



Defence
Safety Authority

Service inquiry

Death of a service person
following completion of a
military exercise at Drifffield
Fieldcraft Training Area

21 September 2023

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Part 1.1

Covering note & glossary

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Part 1.1 – Covering note

DSA DG/SI/04/23

21 Sep 24

DG DSA

Service inquiry into the death of a service person following completion of a military exercise at Driffeld Fieldcraft Training Area on 21 September 2023

1. The service inquiry panel assembled at MOD Boscombe Down, on 11 October 2023 by order of the Director General of the Defence Safety Authority (DG DSA) for the purpose of investigating the accident involving Private Nabin Thapa, 6 Regiment Royal Logistic Corps on 21 September 2023, and to make recommendations in order to prevent reoccurrence. The panel has concluded its inquiries and submits the provisional report for the convening authority's consideration.

2. The following inquiry papers are enclosed:

Part 1	Report	Part 2	Record of proceedings
Part 1.1	Covering note and glossary	Part 2.1	Diary of events
Part 1.2	Convening orders & TORs	Part 2.2	List of witnesses
Part 1.3	Narrative of events	Part 2.3	Witness statements
Part 1.4	Findings	Part 2.4	List of attendees
Part 1.5	Recommendations	Part 2.5	List of exhibits
Part 1.6	Convening authority	Part 2.6	Exhibits
comments		Part 2.7	List of annexes
		Part 2.8	Annexes
		Part 2.9	Schedule of matters not germane to the inquiry
		Part 2.10	Master schedule

[Signature]

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Royal Navy
President

[Signature]

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Army
Panel Member 1

[Signature]

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Royal Air Force
Panel Member 2



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Glossary

6RLC	6 Regiment Royal Logistics Corps
7LMBCT	7 Light Mechanised Brigade Combat Team
32 Sqn	32 Squadron
62 Sqn	62 Squadron
600 HQ Sqn	600 Headquarters Squadron
ACSO	Army Command Standing Order
Adjt	Adjutant
AED	Automated external defibrillator
AGAI	Army General and Administrative Instruction
ALARP	As low as reasonably practicable
APRC	Army Personnel Research and Consultancy
APSG	Army Personnel Services Group
ARITC	Army Recruiting and Initial Training Command
ATC	Army Training Centre
ATSB	Australian Transport Safety Bureau
BAeBB	British Army electronic battle box
BAMS	Bidding and Allocation Management System
BCS	Battlecraft syllabus
BSG Tac HQ	Brigade Support Group Tactical Headquarters
CAD Log	Computer-aided despatch log
Capt	Captain
Ch	Chapter
CMT	Combat medical technician
CO	Commanding officer
Cpl	Corporal
CPR	Cardiopulmonary resuscitation
CSI	Crime scene investigation
CT	Collective training
CTL	Collective training level
DAIB	Defence Accident Investigation Branch
DG DSA	Director General of the Defence Safety Authority
DIO	Defence Infrastructure Organisation
DIU	Defence Inquests Unit
DMICP	Defence Medical Information Capability Programme
DMS	Defence Medical Services
DMSR	Defence Medical Services Regulator
DPHC	Defence Primary Healthcare
DSCU	Defence Serious Crime Unit
DURALS	Defence Unified Reporting and Lessons System
EASP	Exercise action safety plan
ECG	Electrocardiogram

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ECO	Exercise conducting officer
ED	Exercise director
Ex IK	Exercise INKAS KHANJAR
FATD	Field Army training directive
FE	Force elements
FIFA	Fédération Internationale de Football Association
FM	Fire and manoeuvre
FOC	Full operational capability
FTA	Fieldcraft training area
GP	General practitioner
HEMS	Helicopter Emergency Medical Services
HF	Human factors
HLS	Helicopter landing site
HM	His Majesty
HQ	Headquarters
	
Hrs	Hours
IMA	Initial medical assessment
INM	Institute of Naval Medicine
IPC	Initial planning conference
IR	Integrated review
ITR	Individual training requirement
IWS	Infantry weapons systems
JCCC	Joint Casualty and Compassionate Centre
JOMOC	Joint Operational Meteorology and Oceanography Centre
JPA	Joint Personnel Administration
JSP	Joint Service Publication
Lt	Lieutenant
LVACM	Left ventricular variant arrhythmogenic cardiomyopathy
Maj	Major
MEL	Main events list
Min	Minutes
NATO	North Atlantic Treaty Organisation
NCO	Non-commissioned officer
NHS	National Health Service
NoK	Next of kin
NOTICAS	Notification of casualty
NRF	NATO Reaction Force

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OC	Officer commanding
OIC	Officer-in-charge
OMQ	Online medical questionnaire
OPFOR	Opposing forces
Pam 21	Pamphlet 21
PCR	Patient care record
PHEC	Pre-hospital emergency care
PM	Post-mortem report (Autopsy report)
PO	Planning officer
PSMA	Pre-Service medical assessment
Pte	Private soldier
RA	Risk assessment
RAFCAM	Royal Air Force Centre for Aviation Medicine
RMAS	Royal Military Academy Sandhurst
ROLE	Recognition of life extinct
SA (M) 18	Small arms ('Mike') 18 qualification
SCD	Sudden cardiac death
Sec	Seconds
Sect Comd	Section Commander
SEMS	Safety and environmental management system
SI	Service inquiry
SIB	Special Investigation Branch
SNCO	Senior non-commissioned officer
SP	Service person
Sqn	Squadron
SSW	Safe Systems of Work
STWO	Squadron technical warrant officer
Tp Comd	Troop Commander
TRiM	Trauma risk management
UTC	Coordinated universal time
VF	Ventricular fibrillation
VJTF(L)	Very-high readiness Joint Task Force (Land)
VT	Ventricular Tachycardia
WHO	World Health Organisation
WO2	Warrant officer class 2
YAS	Yorkshire Ambulance Service

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Part 1.2

Convening order and TORs

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Service Inquiry Convening Order

11 October 2023

SI President
SI Members

Hd DAIB
DSA HQ Legad

DAIB Mentor
DAIB Office Manager

Copy to:

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PS/Min(Lords)
PS/Min(DPV)
PS/Min(DP)
PS/PUS
PS/2PUS
DPSO/CDS
MA/VCDS

MA/CNS
MA/CGS
PSO/CAS
PSO/COMD UKStratCom
MA/DCGS
MA/CFA
MA/DSA Dep-DG
Dir DDS

DSA-HQ COO
Army StratCen-CSG-Hd
EA/DDC Dir
DDC Head of News
DDC PR News Army
APSG-PersSvcS-DACOS
APSG-PersSvcS-BAS-SO1
APSG-PersSvcS-SI-SO1

DSA/SI/04/23 – Service inquiry into the death of a soldier in a military training exercise on the Driffield Fieldcraft Training Area on 21 September 2023

1. In accordance with Section 343 of the Armed Forces Act 2006 and Joint Service Publication (JSP) 832 – Guide to Service Inquiries¹ and as Director General of the Defence Safety Authority (DG DSA), I have elected to convene a safety service inquiry (SI).
2. The purpose of this SI is to investigate the circumstances surrounding the incident and make recommendations to prevent reoccurrence.
3. The SI panel members will commence their administrative briefings at 1000 hours on Wednesday 11 October 2023 at the Defence Accident Investigation Branch (DAIB), B120 at MOD Boscombe Down. The SI will be formally convened by me at 1400 hours on Wednesday 11 October 2023.
4. The SI panel comprises three members:

President:

Members:

legal advisor to the SI is

. Technical investigation/inquiry support is to be provided by the DAIB and the

nominated mentor for this SI is [REDACTED]

6. The SI panel is to investigate and report on the facts relating to the matters specified in its terms of reference (TOR) at Annex A. The SI panel is to comply with its TOR and record all evidence and express opinions as directed therein. An initial report is to be submitted to me by **Wednesday 15 November 2023**.

7. Attendance at SI activities by advisors/observers, unless extended by the convening authority, is limited to the following:

Head DAIB – unrestricted attendance.

DAIB investigators in their capacity as advisors to the SI panel – unrestricted attendance.

Human factors specialists in their capacity as advisors to the SI panel – unrestricted attendance.

Medical subject matter expert as nominated by Defence Medical Services Regulator – unrestricted attendance

8. The SI panel will continue its induction training at the DAIB facility at MOD Boscombe Down immediately after the SI's convening. Permanent working accommodation, equipment, and assistance suitable for the nature and duration of the SI will be requested at a location proposed by the president and decided by Hd DAIB in due course.

9. Reasonable costs will be borne by DG DSA under UIN [REDACTED]

[REDACTED]

S J Shell CB OBE MA
Air Marshal
DG DSA – Convening Authority

Annex:

A. Terms of reference for the service inquiry into the death of a soldier in a military training exercise on the Drifffield Fieldcraft Training Area on 21 September 2023.

Record of Changes

Date	Change No.	Detail	Made by

Terms of reference for the service inquiry into the death of a soldier in a military training exercise on the Driffield Fieldcraft Training Area on 21 September 2023

1. As the nominated panel for the subject service inquiry (SI), you are to:
 - a. Investigate and, if possible, determine the cause of the accident, together with any contributory, aggravating and other factors and observations.
 - b. Investigate any medical factors that may touch upon the accident.
 - c. Ascertain whether the service personnel (SP) involved were acting in the course of their duties.
 - d. Examine what policies, orders and instructions were applicable and whether they were appropriate and complied with.
 - e. Assess health and safety at work and environmental protection implications in line with JSP 375 and JSP 418.
 - f. Establish the level of training, relevant competencies, qualifications, and currency of the individuals involved in the accident.
 - g. Identify if the levels of planning and preparation were commensurate with the activities' objectives.
 - h. Review the levels of authority and supervision covering the task during which the incident occurred.
 - i. Investigate and comment on climatic conditions, and relevant fatigue implications of the individual's activities prior to the matter under investigation, and any human factors that may have played a part in this accident.
 - j. Examine previous similar incidents in order to identify wider issues and trends and to consider whether any lessons identified have been actioned.
 - k. Report and make appropriate recommendations to DG DSA.
2. The investigation should not seek to attribute blame and you should use JSP 832 Guide to Service Inquiries and DSA 03.10 as guidance for the conduct of your inquiry. You are to report immediately to DG DSA should you have cause to believe a criminal or Service offence has been committed.
3. If at any stage the panel discovers something that they perceive to be a continuing hazard presenting a risk to the safety of personnel or equipment, the president should alert DG DSA without delay to initiate remedial actions. Consideration should also be given at this time to raising an Urgent Safety Notice¹.

¹ This could be an advice or a recommendation safety note.

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Part 1.3

Narrative of events

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Part 1.3 – Narrative of events

Synopsis

1.3.1. At approximately 13:10¹ on 21 September 2023, during a military exercise on the Driffield Fieldcraft Training Area (FTA) (Figure 1.3.1), a service person (SP) collapsed without warning. The SP, Private (Pte) Nabin Thapa, a member of 62 Squadron (62 Sqn), 6 Regiment Royal Logistics Corps (6RLC), received first aid at the scene, but despite this, never regained consciousness and was declared life extinct on arrival at [REDACTED] at 14:49.



Figure 1.3.1 – Driffield FTA, North Yorkshire.

1.3.2. The accident occurred on the final day of Exercise INKAS KHANJAR (Ex IK), an exercise run by 6RLC as part of their preparations prior to joining the very-high readiness Joint Task Force (Land) (VJTF(L)).² Pte Thapa was participating in the exercise alongside other members of 62 Sqn, members of 32 Close Support Sqn (32 Sqn) and members of 600 HQ Sqn.

The lead-up to exercise INKAS KHANJAR (Ex IK)

1.3.3. This section of the report aims to give the reader an understanding of changes that were taking place in the organisation of the British Army, that ultimately led to 6RLC conducting Ex IK.

¹ All times are local time universal time coordination +1 (UTC+1) i.e. British or Western European summertime.

² A North Atlantic Treaty Organisation (NATO) commitment, discussed below.

1.3.4. In March 2021 Her Majesty's Government completed a comprehensive review of the UK's national security and international policy, known as the Integrated Review (IR).³ The IR, and associated Defence command paper led the Army to establish the Future Soldier Programme⁴ which formed part of a re-balancing exercise aimed at ensuring the Army could deliver its operational outputs, particularly in areas such as logistics. As a result of these changes, on 1 May 2022, 6RLC was re-subordinated⁵ from 102 Logistic Brigade to 7th Light Mechanised Brigade Combat Team and Headquarters East (7LMBCT).⁶

1.3.5. The UK was periodically required to assign force elements to [REDACTED]

1.3.6. 6RLC's re-subordination to 7 LMBCT, required a transition from their role as a force logistics regiment, to a more mobile light close support logistics regiment. In order to achieve this change, 32 Sqn, which had been suspended following the disbandment of another regiment,⁷ was reinstated as a squadron of 6RLC. The regiment was declared to be at full operational capability (FOC) on 1 September 2023, once the changes outlined above had been completed.

