From: [redacted]

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Reference: HQAir/RAFAT/Invst/1

COS Pers* 21 Jul 23

CO's REPORT INTO ALLEGATIONS OF COMMAND, LEADERSHIP AND MANAGEMENT FAILINGS FROM WITHIN THE RAF AEROBATIC TEAM (RAFAT)

References:

A. Terms of Reference for the CO's Investigation into allegations of Command, Leadership and Management failings from within the RAF Aerobatic Team (RAFAT) dated 12 Dec 22.
B. Terms of Reference for the CO's Investigation into allegations of Command, Leadership and Management failings from within the RAF Aerobatic Team (RAFAT) Dated 24 Feb 23.
C. AP3392, Vol 4, Lft 303, dated 6 Dec 22.

INTRODUCTION

1. Following a Non-Statutory Inquiry (NSI) into allegations of Unacceptable Behaviours (UB) that occurred within the Royal Air Force Aerobatic Team (RAFAT), COS Pers directed a separate CO's Investigation be undertaken into allegations of command, leadership and management failings within RAFAT. I was appointed as the bespoke Commanding Officer (CO) to oversee that investigation. This report sets out my consideration of the completed Investigating Officers' (IO) Report and my direction for further action.

CONDUCT OF THE INVESTIGATION

2. I was directed to consider the command and leadership of the RAFAT, in the context of the findings of the NSI. The Terms of Reference (TORs) for the Investigation focussed on six specific areas:

a. Investigate their knowledge of and actions regarding sexual relationships between RAFAT personnel, including extra-marital relationships, and any impact they had on operational effectiveness.

b. Investigate their knowledge of and actions regarding unacceptable

behaviours, including allegations of sexualised unacceptable behaviour, bullying, harassment and victimisation.

c. Investigate their knowledge of and actions regarding allegations of RAFAT personnel being under the influence of alcohol whilst conducting safety critical duties.

d. Investigate their knowledge of and actions regarding allegations of outdated leadership and management practices, including bullying, harassment, victimisation and discrimination in the RAFAT.

e. Investigate the relationships and information flow between the subjects and CO RAF Scampton, to assess whether the CO had sufficient oversight of the sqn.

f. Investigate allegations of a bystander culture from the CoC.

3. The first IO was appointed on 12 Dec 22 with the TORs at Reference A. The Investigation originally envisaged [redacted] Respondents and was asked to report by 28 Feb 23. Following analysis of the NSI, the APC casework arising from the NSI and early evidence gathering, a further [redacted] Respondents were identified. The increased scope of the Investigation, the number of witnesses, the considerable volume of witness interview transcripts, the volume of written evidence, and coordinating access to witnesses in [redacted] appointments, necessarily required the Investigation to extend into Jun 23; in turn, this required a change of IO to meet Service workforce requirements. The TORs for the second IO are at Reference B. Every effort was made to draw the Investigation to a close as soon as practicable, including the use of a transcription service and **a pragmatic view on where responsibility within the extended RAFAT chain of command realistically sat**. The Investigation was conducted in accordance with Reference C.

4. The RAFAT Investigation Report (IR) is at Enclosure 1; the anonymised respondent, witness & evidence decode is at Enclosure 2.

CONSIDERATION OF THE EVIDENCE AND CO'S DETERMINATION

5. I have carefully read the RAFAT IR and I am now required to:

a. Assess whether command and leadership failings were evident, and if so, make recommendations to assist the Service in preventing similar failings, both at RAFAT, and more generally in command, leadership and management.

b. Assess whether key personnel comprising RAFAT's chain of command, exercised sufficient supervision and oversight to ensure they were able to exercise appropriate levels of leadership, management, and duty of care over their subordinates.

6. In reaching a decision, I first considered all of the evidence holistically, before focussing on the specific TORs at para 2 above, and the events related to them. I

then weighed that evidence, applying the balance of probabilities[1] as the burden of proof, to identify what if any failings sat with the [redacted] Respondents. In the event that failings were identified, I have recommended Higher Authority consider further action. Throughout, I use individual's ranks contemporary to the events investigated.

