of monitoring and review.

I welcome in particular

- a) full implementation of risk assessment processes
- b) the clear separation of armed sentry and training role
- c) active safety briefing and improved safety awareness training
- d) monitoring and checking of processes in place for safety controls

I know HSE colleagues will be pleased to continue to work with the MOD to get the balance right between challenging training and appropriate risk management accepting fully that all risks cannot be totally eliminated.

This censure will be a matter of public record. Brief details will be placed on HSE's enforcement database and website. A record of these proceedings will be open under the Freedom of Information Act.