1.3.7. As the sole close support logistics regiment of 1st (United Kingdom) Division, 6RLC was tasked with providing a composite logistics squadron and brigade support group tactical headquarters (BSG Tac HQ) for VJTF(L), to be available at 48 hours' notice to deploy. This readiness state, known as R1, was to be adopted on 1 January 2024.

6RLC

1.3.8. At the time of Pte Thapa's accident, 6RLC was based at Dishforth Airfield, Thirsk. The regiment was established for [REDACTED] personnel, split across four squadrons.

Key personalities

1.3.9. The service inquiry panel, referred to as 'the panel' throughout this report, will outline the roles played by individuals before, during and after the accident on 21 September 2023. With the exception of Pte Thapa, the names of all those involved have been anonymised. Witnesses or exercise participants have been given the descriptor of Soldier 1, 2, 3 etc, whilst key personnel are described with their ciphers below:

³ Integrated Review 2021 accessed 19 March 2023 at: <https://www.gov.uk/government/collections/the-integrated-review-2021>

⁴ At the time of publication the future soldier programme stated: "The future Army will be optimised to counter the increasingly wide range of threats to the UK, its people, and its interests. It will be smaller, but more agile, expeditionary and lethal; able to compete above and below the threshold of open warfare in concert with Allies and Partners."

⁵ The endorsed lexicon for a structural change within the Army.

⁶ 7LMBCT was under the operational command (OPCOM) of General Officer Commanding (GOC) 1st (United Kingdom) Division.

⁷ 3 Regiment RLC, to which 32 Close Support Squadron originally belonged, was disbanded on 31 December 2022.

a. **Commanding officer (CO).** The CO commissioned into the RLC in [REDACTED] and assumed command of 6RLC on [REDACTED]. The CO did not deploy on Ex IK, but did visit the exercising troops during the morning of 21 September 2024.

b. **Officer 1.** Officer 1 commissioned into the RLC in [REDACTED]. They joined 6RLC in [REDACTED] in the rank of major. On 21 September 2023 Officer 1 was deployed on Driffield FTA as part of the exercise.

c. **Officer 2.** Officer 2 commissioned into the RLC in [REDACTED]. They joined 6RLC in [REDACTED] in the rank of lieutenant. On 21 September 2023 Officer 2 was deployed on Driffield FTA as part of the exercise.

d. **Officer 3.** Officer 3 commissioned into the RLC in [REDACTED]. They joined 6RLC in [REDACTED] in the rank of captain, they did not deploy on the exercise.

e. **Officer 4.** Officer 4 commissioned into the RLC in [REDACTED] and joined 6RLC as a troop commander in the rank of lieutenant in [REDACTED]. Officer 4 was present throughout the period during which Pte Thapa was receiving first aid and accompanied Pte Thapa to hospital in the ambulance.

f. **Officer 5.** Officer 5 commissioned into the RLC in [REDACTED]. They joined 6RLC in [REDACTED] in the rank of Major. Officer 5 was not present during the exercise.

g. **Senior non-commissioned officer (SNCO) 1.** SNCO 1 joined the Army in [REDACTED]. They joined 6RLC on [REDACTED] in the rank of warrant officer. SNCO1 was present throughout the period during which Pte Thapa was receiving first aid.

h. **SNCO 2.** SNCO 2 joined the Army in [REDACTED]. They joined 6RLC in [REDACTED] in the rank of sergeant.

i. **Non-commissioned officer (NCO) 1.** NCO 1 joined the Army in [REDACTED], joining 10 Queen's Own Gurkha Regiment. In 2013 they transferred to the RLC as a supplier and joined 6RLC in [REDACTED], in the rank of corporal.

j. **Soldier 1.** Soldier 1 joined the Army in [REDACTED] and was assigned to 6RLC on [REDACTED].

k. **Soldier 2.** Soldier 2 joined the Army in [REDACTED] and was assigned to 6RLC [REDACTED].

l. **Soldier 3.** Soldier 3 joined the Army in [REDACTED] and was assigned to 6RLC in [REDACTED].

m. **Soldier 4.** Soldier 4 joined the Army in [REDACTED]. They joined 6RLC in [REDACTED] on promotion to warrant officer class 2. They provided communications to the emergency services during the accident.

n. **Soldier 5.** Soldier 5 joined the Army in [REDACTED] and joined 6RLC in [REDACTED].

o. **Pte Thapa.** Pte Thapa joined the Army on 18 March 2019. He completed Phase 1(basic) training on 21 June 2019 and was assigned to 6RLC on 31 August 2019 as a supplier. During his time at 6RLC Thapa undertook his Phase 2 training at the Defence School of Transport in Leconfield. Pte Thapa deployed on the Driffild FTA for the duration of the exercise.

Exercise INKAS KHANJAR

1.3.10. When 32 Sqn was reinstated into 6RLC it was scaled for [REDACTED] personnel and was, at the time of the accident, still in the early stages of being brought back to FOC. The officer commanding (OC) the squadron held the rank of major and, once the squadron reached FOC, it would comprise three combat support troops.⁸ By September 2023, only two of the three troops within 32 Sqn had its full complement of personnel. The exercise director (ED) explained that at that time, the primary objective of 32 Sqn's OC was to prepare for future regimental tasking, which required a period of training and validation. Ex IK formed part of that preparation.

1.3.11. To prepare for their contribution to VJTF(L) 6RLC was undergoing a period of collective training (CT) and validation. This training was aimed at preparing teams to function as a cohesive force; 6RLC required all squadrons to be validated up to CT level CHARLIE. Table 1.3.1 outlines the training levels up to and including sub-unit.

⁸ A combat support troop consisted of a troop commander, military transport sergeant, troop administration sergeant, section commander, section second-in-command and a complement of drivers, and driver communication specialists.

Training level	Training output scale	Validated by	Defence training level	Defence training level definition
ALPHA	Crew/section	Sub-unit commander	Tier 0	Sub-unit training prepares individuals to operate as teams below unit level.
BRAVO	Troop/platoon	Sub-unit commander		
CHARLIE	Special-to-arm unit	Unit Commander.		

Table 1.3.1 – Collective training levels⁹

1.3.12. Ex IK was planned to take place between 18-24 September 2023, on the Driffield FTA, a former MOD airfield. The area was managed by the Defence Training Estate (DTE), a division of the Defence Infrastructure Organisation (DIO) who were responsible for providing a safe and secure training environment. Driffield FTA, shown in figure 1.3.2 was located approximately fifty miles Southeast of 6RLC's base at Dishforth Airfield.



Figure 1.3.2 – Driffield FTA

1.3.13. The aim of Ex IK was to provide an opportunity for 32 Sqn and 600 HQ Sqn to train to CT level BRAVO ahead of higher-level validation planned for December 2023. 62 Sqn, which had already been validated to CT level BRAVO, took the opportunity to join the exercise to conduct its own training, whilst simultaneously providing support to the other two exercising squadrons. The requirement to provide composite logistic support squadrons to VJTF(L),

⁹ Taken from Field Army Training Directive chapter 3, page 3-4, para 3-17 (b).

necessitated the period of CT that resulted in Ex IK taking place between 18-21 September 2023.

Deploying on Ex IK

1.3.14. On the morning of Monday 18 September 2023 elements of 600 HQ Sqn, 32 Sqn and 62 Sqn formed up in convoy ready to depart for the Driffield FTA. Immediately prior to departure personnel were ordered to hand-in their personal mobile phones until completion of the exercise. After a short brief, detailing the route to be taken, the vehicles departed Dishforth at approximately 10:00.

1.3.15. Personnel deployed to the exercise area wearing body armour and helmets and carrying their personal weapons. The majority of vehicles arrived at approximately 11:00¹⁰ whereupon they dispersed to their various harbour positions and 62 Sqn began to camouflage their vehicles.¹¹ Figure 1.3.3 details the start positions of the three exercising squadrons.

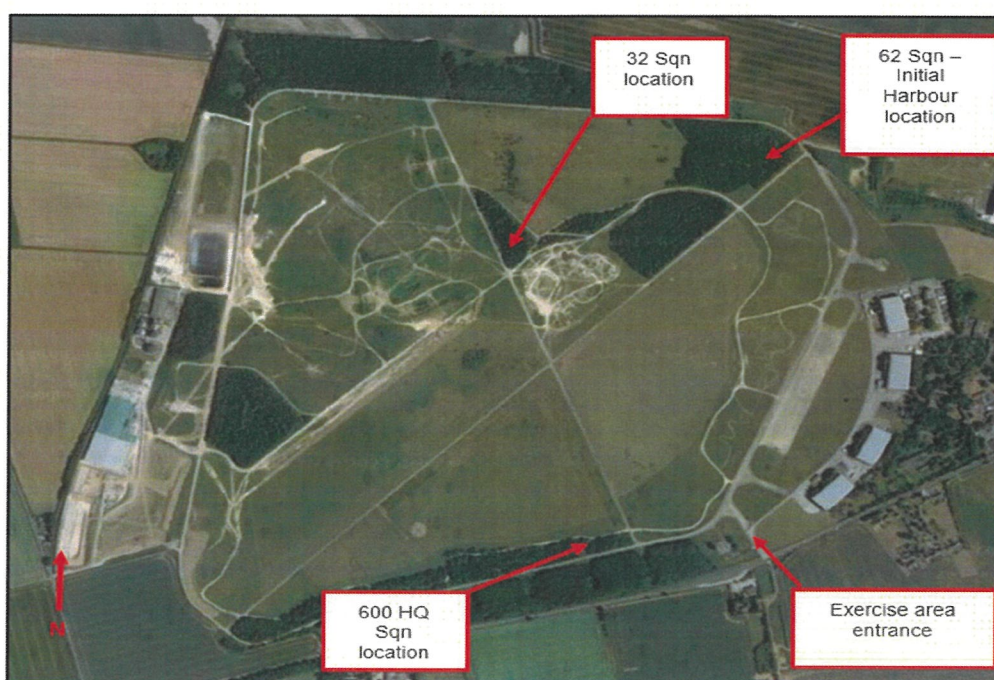


Figure 1.3.3 – Initial squadron locations

1.3.16. The remaining vehicles, along with eight SP arrived at approximately 1700. A further two SP arrived the following day.

¹⁰ During the transit to the exercise area a vehicle belonging to 62 sqn became stuck by the side of the road and had to be recovered. This led to some vehicles not arriving at the FTA until later.

¹¹ Harbour areas were needed for normal halts, for traffic control and to avoid congestion in emergencies but may be developed into staging areas, providing more permanent facilities.

1.3.17. The first three days of the exercise concentrated on trade serials¹² within individual squadrons. Additionally, there were several broader scenarios, controlled and executed by 32 Sqn personnel aimed at testing the security of both 62 and 32 Sqn harbour positions. The main events list (MEL) for the exercise was produced by 32 Sqn; 62 Sqn relied on the same MEL, conducting their own training serials, in line with their specific training objectives, outside of MEL serials.

1.3.18. **Meteorology.** The weather forecast for the week was in keeping for the time of year. It was generally warm with a temperature range of between 9.6°C and 20.1°C. Showers were forecast for the first three days of the exercise, drying up later in the week.

Day 1 – 18 September 2023

1.3.19. The main force arrived at Drifffield FTA at approximately 11:00 and harbour positions were established whilst concurrently taking the opportunity to conduct training lessons and tasks in line with the MEL. Camouflage and concealment training was the final lesson of the day. 32 Sqn personnel entered a period of enforced rest until the following morning.

1.3.20. For a variety of reasons, including the small number of available SP and the staggered arrival of vehicles, 62 Sqn did not finish camouflaging and concealing their vehicles until approximately 22:30. There was a requirement to post sentries around the harbour area throughout the exercise to defend against any opposing forces (OPFOR) and for real-time security to prevent the incursion of civilians onto the area.¹³ On the first day, in an attempt to ensure personnel maximised their rest, NCO 1 added all personnel other than Officer 4 to the sentry list. Two sentries were on watch at any one time and adopted roving patrols, rather than taking up static positions. 62 Sqn personnel did not enter an enforced rest period.