7. **RAFAT in Context**. The IR sets out some important context for RAFAT over the 2018 and 2022 period covered by the investigation. Having considered the evidence and the allegations of UB holistically, I add the following additional comments:

a. RAFAT is an elite unit with a global profile. The burden on the Sqn to deliver is enduring, and at times appears to drive operational output to the detriment of other critical work that would better ensure the organisational structure, health and resilience of the unit as a whole.

b. The high profile of the Team, their regular exposure to VIPs, celebrities and an admiring public, coupled with wide media engagement, promotes the view amongst some personnel that they are 'special' and that normal behaviours and rules do not apply to them. This is manifest in regular instances of UB across the rank structure, which appear more prevalent than in other similar sized units. In turn, the drive to deliver output and avoid reputational damage appears to have driven the RAFAT chain of command to favour retention, and the 'internalisation' of disciplinary and administrative issues, over more appropriate external advice and action required to combat UB.

c. This culture of UB permeates RAFAT and is reinforced and maintained by the selection process, and the requirement for RAFAT flying SQEP to fill pivotal RAFAT command and executive appointments, notably Red 1 and OC RAFAT.

d. Interpersonal relationships of a sexual nature, in and around the workplace, disrupted and adversely affected RAFAT output. This cannot be seen as a private life matter and whilst I note guidance and policy has recently shifted, Service personnel require a clear understanding as to what is acceptable and what is not.

e. It is apparent that together, these factors have hindered the necessary cultural reset identified following AOC 1 Gp's intervention and the NSI. Without a fundamental change in approach, the RAFAT culture that facilitates UB will not change.

8. Where applicable, I have addressed each aspect of the TORs as set out in para 2 above, with regard to each Respondent. My findings have been written to aid any further action and redaction; this makes this Decision Letter repetitive in parts and longer than normal.

[1] which version of events is more likely than not to have occurred.

a. **Knowledge of and actions regarding sexual relationships between RAFAT personnel, including extra-marital relationships, and any impact they had on operational effectiveness.**

[redacted]

9. [redacted] was [redacted] from [redacted]. During this period, the IR identified [redacted] relationships [redacted] that stood to disrupt RAFAT output. **The evidence supports the view that the [redacted] relationship was most likely platonic, and I find, based on the evidence and on the balance of probabilities, this to be the case**. The widely held perception across RAFAT was, however, different. The evidence confirms the perception that they were having an affair undermined the authority of both officers, who held [redacted]. **I find as fact that, on the balance of probabilities, that [redacted] knew about this perceived affair**. The evidence also supports the view that the [redacted] relationship was quite discreet and not widely known about outside the Diamond 9 (the RAFAT display pilots). I accept that [redacted] was most likely not aware of this relationship, which very probably highlights the failure of one o f [redacted], [redacted], to inform [redacted]. The [redacted] relationship endured for a number of months and was very widely known about across the Sqn. People's perceptions were undoubtedly affected by the fact [redacted]

10. Based on the evidence, it is inconceivable that [redacted] had no knowledge of the widespread rumours of the [redacted] relationship, and **I find as fact that, on the balance of probabilities, [redacted] knew about the affair**. The [redacted] Operations Order specifically required [redacted] to report service discipline (SD) maters to the CO, Stn Cdr RAF Scampton, and seek specialist SD/P1 advice. [redacted] failed to report, seek advice, or act in a timely manner regarding the two relationships [redacted] was aware of. The evidence confirms [redacted] in-action precipitated a loss of confidence and trust in the RAFAT chain of command, and in the case of [redacted], amounts to a failure in [redacted] duty of care to [redacted]. In addition, this failure to grip the situation early, caused lasting reputational damage to RAFAT, the Service, and impacted operational efficiency. The evidence suggests there was no malice on [redacted] part and [redacted] conduct was, I judge, more likely down to [redacted] avoidant nature. **Based on the evidence, and on the balance of probabilities, I find that [redacted] was derelict in [redacted] duty, both as [redacted] and as [redacted], in failing to exercise his duty of care towards [redacted] and by not initiating timely and appropriate action over these [redacted] relationships.**

[redacted]

11. [redacted] served on RAFAT as [redacted] from [redacted]; [redacted] was a [redacted] During this period, the IR identified [redacted] relationships [redacted] that stood to disrupt RAFAT

output. **The evidence supports the view that the [redacted] relationship was most likely platonic and I find, on the balance of probabilities, this to be the case**. The widely held perception across RAFAT was, however, different. The evidence confirms the perception that they were having an affair undermined the authority of both officers, who held key appointments [redacted]. It is disappointing that two senior officers failed to pick up on the rumours regarding their relationship or consider how that relationship may appear to others. I do however accept that, in part, they were both a victim of the Culture on RAFAT that sexual relationships when deployed were not unusual. The evidence also supports the view that the [redacted] relationship was quite discreet and not widely known about outside the Diamond 9 (the RAFAT display pilots). **Based on the evidence and on the balance of probability, I find that [redacted] had sufficient grounds to raise the prospect of the relationship with [redacted] but chose not to do so**. The [redacted] relationship endured for a number of months and was very widely known about across the Sqn. People's perceptions were undoubtedly affected by the fact [redacted]

