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MEMORANDUM

To. AD/ASIS DTS(WE) ←
Block B
Ensleigh, Bath
(for Maj. [REDACTED], Rm. 124)

From. NOIO Coulport

Date 30th June 1985
Your Ref.

Tel. Ext 523
Our Ref D/SSC/CPT/7001

Subject. Special Weapons Incident Report

The attached notes on the incident to a Special Stores convoy in Helensburgh on 20th June 1985 are forwarded for discussion on 5th July.

[REDACTED]

Copies

AD/QS DGSWS
Block C
Foxhill, Bath

Cdr. [REDACTED].R.N.
Senior Naval Representative
AWRE Aldermaston

CE RNAD Coulport

Mr [REDACTED] DTS(WE)
Block B
Ensleigh, Bath

NOTES ON MINOR ACCIDENT TO STORES CONVOY AT
HELENSBURGH ON 20 JUNE 1985

Narrative.

1. At approximately 1415 on Thursday 20th June a stores convoy from Burghfield to RNAD Coulport was involved in a minor accident (involving no private vehicles) in Sinclair St. Helensburgh; it was stated that the accident was caused by brake failure, this is subject to a formal inquiry. The convoy commander judged that no "weapon accident" situation had arisen (i.e. the stores were secure and had only shifted slightly in their secured positions) and he took action to convey the damaged vehicle containing the stores to the nearest secure site (CSB Faslane) where the load could be transferred to the spare vehicle. SAD(C) offered to provide assistance in the load transfer, which the convoy commander readily accepted, and provided a stores party together with the necessary equipment and the depot crane as used for similar operations within the depot. He also arranged that a PTO 1 (██████████) witness the operation to provide technical advice and liaison. It is understood that the loads were transferred without incident in accordance with the depot's stores COI's with only minor adjustments (as suggested by ██████████) to ensure continuity of earthing arrangements.
2. On completion of transfer, the convoy proceeded to Coulport where the loads were parked overnight prior to offload in working hours. The damaged vehicle was kept at Faslane until it was recovered by the R.A.F. on Sunday 23rd June.
3. It is understood that no signals were received at RNAD until Monday although a ██████████ was originated by the convoy commander, through COMCLYDE, and the stores were "red-carded" by AWRE (201923JUN85). An AWRE team was organised to visit the depot on Mon 24th (Mr. ██████████ AC(NUC), and Mr. ██████████ ROF(B)). These officers witnessed the satisfactory completion of depot receipt inspections on 24th, the stores were then transferred on 10" rails to store to await use in processing (i.e. until October) subject to any further project instructions. The Chief Engineer has advised DGSWS/AWRE (RNAD 271042Z JUN85) that the stores will be deemed servicable subject to outstanding processing inspections and any advice to the contrary from HQ.
4. NOIO involvement in these affairs arose only from:
 - a. Advice from DTS(WE) (██████████) at 1650 on 20th June that an accident had occurred.
 - b. A requirement on Sunday 23rd June for INO 4 to carry out sampling in Building 8 to allow the stores to be inspected.
 - c. NOIO participation in the examination of the stores in the presence of the AWRE reps.

In fact the sampling was not required but INO 4, through INO 1 (on site), identified a confusion in agreed actions between HMPE and HIFE in that processing should await the arrival of the AWRE team (Note: the AWRE signal was not copied to RNAD until 271430Z JUN). Processing was then halted by the Chief Engineer until Monday.

Comment.

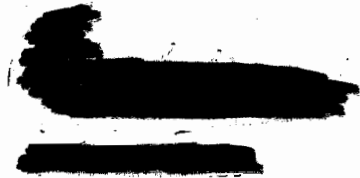
5. The convoy commander's actions appear to have been i.a.w. correct procedures in that he correctly judged the scale of the accident, the immediate actions required and accepted the offer of the best support available locally to transfer the load to the spare vehicle.
6. There is considerable uncertainty in the depot and NOIO as to what may be expected of us in an incident of a more serious nature with a convoy, my minute D/SSC/CPT/7001 dated 24th April also covers this subject.

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7. The signals were slow and appear inadequately copied to keep the depot informed and instructed. A formal sentencing of the stores can only be given by the technical authority and is required quickly and in writing as soon as possible.

Conclusions.

8. The incident was correctly handled from a technical viewpoint.
9. The responsibilities of MOD(N) authorities to assist the R.A.F. convoy commander do not seem to be well defined in an accident situation but in this incident the response by SAD(C) provides probably the correct precedent.
10. There does not seem to have been any "SRT"/"CDA" for the action to be taken in the event of a serious accident to these stores in transit, and the action taken in this incident would not have been possible had the vehicle been incapacitated.



NOIO Coulport