Day 2 – 19 September 2023

1.3.21. After reveille on the second day, Officer 4 directed 62 Sqn personnel to re-camouflage their vehicles, as they deemed the concealment carried out on the evening of Day 1 to be inadequate. Thereafter, there followed some trade-training serials that had not been delivered on the first day; the training was on discrete topics such as powering up the 'box-body'.¹⁴ As per the previous evening, personnel were required to keep sentry, however, Officer 4 directed that personnel would adopt static positions to cover a full 360° arc

¹² Trade serials were training serials pertinent to the SP's army trade ie supplier, driver, infantry etc.

¹³ Drifffield FTA was accessible to members of the public, as such there was a requirement to keep a real-time sentry to ensure civilians did not access the harbour area for their own safety, as well as the security of military equipment at potential risk of theft.

¹⁴ A mobile office, powered by a mobile generator.

around the harbour position. Each position contained two sentries meaning that six SP were on watch at any one time.

Day 3 – 20 September 2023

1.3.22. 62 Squadron reveille took place at approximately 06:30 with personal administration and harbour routine being the first tasks of the day. Following reveille, the section commander was tasked to drive a vehicle from the harbour position to a location where personnel from 32 Squadron could reach it for a resupply serial, in accordance with the MEL. At approximately 10:00, on completion of the resupply serial, Pte Thapa delivered lessons on how to correctly report the identification of individuals and vehicles to other units, after which Soldier 1 delivered a training serial on how to conduct a section attack.¹⁵

1.3.23. Following a break for lunch, NCO 1 led a question-and-answer (Q&A) session lasting approximately 10-15 minutes. During this period, members of 32 Sqn, acting as OPFOR, conducted an attack against the 62 Sqn harbour position. Considering their harbour position to have been compromised, Officer 4 made the decision to relocate to a new position on the exercise area, as shown in Figure 1.3.4.

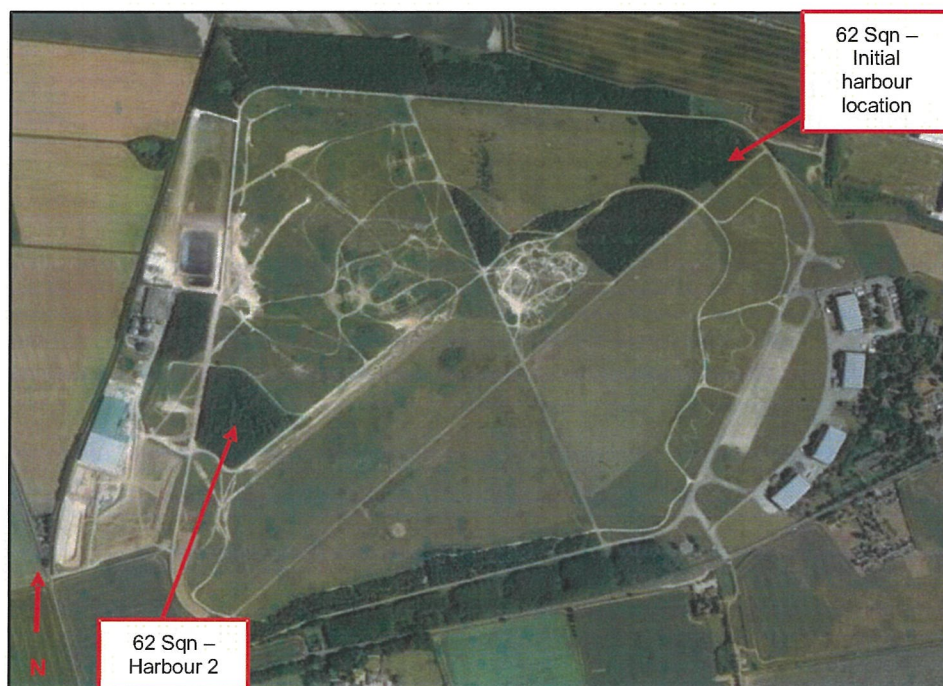


Figure 1.3.4 – 62 Sqn harbour move on 20 September 2023

¹⁵ Although not an instructor Pte Thapa was tasked, along with other members of his squadron, to deliver various lessons throughout the exercise, this was a means of ensuring knowledge was shared amongst soldiers.

1.3.24. The relocation to the second harbour area began at about 16:30 and was complete by approximately 22:30. The move required the vehicles to be concealed and re-camouflaged, a process that was conducted during the hours of darkness. As the move was to be a tactical serial, the use of white-light was prohibited.¹⁶

Day of the accident – 21 September 2023

1.3.25. On the morning of the accident, reveille was at approximately 06:30, and was followed by a stand-to of around 15 minutes.¹⁷ At 08:00 NCO 1 noticed people in civilian clothing near the harbour position and, having considered them to be OPFOR, they raised the alarm. Shortly afterwards, the OPFOR released a smoke grenade and shouted 'gas, gas, gas' to simulate a possible chemical weapons attack.¹⁸ Members of 62 Sqn then donned their respirators in response. At this point Pte Thapa was wearing his helmet, a waterproof layer over his combat jacket and had his body armour on.

1.3.26. At 08:11 a report was sent by 62 Sqn to the HQ informing them that the OPFOR were departing the area. They also reported two members of 62 Sqn as exercise casualties, one of which was Pte Thapa. At 08:12, Officer 4 reported to HQ that they were conducting a clearance patrol to ensure OPFOR were no longer in the area. At 08:27 the serial was reported as complete and both 'casualties' returned to the 62 Sqn harbour position. The purpose of the serial that morning was to assess whether 62 Sqn had learned lessons from the previous day's attack, and to evaluate whether there had been improvements in their responses. Officer 1 deemed that the drills had been completed successfully and to their satisfaction.

1.3.27. Whilst Officer 1 was content with 62 Sqn's response to the exercise, Officer 4 determined that the team could improve on their performance and instructed NCO 1 to spend time rehearsing members of the squadron on section attacks and clearance patrols. NCO 1 conducted a theory lesson prior to exercising the troops on those drills in the vicinity of the harbour area. The extra training was completed by approximately 11:00 after which NCO 1, Officer 4 and SNCO 2, debriefed members of the squadron on their execution of the drills.

1.3.28. At 10:29 a data message¹⁹ was sent by 600 HQ Sqn to all sub-units to the effect that 'all remaining unboxed ammunition was to be used in section attack or fire team manoeuvre training by 13:00 local time'. Following that direction, Officer 4 ordered NCO 2 to redistribute the remaining unboxed ammunition amongst the soldiers for use during section attack and fire and manoeuvre (FM) exercises.

¹⁶ White-light refers to the use of torches or lanterns that have not been covered with a coloured filter.

¹⁷ Stand to, a state of readiness assumed by ground troops at dawn and dusk in wartime.

¹⁸ The UK Armed Forces labelled such attacks as CBRN (Chemical, Biological, Radiological and Nuclear).

¹⁹ Data message / system was a communications digital platform used when not using voice communications.

1.3.29. At some point after 11:00, once the remaining ammunition had been distributed amongst participating soldiers, the section attack and clearance patrol exercise took place in the area outlined in figure 1.3.5 below. It took approximately 15 minutes to complete, during which two enemy positions were cleared. During the exercise Pte Thapa was observed by Soldier 2 to fall and hit his head on his own rifle. Pte Thapa immediately got to his feet and carried on with the exercise seemingly unaffected. Aside from Soldier 2, no other members of the team saw Pte Thapa's fall.

1.3.30. On completion of the clearance patrols, noting that there was ammunition remaining, Officer 4 directed that a short set of FM drills would be conducted, by three pairs of soldiers, over a 30 to 40 metre distance. The location of the drills is detailed in figure 1.3.5 and an outline of the pairs FM lane is at figure 1.3.6. Pte Thapa and Soldier 1 conducted the final FM serial, which finished at approximately 13:00.

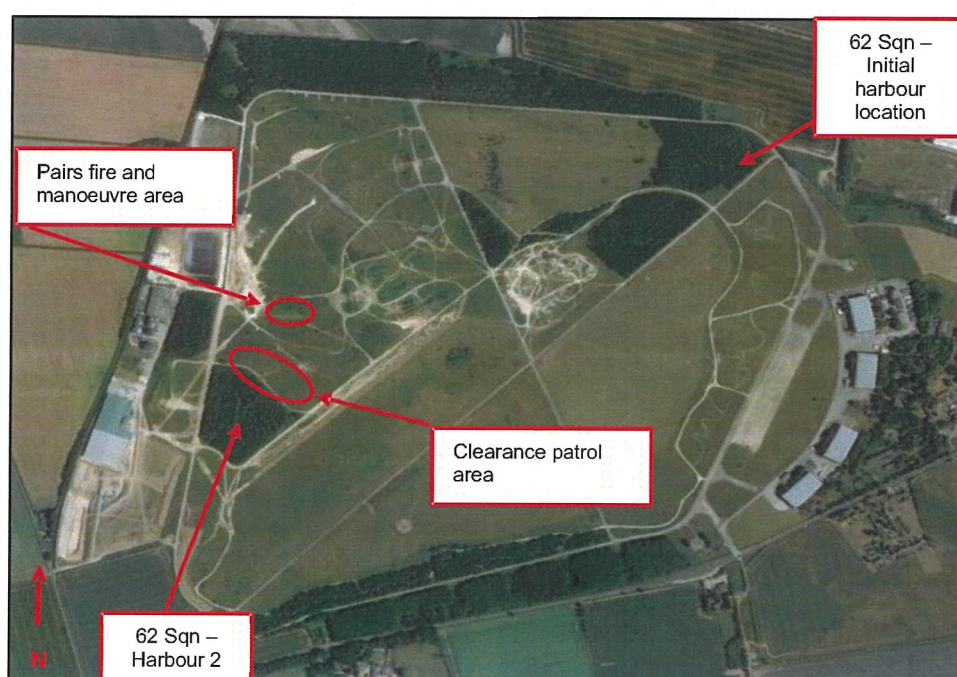


Figure 1.3.5 – Clearance patrol and fire and manoeuvre locations.

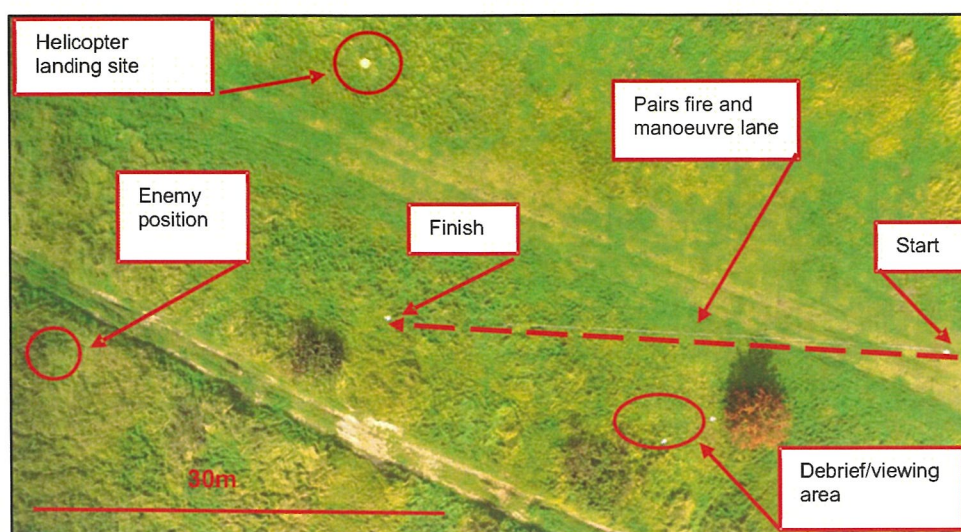


Figure 1.3.6 – Pairs fire and manoeuvre lane.

Accident events

1.3.31. Once Pte Thapa's FM drill had concluded, members of 62 Sqn sat on the ground, close to the area where the drill had taken place, and received a debrief on the serial from Officer 4, SNCO 2 and NCO 1. On completion of the debrief, they were told that they would return to the harbour location to prepare for the end of the exercise.

1.3.32. As personnel were collecting their kit, Officer 4 headed back toward the harbour position. At this point Pte Thapa was observed to slowly fall backwards, from a seated position, onto his back. Initially, those who had witnessed the fall thought it was a joke, or that he was stretching his back, and they tried to help him up, however, he fell backwards once they let go of him. Several soldiers spoke to him and tried to get a response before noting that he was struggling to breathe [REDACTED], at which point his colleagues started shouting for help. On hearing the shouts, Officer 4 made their way back to the scene.

Immediate first aid

1.3.33. At this time, section personnel had started to treat him for suspected heat illness.²⁰ Those not involved in the treatment gathered around to provide shade from the sun, and Pte Thapa's body armour, webbing-belt, upper clothing, boots and socks were removed. Efforts were also made to cool Pte Thapa by lightly covering him in water whilst fanning his body.