12. Based on the evidence, it is inconceivable that [redacted] had no knowledge of the widespread rumours of the [redacted] relationship, and **I find as fact that, based on the evidence and on the balance of probabilities [redacted] knew about the affair**. The WH19 Operations Order specifically required the RAFAT chain of command to report SD maters to the CO, Stn Cdr RAF Scampton, and seek specialist SD/P1 advice. [redacted] failed to report, seek advice over, or act in a timely manner regarding the [redacted] relationships [redacted] was aware of, or manage the perceptions of [redacted] relationship with [redacted]. The evidence confirms [redacted] in-action precipitated a loss of confidence and trust in the RAFAT chain of command, and in the case of [redacted], amounts to a failure in [redacted] duty of care to [redacted]. In addition, this failure to grip this situation early caused lasting reputational damage to RAFAT, and impacted operational efficiency. The evidence suggests there was no malice on [redacted] part and [redacted] conduct was, I judge, more likely [redacted] **Based on the evidence, and on the balance of probabilities, I find that [redacted] failed to exercise appropriate responsibility as a [redacted] and [redacted], in failing to initiate timely and appropriate reporting, or take action, over these [redacted] relationships. [redacted] also failed to guard against, and act on rumours, regarding [redacted] own platonic relationship with [redacted]**

[redacted]

13. [redacted] served as [redacted] from [redacted]. During this period, the IR identified [redacted] relationships [redacted] that stood to disrupt RAFAT output. The evidence confirms that [redacted] informed [redacted] and [redacted] of this after [redacted] left the Sqn in [redacted]. The evidence confirms there was limited awareness of this relationship, perhaps a few scant rumours. **I therefore find as**

fact, based on the evidence and on the balance of probabilities, that [redacted] had no knowledge of the relationship prior to [redacted] informing [redacted] in early 2022.

14. The evidence confirms [redacted] claims to be in an open marriage. [redacted] relationship with [redacted] during [redacted] was widely rumoured across RAFAT and confirms [redacted] took prompt and timely action, following SD/P1 advice. Later that year, [redacted] was engaged in a relationship with one of [redacted] subordinates, an unnamed [redacted]. Prompt reporting of rumours enabled [redacted] to take prompt action on SD/P1 advice.

15. The evidence confirms that [redacted] acted decisively and appropriately in dealing with [redacted] relationships. It is disappointing that [redacted] chose not to take action over [redacted] relationship with a [redacted], even though [redacted] had left the Sqn. This failing is compounded by [redacted] failure to exercise the duty of care [redacted] owed [redacted] personnel as [redacted] especially in the face of the evidence that the chain of command harboured concerns over [redacted] behaviour. **Based on the evidence and on the balance of probabilities, I find this to be a serious failure by [redacted] to appropriately exercise [redacted] responsibilities and duty of care as a [redacted] and as [redacted]. In addition, [redacted] failed to report this relationship to the CO and take SD/P1 advice.**

[redacted]

16. [redacted] started [redacted] current tour as [redacted]; [redacted] is a [redacted] During this period, the IR identified [redacted] relationships [redacted] that stood to disrupt RAFAT output. The evidence confirms that [redacted] informed [redacted] and [redacted] of this after [redacted] left the Sqn on [redacted]. The evidence also confirms there was limited awareness of this relationship, perhaps a few scant rumours. It is disappointing that [redacted] was not more inquisitive, as the chain of command suspected [redacted] was behaving inappropriately and **I find [redacted] could and should have done more to bottom out any suspicions**. That [redacted] didn't, I judge, is down to [redacted] perception that [redacted] responsibilities are focussed almost entirely on delivering [redacted]

17. The evidence confirms [redacted] claims to be in an open marriage. [redacted] relationship with [redacted] during [redacted] was widely rumoured across RAFAT and confirms [redacted] took prompt and timely action, supported by [redacted], following SD/P1 advice. Later that year, [redacted] was engaged in a relationship with one of [redacted] subordinates, an unnamed [redacted]. Prompt reporting of rumours enabled [redacted] to again take prompt action on SD/P1 advice. There is no evidence that [redacted] would be aware of this relationship between [redacted].

