

Justice Committee

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill

Supplementary written submission from Flt Lt James Jones, RAF (Rtd)

Appendix 1 - notes for witnesses on service inquiry procedures and giving evidence

1. Service inquiries are held under the authority of the Armed Forces Act 2006 and the Armed Forces (Service Inquiries) Regulations 2008.
2. The function of a service inquiry is to discover, in accordance with its Terms of Reference, the facts of a matter and any circumstances leading to it, with a view to determining why the incident occurred and what should be done in future to prevent a recurrence. Such an inquiry does not seek to attribute blame or legal liability. It works from Terms of Reference set by the convening authority who is a senior officer with responsibility for the area or establishment where the matter under investigation occurred.
3. The inquiry is undertaken by a panel consisting of a president and 2 or more other members, generally servicemen; but civil servants (or foreign servicemen) are sometimes included. The panel is formed to investigate a specific matter. It carries out its investigation by taking evidence from people involved in or connected with the incident, and technical experts. To reach its findings it may need to review procedures and policies. Once the panel has gathered all the evidence it is required to produce a report in which it may express its findings (based on the evidence) about the matter investigated, and it may make recommendations, or express opinions in accordance with its Terms of Reference in respect of preventing recurrences.
4. The panel will assemble in a suitable place, normally an office, conference room, or classroom on a Service unit/ship/establishment, over a number of days or weeks to carry out its work. The place where the panel sits will depend on the incident being investigated. The panel is not confined to one place and may need to travel between two or more locations to complete its tasks.
5. A service inquiry is not a court; it is not open to the public; it is not adversarial; and it does not make legal rulings. It is important to draw a distinction between the work of a service inquiry and proceedings before a civil court, a Coroner's Inquest or a Fatal Accident Inquiry in Scotland. In a case involving a death, the service inquiry report will, however, be made available to the Coroner or Procurator Fiscal to assist him with his proceedings, if the inquest/inquiry into a death has not already been concluded.

Giving evidence

6. Usually witnesses will travel to the place where the service inquiry is sitting in order to give evidence, which the president may require to be given on oath or solemn affirmation. You may be recalled as required. It may be possible

for the panel to travel to you or for you to give evidence by video conferencing or by other means, if the president of the service inquiry considers this appropriate or necessary.

7. When you are called to attend the inquiry the following procedure should be adopted :

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Letter from the Ministry of Defence to James Jones

Dear Mr Jones

Thank you for your email of 30 September 13 requesting the following information:

"In July 2012 two Tornado aircraft from RAF Lossiemouth collided over the Moray Firth. The MoD announce that a Board of Inquiry would be set up in order to investigate the cause of the accident. Please can I have a copy of the BO/ report?"

I am treating your correspondence as a request for information under the Freedom of Information Act 2000 (FOIA).

A search for the information has now been completed within the Ministry of Defence, and I can confirm that some information in scope of your request is held.

The Service Inquiry (SI) is being conducted internally and is expected to complete by the end of October 2013. It is possible that this accident may lead to a Scottish Fatal Accident Inquiry, to place this information into the public domain ahead of the Inquiry would risk prejudicing its proceedings and could potentially affect its outcome. The final report will be published on the MOD Publication Scheme once agreed with the Procurator Fiscal. As such, this comes under Section 22 of the FOIA, which exempts from disclosure information intended for future publication.

If you are not satisfied with this response or you wish to complain about any aspect of the handling of your request, then you should contact me in the first instance. If informal resolution is not possible and you are still dissatisfied then you may apply for an independent internal review by contacting the Deputy Chief Information Officer, 2nd Floor, MOD Main Building, Whitehall, SW1A 2HB (e-mail CIO-FOI-IR@mod.uk). Please note that any request for an internal review must be made within 40 working days of the date on which the attempt to reach informal resolution has come to an end.

If you remain dissatisfied following an internal review, you may take your complaint to the Information Commissioner under the provisions of Section 50 of the Freedom of Information Act. Please note that the Information Commissioner will not investigate your case until the MOD internal review process has been completed. Further details of the role and powers of the Information Commissioner can be found on the Commissioner's website, <http://www.ico.gov.uk>.

Yours sincerely

Carl Godwin
Military Aviation Authority
24 October 2013

Extract from the Mull of Kintyre Review

3. Previous Reviews and Inquiries

3.1 Introduction

3.1.2 The RAF Board of Inquiry immediately convened to investigate the accident and following extensive investigation delivered its report to the RAF Higher Authority on 3 February 1995. The findings were reviewed and signed off by the Higher Authority (the Reviewing Officers) on 3 April 1995. The report was then passed to the RAF Inspectorate of Flight Safety and the Ministry of Defence. On 15 June 1995 specialist officers from the RAF, who were able to discuss and explain the Board's findings, handed over the report to most of the next of kin. The then Secretary of State for Defence, the Rt Hon Malcolm Rifkind MP, made a statement to the House of Commons announcing the Board's findings and the placing of the Military Aircraft Accident Summary in the House of Commons Library. As an unclassified document it did not detail the comments of the chain of command.

3.1.2 A Board of Inquiry was an internal process convened for Armed Services reasons to determine how a serious incident happened and why, and to make recommendations to prevent a recurrence. The Board of Inquiry was not a substitute for a legal inquiry into the cause and circumstances of a death. So on completion of the Board the Ministry of Defence discussed with the Lord Advocate (the chief law officer in Scotland) and Solicitor General for Scotland (responsible for the Procurator Fiscal Service who were the public prosecution service and carried out functions broadly equivalent to a coroner) the need to hold a public Fatal Accident Inquiry under Section 1(1)(a)(i) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976. Shortly before publication of the Board of Inquiry report the Lord Advocate concluded that a Fatal Accident Inquiry was necessary because some of those on board at the time of the crash were engaged in the course of their employment and, while not mandatory in respect of all of the deaths, the inquiry should relate to all on board. The Inquiry was held over 18 days in Paisley Sheriff Court from 8 January to 2 February 1996 and heard from 38 civilian and military witnesses. The Sheriff found that he could not determine the cause of the accident and did not agree with the determination of gross negligence by the Reviewing Officers.

3.1.3 Following the Sheriff's determination questions were raised about the inconsistency between the two inquiry findings and particularly the difference of opinion between the Board and the Reviewing Officers. In the intervening years the accident has been debated in and outside Parliament and a number of articles have been written and broadcast.

3.1.4 The concerns raised prompted the House of Commons Defence Committee to investigate the lessons to be learned from the accident with the Committee reporting in May 1998. The Committee was clear from the outset that it was not a further "*court of appeal*" but sought to clarify the conflicting messages about the possible cause of the accident. This investigation was followed by the Parliamentary Public Accounts Committee in November 2000, who investigated the Ministry of Defence's acceptance into service of the Chinook HC-2.