1.3.34. On checking his vital signs Soldier 3 noticed that Pte Thapa was not breathing, nor could a pulse be detected. CPR was quickly commenced [REDACTED]

²⁰ Pte Thapa was wearing a GORE-TEX™ water-proof jacket, despite the weather being dry and warm.

[REDACTED]

1.3.35. When Officer 4 arrived at the scene they raised the alarm to Officer 1 by telephone.²¹ SNCO 1 confirmed that they could not find a pulse, which prompted Officer 4 to ask Officer 1 to call an ambulance. At 13:17 Soldier 4 dialled 999 using their personal mobile phone and along with Officer 1, headed to the scene of the accident, They remained on the phone with the call handler until the paramedics arrived.

1.3.36. Whilst awaiting the arrival of an air ambulance NCO 1 and Soldier 5 set up a helicopter landing site close to the scene of the incident (as annotated on figure 1.3.6 above).

Emergency services response

1.3.37. At 13:41 two police officers arrived at the scene followed, at 13:45, by an air ambulance, crewed by a critical care paramedic. Members of the section continued to provide CPR and rescue breaths whilst the paramedic prepared their equipment.

1.3.38. During treatment at the scene the paramedic administered [REDACTED] electrical shocks were also delivered using their automated external defibrillator (AED). The paramedic in charge determined that a road move to hospital would be more suitable as the helicopter did not have enough space for them to effectively conduct the necessary advanced life support during transit.

1.3.39. The land ambulance arrived on the scene at 13:47 and a decision was made to transfer Pte Thapa to that ambulance using a police 4x4 due to the undulating terrain. The transfer was completed at 14:00 and the ambulance departed for hospital at 14:05. On arrival at [REDACTED] Pte Thapa [REDACTED]

1.3.40. On arrival at [REDACTED], the medic in charge of Pte Thapa's care took the decision that further treatment was futile. [REDACTED]

²¹ Having been unable to contact the second in command (2IC) of both 600 squadron and 32 squadron.

[REDACTED] The time of death was recorded as 14:49.

1.3.41. A crime scene investigation (CSI) team from Yorkshire and Humberside Police attended the scene at 16:55. They conducted an examination of the site, took photographs of equipment and location, and secured Pte Thapa's clothing and equipment. It was agreed that his rifle would be sealed and kept by the Army and that the box was not to be opened unless HM Coroner had given permission. Officer 2 signed the sealed box along with a member of the CSI team.

1.3.42. [REDACTED] At 23:00, having returned to Driffeld to secure any evidence, the CSI team departed the scene.

Post-accident events

Defence Unified Reporting and Lessons System (DURALS) and informing Defence Accident Investigation Branch (DAIB)

1.3.43. **DURALS report.** The reporting of the accident to wider defence to initiate response actions was undertaken using DURALS.²⁴ DURALS Occurrence Report Army – 22009 was created at 12:50 on 22 Sep 2023.

1.3.44. **The DAIB.** The DAIB was informed of the accident by a member of 6RLC at 15:23 on 21 September 2023. A triage team was deployed to Dishforth, arriving on scene at 10:30 on 22 September 2023.

Accident Timeline

1.3.45. **Key Timings.** Table 1.3.2 shows the timings of key events during Ex IK:

²⁴ DURALS was an online system allowing users to report accidents. The aim of this multifunctional platform is to support organisational learning through risk identification and management (RIM), trend analysis and knowledge exploitation (KE).

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Timings	Event
18 September 2023	
06:00 - 09:59	Preparations for deployment from Dishforth airfield
10:00	Convoy departs Dishforth
11:00 - 17:00	Vehicles arrive at Driffield and establish harbour positions
22:30	62 Sqn complete camouflage of vehicles
18:01 - 23:59	Night routine
19 September 2023	
00:01 - 06:00	Night routine
06:01 - 12:00	Reveille, daily routine and training serials
12:01 - 18:00	Daily routine, instructor led fieldcraft lessons
18:01 - 23:59	Night routine
20 September 2023	
00:01-06:00	Night routine
06:30	Reveille and stand-to
06:30-08:00	Administration
08:01 - 10:00	Resupply serial led by NCO 1
10:01 - 12:00	Soldier-led fieldcraft lessons
12:00	Lunch, NCO 1 Q&A session, contact serial
16:30	Relocate to new harbour area
17:00-22:30	Arrive new harbour and establish harbour area
22:30 – 23:59	Night routine
21 September 2023	
00:01 - 06:00	Night routine
06:30 - 08:00	Reveille and stand-to
08:01 – 08:27	CBRN contact serial, administration
10:29	Order to expend all remaining ammunition received over 'data'
10:01 -11:00	Section clearance patrol
11:00 – 11:15	De-brief, administration
13:00	Section attack/Clearance patrol and pairs fire and manoeuvre
13:01 – 13:10	De-brief
13:10	Pte Thapa collapse
13:16	Call from Officer 4 to inform ED of casualty
13:17	Soldier 4 dials 999. Call lasts 24mins 34 seconds
13:41	Civilian Police arrive
13:45	HEMS specialist team arrive and take over care of Pte Thapa
13:47	Ground ambulance arrives at Driffield FTA
13:52	Pte Thapa stabilised and loaded on to police vehicle
14:00	Pte Thapa transferred from police vehicle to ambulance
14:05	Ambulance leaves Driffield training area heading for [REDACTED]
14:49	Arrival at [REDACTED] Pte Thapa declared life extinct.
14:30 – 16:00	Collapse harbour area, prepare to return to Dishforth airfield
16:01 – 19:00	32 and 62 Sqns return to Dishforth airfield
20:01 – 21:00	Debriefing at Dishforth airfield Cpls club
22 September 2023	
08:30	Commanding officer brief to 6 Regt RLC

Table 1.3.2 – Key timings during Ex IK

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Part 1.4

Analysis and findings

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Part 1.4 – Analysis and findings

1.4.1. All times are local¹ and are expressed in hours and minutes (hrs:min). Timings derived from electronic equipment or the ambulance service computer aided despatch (CAD) log are expressed in hours, minutes and seconds (hrs:min:sec).

Introduction

1.4.2. The main body of this part of the report contains the analysis and findings of the panel, split into the following sections:

- a. Section 1: Cause of death and medical history.
- b. Section 2: The accident and medical treatment.
- c. Section 3: Exercise planning.

1.4.3. **Medical causation.** The panel differentiated medical causation from the 'causal factors' defined in paragraph 1.4.4 (a-e). One of the SI's principal aims was to identify lessons that Defence could take forward to mitigate the risk of similar accidents happening in the future. To facilitate this, the panel also makes targeted recommendations that can be tracked to closure. To that end, for the purpose of this report, the accident factors were limited to those in which Defence could identify lessons and apply measures to reduce the likelihood of reoccurrence. While it was not the purpose of the SI to ascertain the cause of death, the panel subjected it to analysis in order to provide context to the reader and act as the foundation for the report's recommendations. The investigation areas covered in this part of the report broadly follow a fact, analysis and conclusion structure.

Accident factors

1.4.4. Once an accident factor had been determined to have been present, it was then assigned to one of the following categories:

- a. **Causal factor(s).** 'Causal factors' are those factors which, in isolation or in combination with other causal factors and contextual details, led directly to the accident. Therefore, if a causal factor was removed from the accident sequence, the accident would not have occurred.
- b. **Contributory factor(s).** 'Contributory factors' are those factors which made the accident more likely to happen. That is, they did not directly cause the accident. Therefore, if a contributory factor was removed from the accident sequence, the accident may still have occurred.
- c. **Aggravating factor(s).** 'Aggravating factors' are those factors which made the final outcome of the accident worse. However, aggravating factors do not cause or contribute to the

¹ Coordinated universal time (UTC) also referred to as Greenwich mean time (GMT).

accident. That is, in the absence of the aggravating factor, the accident would still have occurred.

d. **Other factor(s).** 'Other factors' are those which, whilst shown to have been present, played no part in the accident in question but are noteworthy in that they could contribute to or cause a future accident. Typically, other factors would provide the basis for additional recommendations or observations.

e. **Observations.** 'Observations' are 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 terminology

1.4.5. The probabilistic terminology detailed in Figure 1.4.1 clarifies the terms used in this report to communicate levels of uncertainty within the text. It is based on terms published by the Intergovernmental Panel on Climate Change in their guidance note for Consistent Treatment of Uncertainties² as well as the Australian Transport Safety Bureau in their paper titled Analysis, Causality and Proof in Safety Investigations.³

² <https://www.ipcc.ch/pdf/supporting-material/uncertainty-guidance-note.pdf>.

³ <https://www.atsb.gov.au/media/27767/ar2007053.pdf>.

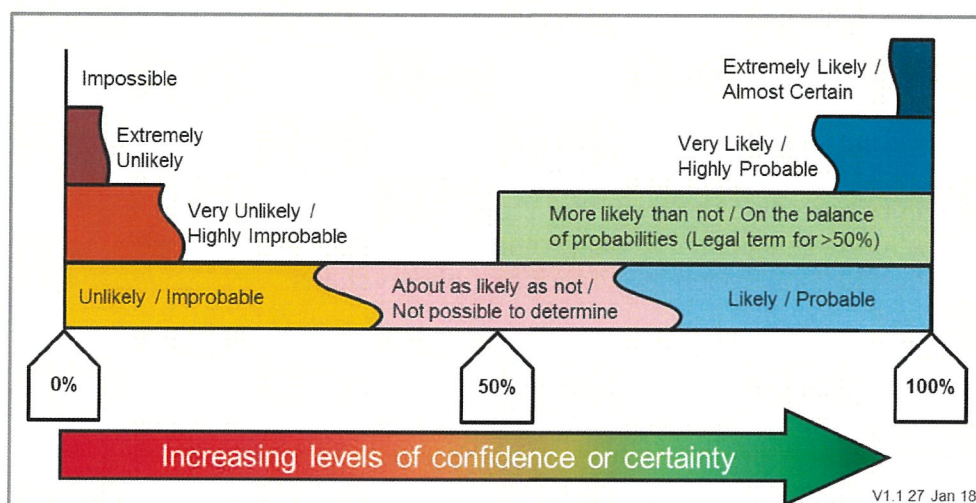


Figure 1.4.1 – probabilistic terminology

Available evidence

- 1.4.6. The panel had access to the following evidence:
- a. Formal witness interviews.
 - b. Environmental and weather data from Joint Operational Meteorology and Oceanography Centre (JOMOC).
 - c. Unit risk assessments (RA).
 - d. Defence Unified Reporting and Lesson System (DURALS) reports produced by 6 RLC.⁴
 - e. Army human resources information from the 'MUSTER' application.⁵
 - f. Pte Thapa's service medical records and pre-joining medical screening from the Defence Medical Information Capability Programme (DMICP) system.
 - g. Pte Thapa's patient care record (PCR) detailing his treatment by NHS paramedics.
 - h. Physical evidence including: Pte Thapa's bergen and it's contents; his e-cigarettes; and various pieces of paperwork.
 - i. Various media including: photographic evidence produced by the DAIB triage team; photographs taken by the SI panel; and 999 voice calls produced by Yorkshire Ambulance Service (YAS).

⁴ This was rebranded as 'MySafety' in June 2024.

⁵ MUSTER was a personnel management and task tracking tool.

j. Reports including: Post-mortem (PM) report produced by a consultant pathologist at [REDACTED] including a second opinion by a professor of histopathology at [REDACTED] and expert medical reports produced by defence consultants in pre-hospital emergency care and cardiology.

Services

1.4.7. The panel had access to the following services:

- a. Formal witness interviews.
- b. Defence Accident Investigation Branch (DAIB).
- c. Yorkshire Ambulance Service (YAS).
- d. Defence Medical Services Regulator (DMSR).
- e. Defence Medical Services (DMS).
- f. Army Personnel Research Centre (APRC).
- g. His Majesty's (HM) Coroner.
- h. Defence Inquests Unit (DIU).
- i. Institute of Naval Medicine (INM).
- j. Epiq Global Limited transcription services.
- k. Royal Air Force Centre for Aviation Medicine (RAFCAM).
- l. Joint Casualty and Compassionate Centre (JCCC).
- m. 6 Regiment Royal Logistics Corps (6RLC).
- n. Army Personnel Services Group (APSG).
- o. Capita.
- p. Yorkshire & The Humber Police.
- q. Special Investigation Branch (SIB), Royal Military Police⁶
- r. Defence Primary Healthcare (DPHC).
- s. Army Recruiting and Initial Training Command (ARITC).

⁶ The SIB rebranded as the Defence Serious Crime Unit in 2024.