18. The evidence confirms that [redacted] supported [redacted] when [redacted] acted decisively and appropriately in dealing with [redacted] relationship with [redacted] one of [redacted] display pilots. It is disappointing that [redacted] chose not to

take action over [redacted] relationship with a [redacted], even though [redacted] had left the Sqn. Whilst this failing is compounded by [redacted] failure to exercise the duty of care [redacted] owed [redacted] personnel as [redacted], especially in the face of the evidence that the chain of command harboured concerns over [redacted] behaviour, I accept [redacted] would have deferred to [redacted] in managing this issue. **Based on the evidence and on the balance of probabilities, I find that [redacted] failed in [redacted] duties and responsibilities as a [redacted] and [redacted], through [redacted] lack of diligence and professional curiosity in pursuing rumours of [redacted] behaviour.**

[redacted]

19. [redacted] has served on RAFAT as the [redacted] from [redacted] [redacted] is a [redacted]. During that period, the evidence confirms [redacted] extra-marital relationships were suspected to have occurred. **I have previously found as fact that the [redacted] relationship was platonic**. The remaining [redacted] relationships were: [redacted]. The evidence confirms that [redacted] was fully aware of [redacted] relationship and that [redacted] reported it to [redacted] after [redacted] The evidence also confirms [redacted] had the knowledge and capacity to act but failed to do so. As a minimum [redacted] had a duty to inform [redacted] immediately and ensure the welfare of [redacted], [redacted] There is no firm evidence that [redacted] was aware of the other relationships, but I judge it likely [redacted] was sufficiently aware of most of the rumours circulating on RAFAT, and more likely than not failed to take appropriate action. **Based on the evidence and on the balance of probabilities, I find that [redacted] failed to exercise appropriate responsibility as a [redacted] and [redacted], in failing to report both the rumours, and subsequent first-hand report of the [redacted] relationship. I further find [redacted] failed to exercise [redacted] duty of care towards [redacted] as [redacted].**

b. **Knowledge of and actions regarding unacceptable behaviours, including allegations of sexualised unacceptable behaviour, bullying, harassment and victimisation.**

20. The IR [redacted] identified [redacted] instances of UB on RAFAT during the period 2018 – 22, which included bullying, sexual harassment, assault and inappropriate comments. Many had an adverse impact on the unit's output. The prevalence of UB has waned somewhat over the period which is attributed to the forcing influence of the NSI and an important intervention by AOC 1 Gp. Notwithstanding this, the stark evidence that appropriate preparation and briefing to negate UB was largely ineffective over the period, points to serious cultural issues on RAFAT. The IR also identifies a prevalent 'bystander' culture which I judge is most likely routed in poor preparation for command and executive appointments, instances of weak leadership, poor structural organisation within RAFAT, and some systemic failings relating to supervision and the proper articulation of personal responsibilities, not least relating to command and control.

21. The IR identifies [redacted] instances where UB was appropriately dealt with by the RAFAT chain of command. The remaining [redacted] instances were not managed in an appropriate or effective manner, and all point to professional failings on the part of the RAFAT chain of command.

22. **WH19**. The evidence confirms WH19 Gave rise to [redacted] occurrences of UB. The evidence points firmly to those in the chain of command displaying: a lack of emotional intelligence; a failure to recognise and tackle the root cause of bullying behaviours; a failure to be professionally curious in routing out UB; a failure to investigate reported UB; a failure to link incidents and perpetrators; and a failure to seek appropriate SD/P1 advise and inform the CO of SD issues.

23. **Ex Spring Hawk 21 (SH21)**. SH21 gave rise to [redacted] instances of UB. The evidence confirms only two were dealt with appropriately. There is evidence of a serious bystander culture, even at RAFAT executive level. The apparent failure to act on UB, as set out in the pre-deployment briefings, likely weakened any deterrence towards further UB. The evidence clearly confirms that confusion existed as to who was the CO, and the RAFAT chain of command failed to reach back to SD/P1 support, instead choosing to deal with issues informally, often failing to recognise the seriousness of the UB.

24. **Display Season 21**. The IR confirms evidence of [redacted] instances of UB, the most serious of which [redacted] was dealt with satisfactorily, with the other [redacted] most likely remaining unsighted by the chain of command.

25. **SH22**. SH 22 gave rise to [redacted] instances of UB, all of which the evidence confirms, were dealt with appropriately by the RAFAT chain of command.