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Analysis of factors

Section 1: Cause of death and medical history

1.4.8. **Introduction.** The following section evaluates the cause of Pte Thapa's death and analyses his recruitment journey, medical screening, and overall medical history. The aim of the section is to determine whether his accident was foreseeable, and, therefore, potentially preventable, in terms of whether there were any medical factors that increased his susceptibility to a sudden death.

Key findings

1.4.9. The panel made the following findings in this section:

- a. Pte Thapa suffered a cardiac arrest, [REDACTED]
[REDACTED]
- b. [REDACTED]
[REDACTED] likely undetectable during the Army's medical screening protocol.
- c. The Army's medical screening protocol was robust and fit for purpose.
- d. There was no significant medical history to point to, with any degree of certainty, any other underlying cause of Pte Thapa's cardiac arrest.
- e. Pte Thapa's death was not foreseeable and, in the opinion of the panel, there were no acts or omissions by any Defence personnel or agency that could or would have prevented his death.

Medical cause of death

1.4.10. The panel had access to Pte Thapa's PM report, following a PM conducted on [REDACTED], which listed the cause(s)⁷ of death as:

a. [REDACTED]
[REDACTED]
[REDACTED]

1.4.11. As part of the PM a specialist histopathology⁸ examination was conducted. This expert examination, undertaken by a professor of histopathology, noted [REDACTED]

⁷ The NHS guidance at the time followed the recommendations of the World Health Organization (WHO) on listing causes of death in medical certificates. It recommended that cause(s) of death be listed in parts; part 1 contained the direct cause of death with its antecedent parts following sequentially, so that cause 1a would be the direct cause of death and the final cause in that part would be attributed to the condition which led to those above it. Part 2 was reserved for conditions present at the time of death which were known or suspected to have contributed to death. The guidance was set out in: [Guidance for doctors completing medical certificates of cause of death in England and Wales \(accessible version\) - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61221/guidance_for_doctors_completing_medical_certificates_of_cause_of_death_in_england_and_wales_accessible_version.pdf).

⁸ A branch of pathology that specialises in the examination of tissue and cell samples in order to study changes and abnormalities associated with diseases.

⁹ [REDACTED]

1.4.12. The panel was further assisted by two Defence medical experts. A consultant in pre-hospital emergency care ('consultant in emergency care') and a Defence consultant in interventional cardiology ('consultant cardiologist').¹² The consultant cardiologist had access to the PM and histopathology reports, an additional report from the panel's consultant in emergency care, and Pte Thapa's medical records. During interview the consultant cardiologist explained that [REDACTED] which increased a person's susceptibility to problematic heart rhythms, the most dangerous of which were ventricular tachycardias (VT) where the heart beats abnormally fast. They also explained that, whilst the condition was genetic, there was no way of determining at what stage of Pte Thapa's life the microscopic changes identified by the histopathologist developed.

1.4.13. It was explained that a VT that did not resolve had the potential to degenerate into an uncoordinated beating of the heart, a rhythm known as ventricular fibrillation (VF) which, if untreated by rapid defibrillation,¹³ often results in cardiac arrest and death. The notes written by the paramedics that attended Pte Thapa described him being in a state of [REDACTED] on their arrival, which later degenerated into [REDACTED]

1.4.14. The panel found no evidence to suggest that there was any other medical cause of Pte Thapa's collapse and cardiac arrest. There was no record of him reporting sick in the weeks preceding his collapse, there was clear histopathological evidence of a genetic heart condition that predisposed a sufferer to fatal arrhythmias, and the panel's two consultant medical experts supported the findings of the PM.

1.4.15. **Conclusion.** The panel was certain that Pte Thapa died of [REDACTED] brought about by a genetic heart disorder, [REDACTED]

Candidate journey and medical screening

1.4.16. **Introduction.** In light of Pte Thapa's death, the panel felt it necessary to conduct an examination of his pre-accident medical history, and his Pre-Service Medical Assessment (PSMA) as part of his candidate journey into joining the Army. The rationale behind analysing these events was to understand whether there was anything in his medical history to indicate an increased susceptibility to sudden death. Additionally, it allowed the panel to assess whether the various stages of medical screening had the opportunity to identify such a vulnerability and, therefore, determine whether the screening

¹⁰ [REDACTED]

¹² The panel had two medical subject matter experts, both consultant doctors. The primary expert was a consultant anaesthetist with a specialism in PHEC; the second consultant brought expertise in cardiology.

¹³ Delivery of an electrical 'shock' by an automated external defibrillator (AED) to reverse the abnormal rhythm.

¹⁴ [REDACTED]

available at the time of Pte Thapa's enlistment was a suitable and effective assessment.

1.4.17. **Candidate journey.** All candidates who commenced the process of joining the Army from within the UK, undertook the same recruitment journey. Pte Thapa was born in Nepal on 28 September 1987 and emigrated to the UK in 2009, becoming a naturalised British citizen thereafter. As he applied to join the Army after becoming a naturalised British citizen, he followed the same enlistment procedure as other British nationals. This consisted of an online medical questionnaire (OMQ) that would sift out candidates suffering from conditions that were incompatible with the entry standards for service in the Army.¹⁵ Following the OMQ, a review of primary healthcare records would take place, including a candidate's medical records, if available. Whilst no medical records from Nepal were retained,¹⁶ the panel's cardiology expert explained that Pte Thapa had no significant medical history from the time of being in the UK up until enlistment.

1.4.18. A candidate who passed these 'paper' stages of medical assessment would be loaded onto a PSMA and, if deemed fit to enter the Army, would undergo an Initial Medical Assessment (IMA) with an Army medical officer at their relevant training establishment. All stages up to and including the PSMA were undertaken by a civilian company, Capita, which held the contract for administering this process. Thereafter, the Army assumed responsibility for any further medical assessment and treatment.

1.4.19. **Pre-enlistment medical history.** In January 2019 Pte Thapa undertook his PSMA, which was conducted in accordance with the Army medical employment policy in force at the time.¹⁷ A family history¹⁸ revealed no episodes of cardiomyopathy,¹⁹ or other heart conditions and no history of sudden death under the age of 40. In line with other candidates, he had a routine electrocardiogram (ECG), which was reported as normal, therefore, no further investigation was conducted. It is important to note that Pte Thapa's ECG trace²⁰ was not contained within his service medical records and was likely destroyed in line with the retention policy in force at the time.²¹ Pte Thapa was declared fit to enter the Army on 23 January 2019.

1.4.20. **Initial Medical Assessment.** On 18 March 2019 Pte Thapa officially joined the Army and was, therefore, under its the medical care from that point onwards.²² The following day, 19 March 2019, he undertook his IMA at the Army Training Centre (ATC) Pirbright. This assessment included a review of the PSMA record, including his ECG, and GP records, but was principally aimed at ensuring there had been no medically significant events between the time of passing PSMA and attending the IMA. During this

¹⁵ Such as cardiomyopathy – a primary disease of the heart muscle.

¹⁶ It was not unusual for candidates born overseas to not have those records at time of enlistment, but Pte Thapa self-declared that he had no previous medical history of significance.

¹⁷ Army General and Administrative Instruction Volume 2, Chapter 78, Army Medical Employment Policy.

¹⁸ This was a stereotyped component of the PSMA and consisted of a self-declaration by Pte Thapa.

¹⁹ A group of diseases that affect the heart muscle.

²⁰ The trace being the hard copy/printout of the ECG reading which showed the electrical activity of the heart measured across all 12 electrodes/leads.

²¹ Policy had been updated since the incident so that all ECG's were electronically scanned to the patient record and would remain with that record.

²² This is the date of his attestation, when soldiers swore their allegiance to the Crown.

assessment his ECG was recorded as acceptable, and it was stated that no echocardiogram was required.²³ The doctor who conducted the assessment explained that they would only classify an ECG as acceptable if they had seen it themselves.

1.4.21. The panel asked its expert in emergency care three specific questions in respect of Pte Thapa's PSMA, namely:

- a. Whether Pte Thapa had a heart condition that was capable of being detected by the recruit medical screening policy that was in force at the time of his enlistment?
- b. Whether any such condition was or was not detected?
- c. Whether it could have been detected with a change to screening policy, and if so, what change would be required?

1.4.22. In answering these questions, the expert explained that no underlying cardiomyopathy was detected and no significant medical conditions, other than a longstanding problem with [REDACTED] that was unrelated to his death, were identified. The expert cardiologist explained that there may have been some subtle abnormalities on an ECG, however, there was no way of knowing when the changes to Pte Thapa's heart developed.

1.4.23. The panel also had access to a previous service inquiry report where another recruit, who underwent the same screening process as Pte Thapa, succumbed to an [REDACTED]. That report established that the recruit medical screening process in place at the time was robust and that ECG interpretation was more stringent than any international guidelines on screening.²⁴ Further, the panel noted that no screening test could eliminate the risk of [REDACTED] entirely as many genetic and inherited cardiac conditions were progressive and ECG abnormalities are often intermittent.

1.4.24. The expert cardiologist explained that an echocardiogram would not have been able to display microscopic changes, so in Pte Thapa's case, even had the changes identified at PM been present at the time of his enlistment, an echocardiogram would not have highlighted them.

1.4.25. Noting that the panel had no ECG trace to provide to its experts, they were keen to confirm that this test had been undertaken. Evidence to support the proposition consisted of the robustness of the medical screen, a tick against ECG on the PSMA form, and a doctor at IMA explaining that they would only annotate that an ECG was acceptable had they seen it themselves. Additionally, accounting for the absence of the actual ECG trace, the same doctor explained that those traces were often destroyed, but that they are now scanned onto the electronic record. The panel found this evidence highly persuasive and concluded that it was almost certain that an ECG was undertaken, interpreted, and returned as normal.

²³ An echocardiogram or echocardiography was the use of ultrasound to measure the internal structures of the heart. It was not routinely undertaken by recruits who joined the Army from within the UK unless there was a medical reason for doing so.

²⁴ The standards of ECG interpretation were more stringent than those advocated by the American College of Cardiology, European Society of Cardiology, the International Olympic Committee, and Federation Internationale de Football Association (FIFA).

1.4.26. The panel noted that Pte Thapa had at least three opportunities (on initial application, at PSMA and IMA) to highlight any cardiac problems or relevant family history and none was declared. Such a declaration would have triggered additional tests and, in some cases, refusal of entry into service. There was no evidence to suggest that Pte Thapa had knowledge of any relevant family history, or whether he chose not to disclose any concerns over his own health.

1.4.27. **Conclusion.** The panel concluded that it was very likely that Pte Thapa did not know that he carried this genetic disorder, and his lack of knowledge or awareness of the medical condition was **not a factor** in his death.

1.4.28. The panel determined that relying on multiple, independent sources of information as part of the medical screening undertaken during a candidate's journey was sensible and led to a robust system.²⁵ Whilst there was a possibility that an ECG may have been capable of detecting abnormalities associated with [REDACTED], the panel found it impossible to determine whether Pte Thapa's condition was sufficiently advanced at the point of medical screening to have highlighted any increased risk to his health.

1.4.29. The panel concluded that Pte Thapa's collapse, without warning, owing to an undiagnosed heart condition was not foreseeable. The medical screening conducted by recruiting group was robust and was **not a factor** in his accident.

²⁵ Candidates' self-declarations, family history, medical records and in-person medical assessments.

Section 2: The accident and medical treatment

1.4.30. **Introduction.** The following section of the report appraises Pte Thapa's accident on 21 September 2023. It will consider his collapse, immediate actions by colleagues and treatment received at the scene. This, and subsequent sections will not repeat every detail set out in the narrative of events at part 1.3, but will outline anything that specifically assists the reader's understanding of events and supports the analysis that follows.

Key findings

1.4.31. The panel made the following findings in this section:

- a. Pte Thapa collapsed, from a seated position, at approximately 13:10 on 21 September 2023. He lost consciousness, and his breathing rapidly deteriorated followed by a loss of pulse.
- b. Pte Thapa's colleagues initially treated him for a suspected heat illness before noticing that he had stopped breathing and had no pulse, then commencing CPR.
- c. The first 999 call was made at 13:17 and the air ambulance arrived on scene at 13:45.
- d. There was no AED available at the scene, nor were personnel directed by the emergency call handler to the nearest device.
- e. All personnel treating Pte Thapa were in-date for their individual training requirements (ITR).

1.4.32. **Day of the accident.** At approximately 06:30 on 21 September 2023, Pte Thapa and his colleagues were woken and, after a short period of stand-to, were free to eat and prepare for the day. Pte Thapa ate and drank with Soldier 3 who explained that they always ate together, and that people were eating enough throughout the exercise. The weather was in keeping with the time of year, but, unlike the previous days, it was dry. At approximately 08:00 there was a short, simulated attack on 62 Sqn's harbour position during which Pte Thapa was instructed to act as a casualty. Officer 4, wishing to maximise the training value, instructed troops, including Pte Thapa, to plan and conduct a clearance patrol and a section attack drill.