26. **Broader Behaviours**. The IR sets out a series of behaviours that came to light during the Investigation. These include organisational issues relating to the lack of a nominated Sqn 2I/C and a Sqn WO, [redacted] poor attitude to alcohol and [redacted] sexual harassment of [redacted] sexual behaviours, the different treatment afforded pilots versus other RAFAT personnel regarding their behaviour, and the poor attitude prevalent on RAFAT towards female personnel. In addition, evidence pointed firmly to the remote and less effective command style that was seen to prevail during the tenure of [redacted], vice the more open and engaging approach adopted by [redacted]. Collectively, these observations confirm that the cultural reset sought by [redacted] following AOC 1 Gp's intervention and the NSI, was not delivered effectively and did to achieve the desired outcome.

[redacted]

27. During [redacted] presided over [redacted] allegations of bullying within the Diamond 9, which threatened RAFAT output, [redacted] instances of sexual harassment against a [redacted] and [redacted] against a [redacted] and [redacted] assault by a [redacted] on an [redacted]. The evidence confirms that none of these serious instances of UB were dealt with appropriately. The evidence also confirms a lack of professional

inquisitiveness, a bystander culture across the RAFAT chain of command and an unwillingness to take action that could be viewed as unpopular. **Based on the evidence and on the balance of probabilities, I find that [redacted] failed to exercise [redacted] responsibilities as a [redacted] and as [redacted] in the conduct of [redacted] duties, failed to seek appropriate SD/P1 advice, failed to keep the CO informed regarding SD issues. I find that these professional failings to be serious and that they most likely perpetuated a culture of UB on RAFAT**.

[redacted]

28. During [redacted] presided over [redacted] allegations of bullying within the Diamond 9. This caused one event to be cancelled and directly threatened RAFAT display output. The evidence confirms that with tensions mounting between pilots, [redacted] abdicated responsibility, leaving [redacted] to intervene. As a consequence, the root cause of the alleged bullying was never tackled, simply the symptoms. The evidence also indicated a lack of professional curiosity as to suspected UB perpetrated by a [redacted] against a [redacted], and by a [redacted] on the same [redacted]. The evidence confirms that none of these serious instances of UB were dealt with appropriately. The evidence confirms a lack of professional inquisitiveness, a bystander culture across the RAFAT chain of command, and an unwillingness to take action that could be viewed as unpopular. I acknowledge that [redacted] was most likely influenced by the extant culture on RAFAT and the relaxed tone and avoidant approach set by [redacted] especially towards personnel issues. **Based on the evidence and on the balance of probabilities, I find that [redacted] failed to exercise appropriate professional curiosity, [redacted] responsibilities as a [redacted] as a [redacted], and those as [redacted] when faced with evidence of UB. I find that this amounts to a professional failing on [redacted] part, which most likely perpetuated a culture of UB on RAFAT**.

[redacted]

29. During [redacted] tenure, [redacted] presided over numerous instances of UB. There is, however, firm evidence of a clear intent to tackle the issue and that appropriate preparation and briefing was carried out before deployments to curb UB. The lack of impact points to deeply embedded cultural issues on RAFAT. The evidence confirms that the prevalence of UB reduced during [redacted] time in [redacted], largely due to [redacted] and [redacted] interventions, spurred on latterly by external interventions (AOC 1 Gp and the NSI). That said, and especially in the period prior to the NSI, the lack of reach back to SD/P1 advice, a failure to keep the CO informed of SD matters, and the perceived failure to tackle UB, was a significant missed opportunity. The bystander culture endured, and the evidence points to either a lack of confidence to act on UB or HR matters or prevarication on the part of [redacted] Critically, the overt messaging and tone set by [redacted] was not followed up effectively, in the early part of [redacted] tour, by [redacted] actions. [redacted] should have recognised this and pursued a root cause analysis as to why instances of UB continued. The evidence strongly suggests that [redacted] failure to act in the early part of [redacted] tour provided a license for continued instances of UB. This approach could be seen as a learning curve, but also points to systemic failings

in how we prepare personnel for command appointments. **Based on the evidence and on the balance of probabilities, I find that [redacted] failed to exercise appropriately [redacted] duty of care and responsibilities as a [redacted], and as [redacted], in the conduct of [redacted] duties, failed to seek appropriate SD/P1 advice, and failed to keep the CO informed regarding SD issues. I find that these to be professional failings mitigated only by a clearly articulated intent and continued improvement throughout [redacted] tour. These failings most likely perpetuated a culture of UB on RAFAT**.