1.4.33. On completion of those drills, and as the soldiers were packing up, a message was received by all sub-units on the FTA to ensure that any unboxed blank ammunition was expended²⁶ by 12:00. The panel was told that the message was sent without the knowledge of the exercise director (ED). 62 Sqn used the opportunity to conduct additional clearance patrol training. It was during one of these clearance patrols that Pte Thapa was observed to fall.²⁷ Whilst some soldiers said he had hit his head, the only person who observed the fall was Soldier 2, who described Pte Thapa getting back to his feet immediately and being otherwise unaffected.

²⁶ Expended in this sense meant that it should be used as part of training serials, i.e. fired from weapons.

²⁷ The panel's medical expert asserted that the fall was not medically significant, which was corroborated by the post-mortem report which did not highlight any head injury.

1.4.34. Once the exercising soldiers had finished their clearance patrol Officer 4 directed that a pairs fire and manoeuvre exercise take place to practice those drills over a 30-metre distance. Of the three pairs of soldiers to conduct the drills, Pte Thapa and Soldier 1 made up the final pair, completing the serial at approximately 13:00. The panel was told that a short debrief followed the exercise, during which the soldiers, including Pte Thapa, were seated on soft ground. Despite the weather being warm and dry, at a little over 16°C, Pte Thapa continued to wear his GORE-TEX™ waterproof outer jacket.

1.4.35. **The accident.** At approximately 13:10 as troops were getting ready to return to the harbour area to have lunch, Pte Thapa was observed to fall backwards, from a seated position. Colleagues tried to help him up, however, he fell backwards again and was described as struggling to breathe. Colleagues shouted to Officer 4 for help and, whilst awaiting their return, started to remove clothing and equipment from Pte Thapa's upper body, provided shade from the sun and cooled him with water. It was explained to the panel that his colleagues had suspected Pte Thapa had fainted due to the heat, therefore, they followed their heat injury prevention training and attempted to rapidly cool him. The panel noted that those treating him were in date for the relevant first aid and heat illness training. The panel's expert in emergency care explained that there were no clinical signs of heat illness outside of his unexpected collapse.

1.4.36. At a point between 13:10 and 13:15²⁸ it was noticed that Pte Thapa was not breathing and that his pulse could not be detected. Officer 4 called the ED to report the casualty and request support.

1.4.37. The panel was told that colleagues initiated CPR once it was realised that Pte Thapa was not breathing and that his pulse could not be detected. Soldier 1, Officer 4, SNCO 1 and NCO 1

At 13:17 Soldier 4, under the direction of the ED, dialled 999 and requested an ambulance. Soldier 4 remained on the call to the emergency operator until paramedics took over Pte Thapa's care.²⁹

1.4.38. At 13:45 a helicopter emergency medical services (HEMS) team, with a critical care paramedic, landed on the helicopter landing site that had been set up by the section commander and Soldier 5. The paramedics

so that CPR could continue. The paramedic delivered with no improvement in rhythm. Despite this treatment and Pte Thapa's heart rhythm degenerated

1.4.39. Troops initially treating Pte Thapa had no AED available on the scene. It was noted by the panel that there was no legislation requiring the

²⁸ The time is bounded by the approximate time of collapse and the time at which the Officer 4 called the ED to raise the alarm.

²⁹ The phone call lasted 24 minutes and 35 seconds.

placing of AED's in any location, nor requiring their carriage for specific events; it was also noted that there was no Defence policy covering the requirement for AEDs. The panel noted that the 999-emergency operator did not discuss the availability of public access AEDs with Soldier 4 whilst they were on the call.

1.4.40. As Pte Thapa was not in a stable condition the decision was made to move him to hospital by road, in an ambulance. The panel was told that this decision was made because there was more space to work on a person in cardiac arrest in the back of an ambulance than there was in the helicopter. The critical care paramedic remained with Pte Thapa and the ambulance departed for hospital at 14:05. On arrival at the hospital Pte Thapa's clinical outlook was [REDACTED] and the decision was taken [REDACTED], at 14:49, to discontinue resuscitation attempts. In total his colleagues and the paramedics had spent more than 100 minutes attempting to resuscitate him.

1.4.41. **Quality of CPR.** The panel's expert in emergency care concluded that Pte Thapa received good care at the scene, including early CPR from his colleagues, which was one of the most significant factors in predicting survival of patients who suffered an out of hospital cardiac arrest. Whilst the expert in emergency care felt that the quality of CPR likely deteriorated as time went on, owing to the likelihood that [REDACTED] conducted close to 25 minutes of continuous compressions, rather than alternating every two minutes, they concluded that it was unlikely to have made a material outcome to the resuscitation. The panel's cardiology expert went further and explained that the CPR was likely of good quality as it is rare for a patient to still be in [REDACTED] for longer than 10 minutes. The fact that paramedics, who arrived on scene 35 minutes post collapse, found Pte Thapa's heart to be in a shockable rhythm was very likely down to the quality of first aid provided by his colleagues.

1.4.42. **Conclusion.** Considering the findings of the panel's experts, which was corroborated by the testimony of the soldiers and paramedics treating Pte Thapa, the panel concluded that it was very likely Pte Thapa received good quality immediate first aid and that subsequent treatment by paramedics gave him the best chance of survival. The quality of immediate first aid and CPR was **not a factor**.

1.4.43. **Availability of AEDs.** At the time of Pte Thapa's accident the availability of AED's was already being considered by another SI panel.³¹ It was noted by both experts to the panel that early defibrillation would have had the potential to bring about a better outcome in Pte Thapa's accident.

1.4.44. Whilst the survival rate for those suffering an out of hospital cardiac arrest was low, at 7.8%, it increases to 25% for those who are still in [REDACTED]. Further, early defibrillation, within 3-5 minutes of collapse has been noted to produce survival rates of between 50-70%. The panel's cardiology expert explained that there was the potential for Pte Thapa to have had a better outcome had he been defibrillated early, as [REDACTED] which was the state his heart

³¹ DSA/SI/07/22_Catterick Service Inquiry. Recommendation: 'the Director of the Directorate of Defence Safety should provide direction on the provision of automated external defibrillators across defence to ensure personnel have access to a device within the timelines set by the Resuscitation Council'. NB the panel became aware that Director of Defence Safety implemented that recommendation on 24 July 2024 by incorporating it in Joint Service Publication 375, management of health and safety in defence.

was in at the time of the paramedic's arrival, was amenable to this treatment. However, as the first shock was delivered more than 30 minutes after he collapsed, his chances of survival would have been extremely low.³² The panel found the evidence of the experts highly persuasive and concluded that it was highly probable that early access to an AED could have resulted in a better chance of Pte Thapa's survival.

1.4.45. Although there was no legislation or Defence policy requiring the carriage of an AED by military personnel on exercise, the panel felt, based on the evidence provided, and with the information from the previous SI to hand, that it was very likely that a lack of access to an AED was an **aggravating factor** of this accident.

1.4.46. **Recommendation: The Director of Defence Safety should update JSP 375 Chapter 5 to direct that activity owners undertake a thorough first aid risk assessment to ensure that an adequate number of automated external defibrillators are available to all personnel across their area of responsibility.**

1.4.47. **Recommendation: Director Land Warfare should update Pamphlet 21 to include guidance on the consideration of carriage of automated external defibrillators, when deployed, so that planning officers consider this as part of their risk assessments.**

³² Every minute without defibrillation reduced chances of recovery by 10%.

Section 3: Exercise planning

1.4.48. **Introduction.** The following section of the report considers relevant aspects of the planning of Exercise INKAS KHANJAR (Ex IK); examining organisational roles, resourcing, preparedness and organisational competence, all under the lens of a safe system of work (SSW).

1.4.49. **Key findings:** The panel made the following findings:

- a. All personnel taking part in Ex IK were suitably qualified for their roles, including being in date for their individual training requirements (ITR).³³
- b. Nobody who deployed on Ex IK was named as being responsible for medical cover in the event of a casualty.
- c. There was more than one version of the exercise action safety plan (EASP), neither of which were compliant with policy extant at the time of the accident.
- d. The RA covering Ex IK was not compliant with extant policy.
- e. There were a number of other deviations from established policy extant at the time of the exercise.
- f. None of the shortfalls in the exercise planning or execution contributed to Pte Thapa's death, though some were considered **other factors**.

1.4.50. **Policy relevant to military exercises.** The following policy documents, relevant to the planning and execution of military exercises, will form part of the analysis within this section of the report:

- a. **Joint Service Publication (JSP) 375** – JSP 375 was the publication that covered the management of health and safety in Defence. The key to Defence's approach to the management of health and safety was a SSW. Whilst a SSW is considered in more detail later in this report, it worked on the basis that events would be planned around safe people, safe places, safe equipment, and safe practices.
- b. **Field Army Training Directive (FATD)** – The FATD supported higher level policy in ensuring the field army was fully prepared, through proper training, to meet its readiness states and operational commitments.
- c. **Battlecraft syllabus (BCS)** – The BCS, located within the FATD, provided direction for sub-unit training within the Army.

³³ The individual training requirement (ITR) consisted of three main elements: core fitness, core education and core combat skills. All Army personnel were required to complete the fitness and education elements annually.

d. **Pamphlet 21 (Pam 21) Training Regulations for Armoured Fighting Vehicles, Infantry Weapons Systems (IWS) and Pyrotechnics.** Pam 21 was for the use of personnel authorised to plan, conduct or supervise training in any of those areas.

e. **Army Command Standing Order (ACSO) 1200 – ACSO 1200** was the Army's Safety and Environmental Management System (SEMS). Its aim was to ensure the Army adopted a positive safety culture throughout the whole force. Amongst other things this document detailed the RA process.

f. **FTA standing orders** – The standing orders for FTA's aimed to satisfy Defence's SSW approach, providing guidance, direction and risk assessments for each FTA. Primarily this ensured the 'safe place' aspect of SSW could be satisfied.

1.4.51. **Safe system of work (SSW).** The SSW was used as a framework within Defence to aid compliance with higher level health and safety policy and legislation. It was based around the principle of identifying hazards and either eliminating the hazard or, where this was not possible, applying control measures that reduced the risk associated with the hazard to a level that was as low as reasonably practicable (ALARP) and tolerable.³⁴ It was broken down into the four areas listed in table 1.4.1.

Term	Definition
Safe equipment	This is equipment that has the necessary safety documents and, for more complex equipment, a safety case. If the equipment does not have a safety case, any hazards associated with the equipment should be included in the activity-specific risk assessment.
Safe person	This is a person who has been given the appropriate information, training, instructions and supervision to enable them to carry out a specific activity.
Safe place	This relates to the space personnel will be in when performing an activity, including any surrounding areas and areas where other people might be affected by the activity. The activity specific risk assessment should consider the proposed use of the space and any control measures put in place.
Safe practice	This covers the safe conduct of any activity. Safe practices are usually written procedures detailing how to perform an activity with minimum risk to personnel, equipment, materials, and the environment. These written methods should be risk assessed to make sure the risk of harm or damage remains ALARP and tolerable

Table 1.4.1 – SSW definitions

1.4.52. As outlined in the narrative of events in part 1.3 of this report, 6RLC was in the process of preparing for a NATO tasking, namely the Very High Readiness Joint Task Force (Land) (VJTF(L)). In order to be declared ready

³⁴ ALARP was defined in JSP 375 Vol 1 Ch 8 as 'When risk has been reduced to a level where applying further control measures would be grossly disproportionate to the benefit that would be gained.'

for this tasking, all force elements were required to be at the appropriate CT level, by December 2023; in this case the required CT level was level 'Charlie'.³⁵

1.4.53. The aim of Ex IK was to ensure 62 Sqn, 32 Sqn and 600 HQ Sqn progressed their CT level; at the time of the exercise 62 Sqn was at CT level 'Bravo' and the other two squadrons were at CT level 'Alpha'.³⁶ The policy relevant to achieving the appropriate CT level was contained in the FATD and the BCS, which could be accessed through the British Army Electronic Battle Box (BAeBB).³⁷ The relevant documentation was easily accessible and, by virtue of being stored electronically, could be updated with relative ease, therefore ensuring personnel always had access to extant policy.

1.4.54. The panel considered that the BCS, which provided direction on how to train to each level, underpinned the FATD which aimed to ensure elements of the field army were fully trained to meet their operational requirements. The panel felt that providing direction on how to train in a progressive manner, with the aim of ensuring soldiers were ready for their future tasks was not only sensible, but necessary. The Army's provision of policy to aid safe training was viewed by the panel as supporting the safe person and safe practice pillars of the SSW.