[redacted]

30. During [redacted] tenure as [redacted] has presided over numerous instances of UB in the [redacted] era. Noting [redacted] clearly articulated intent to deal with UB, and [redacted] initial failure to achieve this, [redacted] must take some responsibility for perpetuating the extant RAFAT Culture through [redacted] own inactions and approach, especially the bystander culture, through [redacted] narrow focus on [redacted] The evidence does, however, confirm several instances of timely and appropriate action to prevent or deal with UB; this confirms [redacted] awareness of [redacted] OC's intent and ability to act effectively. [redacted] management of [redacted] reception [redacted], and the subsequent sharing of information by [redacted] ostracised several members of the Diamond 9 and ultimately affected Sqn output. [redacted] failure to back brief the OC on this issue, to interject to ensure the [redacted] incident was managed appropriately, to stop the [redacted] or keep a closer eye on [redacted] predatory behaviour, all served to perpetuate a culture of UB on RAFAT. The evidence confirms that [redacted] avoidance of [redacted] broader responsibilities as an [redacted] and a [redacted], serves to undermine [redacted] authority and that of the RAFAT chain of command. **Based on the evidence and on the balance of probabilities, I find that [redacted] has failed, on occasion, to exercise appropriately [redacted] responsibilities as a [redacted], and as [redacted], in the conduct of [redacted] duties, and in [redacted] duty of care to [redacted] personnel. These failings have most likely perpetuated a culture of UB on RAFAT**.

[redacted]

31. [redacted] More recently, there is firm evidence of [redacted] acting in an appropriate and timely manner to deal with UB [redacted] Prior to that, there is equally firm evidence that [redacted] failed to report UB up the RAFAT chain of command, was an active bystander to UB, and failed to exercise [redacted] duty of care to subordinates [redacted]. There is also clear evidence that [redacted] displayed questionable judgement in the immediate aftermath of the advanced party incident [redacted]. I judge it more likely than not, that [redacted] actions and approach have been heavily influenced by the tone set buy successive [redacted] and the prevailing culture on RAFAT. **Based on the evidence and on the balance of probabilities, I find that [redacted] has failed, on occasion, to exercise appropriately [redacted] responsibilities as a [redacted] and [redacted], in the conduct of [redacted]**

duties and [redacted] duty of care to [redacted] subordinates. These failings have most likely helped perpetuated a culture of UB on RAFAT.

c. **Knowledge of and actions regarding allegations of RAFAT personnel being under the influence of alcohol whilst conducting safety critical duties.**

32. The IR sets out several occasions where safety critical duties were alleged to have been undertaken by personnel under the influence of alcohol but found no firm evidence to support those allegations. The IR did find evidence of active management of alcohol consumption and of those personnel who over indulged. The conclusion that active intervention and management action was required to prevent access to safety critical duties by those under the influence is worrying and requires separate action to change this aspect of RAFATs culture.

d. **Knowledge of and actions regarding allegations of outdated leadership and management practices, including bullying, harassment, victimisation and discrimination in the RAFAT.**

[redacted]

33. The IR presents firm evidence that [redacted] more likely than not exhibited a relaxed style of leadership, was at times perceived to be too absent from the Sqn, and on occasion found [redacted] trust in [redacted] misplaced. There was no evidence that [redacted] had any real focus on driving out UB or the implementation of the Wigston Report. The continuation of the 'diamond 9 of trust' operating beyond flying, and their failure to call out UB, is an example. Changing this culture requires strong leadership, not least by [redacted]; there is no evidence of any real personal application by [redacted] in this regard. The evidence points firmly to [redacted] focus on the Display Team and their outputs, to the detriment of [redacted] leadership of the wider Sqn and its management. There is clear evidence of a disconnect over the conduct of [redacted] duties and the role of a [redacted]. **The IR found no evidence that [redacted] was derelict or negligent in the general conduct of [redacted] duties. I support this assertion** but find that [redacted] evident failure to stamp [redacted] authority on RAFAT and define appropriately key Sqn roles and responsibilities, to be disappointing. **Based on the evidence and on the balance of probabilities, I find that [redacted] failed to exercise appropriate professional diligence in the execution of [redacted] duties as [redacted].** I opine this, in part, reflects inadequate preparation for [redacted]

[redacted]