1.4.55. **Conclusion.** The panel concluded that the Army provided appropriate policy and direction to aid units in delivering safe and effective training to their personnel. Placing the policy within the BAeBB ensured that all units could easily locate and use the most up to date versions of relevant training policy. The panel concluded that the provision of training policy supported the safe practice and safe person pillars of a SSW and were, therefore, **not a factor**.

1.4.56. **Planning the exercise.** Officer 2 and Officer 3 took the initiative to plan Ex IK. Planning began on 14 June 2023 with an initial planning conference.

1.4.57. The panel was told that for several reasons, including other commitments, personnel trawls,³⁸ and personnel deemed medically unfit to deploy, 62 Sqn was constrained in how many people it could deploy on exercise. To that end, as planning progressed, the decision was made that 62 Sqn would conduct its own trade skills training whilst simultaneously providing support to 32 Sqn's training. The panel was told that the workload on parts of 6RLC was placing a strain on people's personal relationships and there was a feeling that many were overworked.

1.4.58. **Pam 21.** As Ex IK was a blank firing exercise, it was covered by the provisions of Pam 21. The panel noted that the regulations within Pam 21 consisted of approved best practice and that those regulations were mandatory. Pam 21 was for the use of personnel authorised to plan, conduct or supervise this training and should have been followed. As with the BCS, it

³⁵ CTL Charlie was special-to-arm unit training as outlined in table 1.3.1 in part 1.3.

³⁶ The CTL started at Alpha and progressed up to Charlie, therefore 62 Sqn was further ahead in its CTL than the other two squadrons, who were both aiming to reach CTL 'Bravo' by the end of Ex IK.

³⁷ [British Army electronic Battle Box \(BAeBB\)](#). The Battle Box was an electronic repository that contained published doctrine produced by Warfare Branch, HQ Land Warfare Centre.

³⁸ A trawl described personnel being taken from their core roles to fulfil short-notice tasks for other parts of Defence.

was held on and accessed through the BAeBB, which ensured that the most up to date version was always available to planning officers.

1.4.59. Pam 21 explained the SSW and rules for awarding qualifications to plan, conduct, and supervise all blank firing with IWS and OME. The chapters relevant to simulated training³⁹ were:

- a. **Chapter 1.** This chapter explained the SSW and the qualification and authorisation process for all forms of live and blank firing training with infantry weapons.
- b. **Chapter 2.** This chapter prescribed the responsibilities of key personnel in the planning process that was relevant to all forms of training with infantry weapon systems and pyrotechnics.
- c. **Chapter 3.** This chapter contained the regulations for training using various forms of training simulation with infantry weapon systems including additional planning considerations specific to blank ammunition and pyrotechnics.

1.4.60. The following key roles, mandated by Pam 21, will be analysed in more detail in this section:

- a. Exercise director (ED)
- b. Senior planning officer (SPO)
- c. Planning officer (PO)
- d. Exercise conducting officer (ECO)

1.4.61. **Exercise director.** It is the responsibility of the Exercise Director, normally the unit Commanding Officer / Service DH equivalent to:

- a. Formally appoint, in writing, an SPO.
- b. Ensure the SPO had the necessary qualifications in relation to the activity being undertaken.
- c. Ensure the SPO was of the appropriate rank.
- d. Ensure the SPO was sufficiently experienced.
- e. Ensure the SPO had completed the mandatory safety risk management training and that they were competent in risk assessments.

1.4.62. **The ED for Ex IK.** Whilst Pam 21 stated that the ED was 'normally' the unit CO, the position of ED for Ex IK was filled by Officer 5.⁴⁰ The panel determined that the decision to appoint Officer 5 to the role, instead of the CO,

³⁹ Simulated training in this context refers to people operating real equipment in a real environment with simulated effects (such as blank ammunition and pyrotechnics to simulate live ammunition).

⁴⁰ The minimum rank to act as ED for training simulations was a lieutenant or sergeant.

did not contravene the regulations as the words 'normally the unit CO' allowed for the exercise of discretion.

1.4.63. The panel was presented with no evidence to demonstrate that the ED formally appointed the SPO in writing, as required by the regulations. The panel concluded, therefore, that it was very likely that the SPO was not formally appointed and, although this deviated from the procedure laid down in Pam 21 it was **not a factor** in Pte Thapa's death. However, the panel felt that by not following the procedure 6RLC missed the opportunity to ensure the SPO was competent for the role they were assuming. This deviation from Pam 21 had the potential to put personnel at risk of accident or injury in the future and was, therefore, an **other factor** subject to the overarching recommendation at the end of this section.

1.4.64. **Senior planning officer.** The SPO was responsible for ensuring that the exercise was planned properly; they were not required to deploy on the exercise. Amongst their responsibilities the SPO was to appoint a PO and an ECO, ensuring that they were:

- a. Competent, qualified and of sufficient experience for the training.
- b. Given supervision and guidance.
- c. Given refresher training if required.
- d. Given sufficient time, resources, manpower⁴¹ and medical cover.

1.4.65. The SPO could not appoint themselves to be the PO or ECO. They also had a duty to ensure that:

- a. The plan met the aim and objectives of the training (countersigning the EASP).
- b. There were sufficient competent safety staff.
- c. The exercising troops were competent and had completed the necessary progression of training.
- d. If there were insufficient resources or manpower concerns, in particular, qualified or authorised safety staff or competent exercising troops, the SPO was to refer the matter back to the ED for a decision.

1.4.66. **SPO competence.** According to Pam 21, to be considered competent, an individual had to be qualified, experienced and current, each defined as:

- a. **Qualified.** A qualified individual must have attended and passed one of the qualifying courses laid down in this chapter and remained

⁴¹ At the time of writing Defence had adopted the term workforce vice manpower, however, the document quoted, that was in circulation at the time of the accident, used the term manpower, hence its inclusion in the report.

current.

b. **Experienced.** To be deemed experienced an individual must possess the knowledge and skill acquired through participation in or exposure to the same or similar training in that appointment on a qualifying/authorising course or over a period of time.

c. **Current.** Regardless of rank and appointment, it was the individual's responsibility to remain current in all aspects of the role in which they were to be employed.

1.4.67. Officer 3 was the nominated SPO for Ex IK. They held the relevant rank and qualification to act as the SPO for this type of exercise, namely the SA(M) (18) qualification.⁴² However, during interview Officer 3 explained that they had not used the skills taught during their qualifying course since completing their initial officer training. They also explained that they were unaware of the SPO checklist, contained within Pam 21, which guided the SPO through all of the relevant considerations.

1.4.68. Whilst the panel accepted that Officer 3 was qualified to act as SPO, they concluded that it was very likely they had neither the experience, nor the currency, to have enabled them to be considered competent to safely execute the role. There was no evidence to suggest that the competence of the SPO had any relevance to the accident; the panel concluded it was **not a factor** in Pte Thapa's death. However, an SPO held a principal role within the Pam 21 regulations, including appointing key personnel and counter-signing safety documentation. To that end, the panel concluded that the appointment of an SPO who could not be considered competent, according to the definitions outlined above, constituted an **other factor**, due to the possibility that it could cause an accident, and/or put personnel at risk in the future. This factor is subject to the overarching recommendation at the end of this section.

1.4.69. **Planning officer.** In accordance with Pam 21 the PO was responsible for the design of the training that was to take place. The PO had to be competent and qualified, in the same terms as previously defined, and would normally also assume the role of the ECO. It was the PO's duty to ensure that:

a. A detailed plan was produced that met the aim of the training and had considered:

- (1) The requirements of the SSW, in particular the prerequisite criteria for training with IWS and pyrotechnics.
- (2) The rules and regulations contained in the relevant chapters of Pam 21 and other relevant publications.

⁴² The designation SA(M) 18 is broken down as follows: SA signified small arms, the letter M (Mike) was the designator for blank ammunition and/or pyrotechnics and the number 18 was the year that course was created.

- b. If, as a result of the detailed planning, the PO considered there were insufficient resources or manpower available, they were to refer the matter back to the SPO for a decision.
- 1.4.70. Officer 2 was appointed to the role of PO for the duration of Ex IK. They held the SA(M) 18 qualification and were involved in the planning of the exercise from its inception. It was mandatory for the PO to produce written instructions in the form of an EASP covering each activity involving blank ammunition and/or pyrotechnics. Officer 2 produced the first of two versions of an EASP used during Ex IK.
- 1.4.71. **Contents of an EASP.** An EASP template was included on the BAeBB Pam 21 portfolio for use by those planning exercises. Amongst the items to be covered in an EASP for blank firings, Pam 21 suggested the following:
- a. The ECO's responsibilities before, during and after firing.
 - b. The responsibilities of safety supervisors/exercise assistants specific to each weapons/pyrotechnic employed on the exercise.
 - c. The responsibilities of all other exercise staff.
 - d. Description of the rehearsal/walkthrough procedures.
 - e. Safety briefings for all exercise staff and participating troops.
 - f. Sketch maps to be included where applicable.
- 1.4.72. **Multiple EASPs.** The panel identified two EASPs covering Ex IK, both of which broadly followed the template available on the BAeBB. Whilst neither EASP was dated, nor signed,⁴³ the panel identified that version one, produced by Officer 2 was the only version to be uploaded to the Bidding and Allocation Management System (BAMS).⁴⁴ The panel concluded, therefore, that for policy purposes version one was extant at the time of Pte Thapa's collapse.
- 1.4.73. The panel was told that the second version of the EASP came into force at a point between the exercise starting and Pte Thapa's accident. However, it was only formally written up on the afternoon following Pte Thapa's death. Whilst only version one was loaded onto BAMS, there were various accounts of personnel being aware of changes to the EASP. To that end the panel felt it necessary to briefly consider differences between the two (Table 1.4.2).

⁴³ This document was neither physically, nor electronically signed.

⁴⁴ The bidding and allocation management system (BAMS Online) went live across the defence training estate (DTE) in 2019; it enabled units to book facilities on the UK's training areas and ranges.

Item	Version one ⁴⁵	Version two
Written by:	Officer 2	Officer 3
Date checked:	23 Aug 24 by Officer 3	Unknown
Uploaded on BAMS:	Yes	Unknown
Exercise director:	Officer 5	Officer 1
Senior planning officer:	Officer 3	Officer 3
Planning officer:	Officer 2	Officer 2
Exercise conducting officer:	Officer 3	Officer 2
Medical cover:	Combat Med Tech	Combat Med Tech

Table 1.4.2 – Differences between EASP version 1 and 2

1.4.74. Aside from the differences between the two documents, the panel identified several minor irregularities such as the use of outdated terms, or the inclusion of contact details that were no longer in use. Those minor problems, whilst not of relevance in the accident, led the panel to conclude that the documents were likely created by copying and pasting previous iterations of EASPs, rather than being created as a bespoke document from the readily available, and updated templates. In any event, the existence of those discrepancies led the panel to conclude that it was very likely the EASPs had not been subjected to sufficient scrutiny.

1.4.75. **Exercise conducting officer.** In accordance with Pam 21 the ECO was responsible for the safe conduct of activities on the exercise, including firing, in accordance with the plan. The ECO had to be competent and qualified, in the same terms as described above. They were to be present during the exercise, could simultaneously hold the role of PO, and could be assisted by an appropriate number of exercise assistants. The ECO was responsible for ensuring:

- a. Compliance with the regulations for the use of blank ammunition and pyrotechnics.
- b. If pyrotechnics required destruction in situ, using explosives, they, or a member of their staff were to be qualified to do so.

1.4.76. The panel could not positively determine who held the position of ECO for the duration of the exercise. According to version one of the EASP, highlighted in table 1.4.3, the ECO was originally Officer 3, however, as Officer 3 was the SPO, they were prohibited from holding the role of ECO, as outlined in Pam 21. The panel noted that version two of the EASP had Officer 2 as the ECO, however, whilst Officer 2 was competent to hold the role, the panel was given the following, contradictory accounts:

- a. The panel were told that the ECO was originally Officer 5, prior to the appointment being taken by Officer 1 as they were actually on the exercise for its duration.
- b. Officer 3 was the SPO, and, therefore, responsible for appointing the ECO. They were also, originally, the ECO, but after

⁴⁵ There was a further discrepancy with version numbers provided by 6RLC, in this report version 1 of the EASP refers to that uploaded onto BAMS.

realising they would not be deploying on the exercise, handed the duty over to Officer 2.

c. Officer 5 was originally the ED before becoming part of the planning team. They did not accept being the ECO at any stage.

1.4.77. The panel found that the only officer who was set to be deployed on the exercise for its entirety and capable of being the ECO throughout was Officer 2; however, Officer 2 was clear that they did not assume this role.