34. [redacted] primary responsibility was the safe and effective delivery of [redacted]; in this regard the evidence confirms [redacted] was heavily loaded. There is no evidence of [redacted] proactively seeking to drive out UB or learn from the Wigston Report. The IR reflects [redacted] disappointment in aspects of [redacted] management of UB ([redacted]), whilst [redacted] felt frustrated

by the need to cover for [redacted] OC when [redacted] was absent. There is evidence that [redacted] was blasé towards UB and that the selection of RAFAT pilots served only to perpetuate that stale RAFAT Culture and approach. The evidence regarding the debrief of the [redacted] did point to [redacted] not seeing clear evidence of bullying behaviour for what it was, and consequently failing to act. The evidence also suggests [redacted] singular focus on flying served to undermine [redacted] authority and position as a RAFAT Executive. In addition, the diamond 9 of trust continues to be perpetuated for matters outside flying; changing this culture requires strong leadership, not least by [redacted]. There was no evidence of any personal application by [redacted] in this regard. **The IR found no evidence that [redacted] was derelict or negligent in the general conduct of [redacted] duties.** I support this assertion but was drawn to the missed opportunities and negative impact of [redacted] Failure to accept [redacted] wider responsibilities as an [redacted] and [redacted]. **Based on the evidence and on the balance of probabilities, I find that [redacted] at times, failed to exercise appropriate professional diligence in the execution of [redacted] duties as [redacted] and as a [redacted].**

[redacted]

35. The evidence in the IR confirms [redacted] is in interested in and engaged with all aspects of the Sqn. [redacted] intent is clear, [redacted] had a firm understanding of the implications of the Wigston Report and the very public 15 Sqn RAF Regt UB incident. The evidence confirms that [redacted] was, on occasions, let down by [redacted] executives, who did not consistently up-brief issues of import. The lack of a nominated 2IC, an executive focussed on people or an empowered Sqn WO, were contributory factors. That said, there is clear evidence that [redacted] clear intent to tackle UB made some progress and [redacted] approach saw some changes in approach, and some acceptance of greater responsibility, by the Sqn's executives. I judge that a more concerted and enduring approach will be required to change RAFATS culture. **The IR found no evidence that [redacted] was derelict or negligent in the general conduct of [redacted] duties. I support this assertion.**

[redacted]

36. As [redacted] focus is on the [redacted]; in this regard the evidence confirms [redacted] was heavily loaded. There is evidence of a poor people management and a lack of interpersonal skills, including towards the Sqn's engineers. The IR highlights a reluctance to accept any responsibility that [redacted] does not see as [redacted] core duties [redacted]. The implication of this is the perpetuation of stovepipes and the bystander culture. This suggests wider systemic issues with the way we train and prepare officers in the Flying Branch for command at OF3 and above. In addition, the diamond 9 of trust continues to be perpetuated for matters outside flying; changing this culture requires strong leadership, not least by [redacted] There is no evidence of any application by [redacted] in this regard. The evidence points to a selection process that perpetuates a stale, and at times unacceptable, RAFAT culture. **The IR found no evidence that [redacted] was derelict or negligent**

in the general conduct of [redacted] duties. I support this assertion but was drawn to the missed opportunities and negative impact of [redacted] failure to accept [redacted] wider responsibilities as an [redacted] and [redacted] **Based on the evidence and on the balance of probabilities, I find that [redacted], at times, failed to exercise appropriate professional diligence in the execution of [redacted] duties as [redacted] and as a [redacted].**

[redacted]

37. [redacted] has also [redacted] on RAFAT. The evidence points to [redacted] being a very busy job. The evidence suggests [redacted] is engaging, open and likely a people person, since several individuals have reported instances of UB to [redacted]. [redacted] failure to act is a matter of evidence but I judge the reasons are most likely cultural. There are resent signs that [redacted] approach has started to change some people's perceptions, but I judge it will require a concerted effort to change the culture noting the pilot and command selection process.

38. Of more concern is the firm evidence that [redacted] has breached confidentiality on [redacted] occasions. Whilst other Sqn executives reported no concerns with [redacted] confidentiality, they all sit within the same confidential bubble. I agree with the IO that, **based on the evidence, it is more likely than not that [redacted] did, on [redacted] occasions, unnecessarily and inappropriately divulge sensitive, privileged or hearsay information. I find this was a significant professional failing which most likely served to undermine [redacted] authority and that of the RAFAT chain of command.**

e. **The relationships and information flow between the subjects and CO RAF Scampton, to assess whether the CO had sufficient oversight of the sqn.**

39. The IR highlights very clear evidence that none of the RAFAT chain of command in post over the period covered by the IR, up to and including OF5, properly understand the command and control arrangements in place for RAFAT, both at unit and when deployed. In many cases their misunderstanding was woeful. This is a worrying scenario. These failings in understanding point firmly to systemic failings in the way the Service prepares personnel for command at OF 3 and above, a general lack of understanding of command and control and the authority vested in a service person's CO, and who that is. This is essential information to every service person. Whilst the Operations Order may be clearly written, I opine that poor training has led to a broader lack of understanding. In addition, AOC 1 Gp wrote to [redacted] raising important UB issues but failed to copy in [redacted]. These systemic failures point to wider issues that could seriously impact the RAF's transition to the Airbase, Airwing construct, and should sound a loud warning bell now.