1.4.78. Officer 3 was the SPO throughout the exercise and therefore responsible for appointing the ECO and for quality-checking the EASP produced by the PO. Officer 3 checked version one of the EASP on 23 August 2023 and allowed it to be uploaded to BAMS. The EASP was uploaded despite Pam 21 stating that the SPO and ECO could not be the same person. Whilst Officer 3 told the panel they later appointed Officer 2 as the ECO, which was reflected on the undated version 2 of the EASP, Officer 2 did not recall being formally appointed to the role.

1.4.79. The panel could not determine who held the role of ECO during Ex IK and concluded that it was extremely likely that nobody fulfilled this role. Whilst this was **not a factor** in Pte Thapa's accident, the panel concluded that the lack of clarity in written instructions, and the absence of an ECO constituted an **other factor**. This factor is covered by the overarching recommendation at the end of this section.

1.4.80. **Medical cover.** In accordance with Pam 21, exercises involving the use of blank ammunition and pyrotechnics required only basic medical cover, consisting of a soldier trained in first aid, a first aid kit, stretcher, safety vehicle and means of communication with the emergency services.

1.4.81. Pam 21 required that a soldier nominated to be the exercise medic could not fulfil any other role. This was to ensure that they could react to an accident and to mitigate the risk of them becoming a casualty themselves. As outlined in the EASP, and highlighted in Table 1.4.3, the planning team for Ex IK had arranged for a combat medical technician (CMT) to act as medic for the exercise.⁴⁶

1.4.82. The panel was told that on the Friday preceding the start of Ex IK, the CMT was removed by the medical centre. Whilst the cause for the removal of the CMT was unclear, the panel was told that several officers, including Officer 2 and Officer 3, were aware of the change. Both Officer 2 and Officer 3 correctly identified that a CMT was not needed, however, there was no evidence to show that a soldier was nominated to fulfil the role of first aider in their place.

1.4.83. The panel concluded that it was extremely likely there was no first aider nominated solely to provide medical cover during Ex IK. It was also determined that, despite being written after the CMT had been withdrawn from the exercise, version two of the EASP still listed a CMT in that role.

⁴⁶ A CMT was more highly qualified than a soldier acting as a team medic.

1.4.84. The panel concluded that a lack of dedicated first aider had no bearing in Pte Thapa's accident. However, it did constitute an **other factor**, subject to the overarching recommendation at the end of this section, as missing the opportunity to ensure appropriate medical cover was in place could put service personnel at risk in the future.

1.4.85. **Risk assessments.** JSP 375, ACSO 1200 and Pam 21 all required military training exercises to be covered by an appropriate plan and an RA. The purpose of the RA was to identify possible hazards, assess the risk posed by such a hazard against the likelihood of the hazard occurring, and to implement control measures such that the identified risk was reduced to ALARP.

1.4.86. The panel found the RA for Ex IK to contain several errors. There were references to different training areas and an out-of-date reference to the range standing orders for Drifffield FTA. The panel was told that the RA had been reviewed by several personnel and that this had influenced the planning of the exercise. However, the original and electronic copies of the RA were undated and unsigned, and the details of the authorising officer were missing. The panel concluded that the inclusion of outdated references, allied with the absence of date, and relevant signatures, effectively invalidated the RA. Whilst this was **not a factor** in Pte Thapa's death, the approach to the production of this RA had the potential to put personnel at risk and was, therefore, an **other factor** subject to the overarching recommendation at the end of this section.

1.4.87. **Drivers' hours.** JSP 800 governed Defence's approach to the control and operation of Defence road transport. As part of this policy drivers of Defence vehicles operated under one of four schemes, which managed maximum driving and rest periods. The panel was presented evidence to show that the eight drivers of 62 Sqn exceeded their maximum daily duty period for driving and that they did not achieve their minimum rest periods.

1.4.88. There was no evidence to suggest that members of 62 Sqn had an effective method of managing drivers' hours during the exercise. Although it was highly likely that these deviations led to members of 62 Sqn being tired, the panel determined it was **not a factor** in Pte Thapa's death. However, the panel felt that non-compliance with drivers' hours regulations put Defence personnel and civilian road users at increased risk and, in the opinion of the panel, this deviation from policy was considered an **other factor** subject to the overarching recommendation at the end of this section.

1.4.89. **Panel's conclusions on planning and execution of Ex IK.** There was no evidence to suggest that the sub-units undertaking Ex IK signed onto the exercise area in accordance with the Drifffield FTA standing orders, conducted proper safety briefs, nominated a named medic, abided by drivers' hours regulations or operated under a valid risk assessment, all of which were responsibilities linked to the ECO. The panel determined that it was very likely that nobody assumed the role of ECO during the exercise and that this oversight could realistically be linked to the standard of the written instructions, namely EASPs, which contained out-of-date information. It was very likely that the EASPs contained erroneous detail copied from previous documents.

1.4.90. The finding that the updated EASP (version two) also contained the same out-of-date information as the original, suggested that neither document had been subjected to sufficient scrutiny. The panel noted that Officer 3, in their role as SPO had responsibility for cross-checking those documents. However, whilst qualified to hold the role of SPO, they lacked currency and experience and so, the panel concluded, could not be considered competent to carry out the role. The panel felt that the overall responsibility for ensuring the SPO was competent lay with the regimental chain of command.

1.4.91. The panel concluded that it was very likely that by not appointing the SPO in writing the 6RLC chain of command missed the opportunity to ensure the exercise would be planned and conducted in accordance with extant policy. Whilst none of the panel's findings in this section were factors in Pte Thapa's death, the panel concluded that the individual and cumulative effect of these **other factors** was capable of putting service personnel at risk.

1.4.92. **Recommendation. Deputy Chief of the General Staff should implement a suitably robust assurance regime in order to ensure adherence to published policy and regulations governing training with ordnance, munitions, and explosives.**

Summary of findings

Causal factors

1.4.93. The panel did not identify any causal factors which led directly to the accident (see para 1.4.3 for differentiation between medical causation and causal factors).

Contributory factors

1.4.94. The panel did not identify any contributory factors that may have made the accident more likely.

Aggravating factors

1.4.95. The panel identified one potential aggravating factor that made the outcome worse.

- a. Although there was no law or Defence policy requiring the carriage of an AED by military personnel on exercise, the panel felt, on the basis of the evidence provided, and with the information from the previous SI to hand, that a lack of access to an AED was a **potential aggravating factor** of this accident.

1.4.45

Other factors

1.4.96. The panel identified seven other factors that, whilst not causal or contributory in the accident, may cause or contribute to a future accident.

- a. The panel was presented with no evidence to demonstrate that the ED formally appointed the SPO in writing, as required by the regulations. The panel concluded, therefore, that it was very likely that the SPO was not formally appointed and, although this deviated from the procedure laid down in Pam 21 it was **not a factor** in Pte Thapa's death. However, the panel felt that by not following the procedure 6RLC missed the opportunity to ensure the SPO was competent for the role they were assuming. This deviation from Pam 21 had the potential to put personnel at risk of accident or injury in the future and was therefore an **other factor** subject to the overarching recommendation at the end of this section.

1.4.63

- b. Whilst the panel accepted that Officer 3 was qualified to act as SPO, they concluded that it was very likely they had neither the experience, nor the currency, to have enabled them to be considered competent to safely execute the role. There was no evidence to suggest that the competence of the SPO had any relevance to the accident, therefore the panel concluded it was **not a factor** in Pte Thapa's death. However, a SPO held a principal role within the Pam 21 regulations, including appointing key personnel and counter-signing safety documentation. To that end the panel concluded that the appointment of a SPO who could not be considered competent, according to the definitions outlined above, constituted an **other factor**, due to the possibility that it could cause an accident, and/or put personnel at risk in the future. This

1.4.68

factor is subject to the overarching recommendation at the end of this section.

c. The panel could not determine who held the role of ECO during Ex IK and concluded that it was extremely likely that nobody fulfilled this role. Whilst this was **not a factor** in Pte Thapa's accident, the panel concluded that the lack of clarity in written instructions, and the absence of an ECO constituted an **other factor**. This factor is covered by the overarching recommendation at the end of this section. 1.4.79

d. The panel concluded that a lack of dedicated first aider had no bearing in Pte Thapa's accident. However, it did constitute an **other factor**, subject to the overarching recommendation at the end of this section, as missing the opportunity to ensure appropriate medical cover is in place could put service personnel at risk in the future. 1.4.84

e. The panel found the RA for Ex IK to contain several errors. There were references to different training areas and an out-of-date reference to the range standing orders for Driffield FTA. The panel was told that the RA had been reviewed by several personnel and that this had influenced the planning of the exercise. However, the original and electronic copies of the RA were undated and unsigned, and the details of the authorising officer were missing. The panel concluded that the inclusion of outdated references, allied with the absence of date, and relevant signatures, effectively invalidated the RA. Whilst this was **not a factor** in Pte Thapa's death, the approach to the production of this RA had the potential to put personnel at risk and was, therefore, an **other factor** subject to the overarching recommendation at the end of this section. 1.4.86

f. There was no evidence to suggest that members of 62 Sqn had an effective method of managing drivers' hours during the exercise. Although it was highly likely that these deviations led to members of 62 Sqn being tired, the panel determined it was **not a factor** in Pte Thapa's death. However, the panel felt that non-compliance with drivers' hours regulations put Defence personnel and civilian road users at increased risk and, in the opinion of the panel, this deviation from policy was considered an **other factor** subject to the overarching recommendation at end of this section. 1.4.88

g. The panel concluded that it was very likely that by not appointing the SPO in writing the 6RLC chain of command missed the opportunity to ensure the exercise would be planned and conducted in accordance with extant policy. Whilst none of the panel's findings in this section were factors in Pte Thapa's death, the panel concluded that the individual and cumulative effect of these **other factors** was capable of putting service personnel at risk. 1.4.91

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Part 1.5

Recommendations

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Part 1.5 – Recommendations

1.5.1. **Introduction.** The following recommendations are made in order to enhance Defence Safety:

1.5.2. **The Director Directorate of Defence Safety should:**

- a. The Director of Defence Safety should update JSP 375 Chapter 5 to direct that activity owners undertake a thorough first aid risk assessment to ensure that an adequate number of automated external defibrillators are available to all personnel across their area of responsibility. 1.4.46

1.5.3. **Director Land Warfare should:**

- a. Update Pamphlet 21 to include guidance on the consideration of carriage of automated external defibrillators, when deployed, so that planning officers consider this as part of their risk assessments. 1.4.47

1.5.4. **Deputy Chief of the General Staff should:**

- a. Implement a suitably robust assurance regime in order to ensure adherence to published policy and regulations governing training with ordnance, munitions, and explosives. 1.4.92

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Part 1.6

Convening authority comments

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PART 1.6 – Convening authority comments

Introduction

1.6.1. This service inquiry (SI) was convened to investigate the circumstances surrounding the tragic death of Private (Pte) Nabin Thapa of 6 Regiment, Royal Logistics Corps (6RLC), following his sudden collapse at the Driffield fieldcraft training area.

1.6.2. The SI panel has submitted its report to me after 12 months of detailed evidence gathering, interviews and analysis. While Pte Thapa's death was as a result of natural causes precipitated by a genetic heart condition and was unforeseeable, the lack of availability of an automated external defibrillator was a potential aggravating factor.

1.6.3. The panel has submitted its recommendations to me and I would urge all commands to consider their wider applicability, particularly with regard to the planning, execution and assurance of military exercises – I am not convinced this issue is specific to 6RLC. Having reviewed the report, I agree with the panel's findings and offer the following observations.

Heat illness prevention training and medical care

1.6.4. Pte Thapa's colleagues initially followed the heat illness prevention protocol, demonstrating greater awareness of heat illness and its treatment. Their subsequent, rapid commencement of CPR when his condition deteriorated undoubtedly provided him the best chance of survival and underlines the importance of basic life support training and regular drills. Pte Thapa's colleagues worked extremely hard to save his life and should be commended for their efforts.

Exercise planning and assurance

1.6.5. Defence has thorough and effective policy to ensure exercises are planned and executed safely. It is apparent that there were deviations from this policy. Whereas I am confident that policies are appropriate and robust, I am not persuaded that the planning and execution of exercises are assured to a suitable degree. Commanders at all levels should seek out opportunities to assure their exercises.

Conclusion

1.6.6. I am content that this tragic accident has been thoroughly and rigorously investigated. On behalf of the Defence Safety Authority, I offer my sincere condolences to Pte Nabin Thapa's family, friends and loved ones.

S J Shell CB OBE MA
Air Marshal
Director General Defence Safety Authority