40. That aside, and despite clearly written Operations Orders, the evidence confirms significant failings by [redacted] and [redacted] to report SD matters to the CO and seek specialist SD and P1 advice and support. These failings were manifest, undermined trust and confidence in the RAFAT chain of command,

especially during [redacted] tenure, supressed victim reporting, and perpetuated instances of UB. **These failings are highlighted and attributed in my earlier determinations above.**

f.	**Allegations of a bystander culture from the CoC.**

41. Notwithstanding the evidence that formal active bystander training was not introduced until well into the period under investigation, there are more fundamental drivers for our officers and service personnel to conduct themselves in an appropriate manner. This approach is encapsulated in AP1, the Core Values and Standards of the RAF, during leadership training, in legislation (HASAW Act) and in various MOD and RAF policies. Doing the right thing underpins our Total Safety Approach, which was sufficiently mature in 2018 to reasonably shape behaviours.

42. **The IR sets out robust evidence of a widespread bystander culture on RAFAT, at every level up to and including the OC**. I opine that this is perpetuated by RAFAT's culture, its relatively flat structure, its elite status, and at time weak leadership, which in turn is preserved by the selection process. The evidence points to a gradual shift towards an increased willingness to act. Changing RAFAT's culture is at the heart of removing this bystander culture, which supresses victim reporting, perpetuates UB, undermines confidence on the chain of command and demonstrably affects outputs. **Failings in this regard are highlighted and attributed in my earlier determinations above.**

FURTHER ACTION – CO'S DETERMINATION

43. Having considered the evidence in the IR holistically, there is very clear evidence of professional failings on the part of all [redacted]. **This finding reflects a pragmatic view on where responsibility within the extended RAFAT chain of command realistically sat**. There was evidence of failures by others, but I have carefully assessed the command climate and culture on RAFAT over the period and concluded that the responsibility for the failings identified in the evidence must sit with [redacted] in post over that period.

44. Having reached determinations on all aspects of the Investigation's TORs, I recommend administrative action is initiated against the following personnel for their failings determined above:

[redacted]

WIDER RECOMMENDATIONS

45. This Investigation provided an opportunity to look into a high performing, elite team, who remain central to the RAF and UK Defence's engagement strategy. A number of observations have arisen which drive the following recommendations, all aimed at promoting continuous improvement.

46. I recommend that:

a. Work is initiated to change RAFAT's culture. This has read across the findings of the Command and Leadership Review (CLR) completed in 2021.

b. OC RAFAT's job spec is reviewed to open up the essential attributes to include potential commanders with broader experience and perspectives.

c. Given their public exposure, bespoke D&I training is undertaken by RAFAT personnel to promote an inclusive team that actively calls out and acts on UB, over and above the operational demands placed on the unit. This has links with the findings of the CLR.

d. Training and preparation for command appoints at OF3 and above is reviewed and better structured to properly equip our commanders for command. This also links to the CLR.

e. The internal command structure of RAFAT is reviewed to ensure:

(1) A 2IC position is nominated and empowered.

(2) A Sqn WO is nominated and empowered.

(3) A RAFAT Executive is given the focus for People.

f. Action is taken to ensure RAFAT personnel access alcohol responsibly and that the risk of those engaged in safety critical duties whilst under the influence of alcohol is significantly reduced.

g. The lived experience of female personnel on RAFAT is reviewed and action taken to redress the shortcomings and failings identified. This also has links with the CLR.

h. The RAF publishes an RAF command and control guide, aimed at all RAF personnel, setting out the different duties, roles and responsibilities that sit therein and how they should interface with those functions to support the next Generation Air Force, its structure and its lay down.

i. The RAF publishes clear guidance on relationships in the workplace, and how that may affect outputs and how that relates to the Service Test.

[redacted]

[redacted]

Enclosures:

1. CO's Investigation into Allegations of Command, Leadership and management Failings from within the RAF Aerobatic Team (RAFAT) Report, dated 16 Jun 23.
2. [redacted] CO's RAFAT Investigation Anonymised Respondent, Witness & Evidence Decode.