Service Inquiry into the circumstances leading to the death of a Service Person on 06 February 2019 at the Royal Military Academy Sandhurst

APSG/SI/19

24 June 2022

PART 1.1

Covering Note and Glossary

PART 1.1 – COVERING NOTE

APSG/SI/2019/

24 Jun 22

SERVICE INQUIRY INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH AND PRIOR SELF HARM OF A SERVICE PERSON.

1. The Service Inquiry Panel formally convened at Trenchard Lines, Upavon, Wiltshire at 0830hrs on 07 Oct 19 by order of Major General **D F CAPPS CBE** for the purpose of investigating the circumstances leading to and surrounding the death and prior self-harm of a Service Person. The Panel has concluded and submits the final report for the Convening Authority's consideration.

2. The following inquiry papers are enclosed:

   Part 1.1 – Covering Note and Glossary

   Part 1.2 – Convening Orders, TORs and Executive Summary

   Part 1.3 – Narrative of Events

   Part 1.4 – Analysis and Findings

   Part 1.5 – Recommendations

   Part 1.6 – Convening Authority Comments

   Part 1.7 – Reviewing Authority Comments

PRESIDENT

[redacted]

[Signature]

President Service Inquiry

MEMBERS

[Signature]	[Signature]	[Signature]
[redacted]	[redacted]	[redacted]
Panel Member	Panel Member	Panel member

PART 1.1 – GLOSSARY

Serial (a)	Acronym/Abbreviation (b)	Definition (c)
	AAC	Army Air Corps
	Ac	Academy
	Admin	Administration
	Adjt	Adjutant
	AGAI	Army General Administrative Instruction
	AGC(ALS)	Adjutant General's Corps (Army Legal Services)
	AGC(SPS)	Adjutant General's Corps (Staff & Personnel Support)
	AI	Assistant Instructor
	AO	Assisting Officer
	AOSB	Army Officer Selection Board
	APC	Army Personnel Centre
	APSG	Army Personnel Services Group
	ARITC	Army Recruitment Initial Training Command
	ASLS	Army (Recruitment Initial Training Command) Staff Leadership School
	ATR	Army Training Regiment
	AWS	Army Welfare Service
	BAS	Bereavement and Aftercare Service
	BT	Basic Training
	CA	Climate Assessment
	CABS	Communications and Applied Behavioural Science
	CAP	Care Assessment Plan
	Capt	Captain
	CAT	Coaching and Advisory Team
	Cat	Category
	CATAC	Combined Arms Tactics Course
	CC	Commissioning Course
	CI	Chief Instructor
	CM	Court Martial
	CMCR	Commanders Monthly Clinical Review
	CMHN	Community Mental Health Nurse
	CoC	Chain of Command
	CO	Commanding Officer
	CODC (CO DES)	Commanding Officers Designates Course
	Comd	Commander
	Coy	Company
	CPN	Clinical Psychiatric Nurse
	CPR	Cardio Pulmonary resuscitation
	CSgt	Colour Sergeant
	CSM	Company Sergeant Major

	DBH	Discrimination, Bullying and Harassment
	DCA	Defence Consultant Advisor
	DCMH	Departments of Community Mental Health
	DIA	Defence and International Affairs
	Div	Division
	DIU	Defence Inquest Unit
	DMICP	Defence Medical Information Capability Programme
	DOB	Date of Birth
	DoC	Duty of Care
	DPHC	Defence Primary Health Care
	DRS	Defence Recruitment System
	DS	Directing Staff
	DSH	Deliberate Self-Harm
	DSMO	Deputy Senior Medical Officer
	DTTT	Defence Train The Trainer
	EC	Emergency Contact
	Ex	Exercise
	GOC	General Officer Commanding
	G1	General Staff Division 1 – Personnel & Administration
	HC	Home Command
	HIL	High Interest List
	HOTO	Hand Over Take Over
	HQ	Headquarters
	IAT	Initial Assessment Team
	INCREP	Incident Report
	IRTB	Issue, Recommendation, Timing, Background
	ITC	Initial Training Centre
	ITG	Initial Training Group
	ITT	Initial Trade Training
	JCCC	Joint Casualty and Compassionate Centre
	JPA	Joint Personnel Administration
	JSP	Joint Service Publication
	KSE	Knowledge, Skills, Experience
	L3CA	Level 3 Climate Assessment
	LA	Learning Account
	LAR	Learning Account Review
	LCpl	Lance Corporal
	LEGAD	Legal Advisor (To the Panel)
	LFSO	Land Forces Standing Order
	Lt Col	Lieutenant Colonel
	Maj	Major
	MATTs	Military Annual Training Tests
	MDT	Multi Disciplinary Team
	MDTM	Multi Disciplinary Team Meeting
	MEL	Main Events List
	MH	Mental Health

	MO	Medical Officer
	MPAR	Mid-Period Appraisal Report
	MRS	Medical Reception Station
	NC	New College
	NCO	Non-Commissioned Officer
	NOK	Next of Kin
	NOTICAS	Notification of Casualty (Report)
	NRC	National Recruiting Centre
	OC	Officer Commanding
	OCdt	Officer Cadet
	OF3	Officer Grade 3 (Major)
	OF5	Officer Grade 5 (Colonel)
	Ofsted	Office for Standards in Education
	OS	Official Sensitive
	OSP	Official Sensitive Personal
	PHCT	Primary Health Committee Team
	PIPOT	Person in Position of Trust
	Pl Comd	Platoon Commander
	PO	Potential Officer
	PPSI	Permanent President of Service Inquiry
	PT	Physical Training
	PTSD	Post-Traumatic Stress Disorder
	RA	Royal Artillery
	RAChD	Royal Army Chaplains Department
	RAF	Royal Air Force
	RE	Royal Engineers
	Regt	Regiment
	RLC	Royal Logistics Corps
	RMAS	Royal Military Academy Sandhurst
	RMP	Royal Military Police
	RMP SIB	Royal Military Police Special Investigation Branch
	RSB	Regimental Selection Board
	RSM	Regimental Sergeant Major
	RTU	Returned to Unit
	R18W	Regulation 18 Witness
	SAA	Skill At Arms
	SAF	Student Assessment Form
	SCD	Supervisory Care Directive
	Sgt	Sergeant
	SH	Self Harm
	SHA(A)	Senior Health Advisor (Army)
	SI	Service Inquiry
	SME	Subject Matter Expert
	SMO	Senior Medical Officer
	SNCO	Senior Non-Commissioned Officer
	SO1	Staff Officer Grade 1 (Lieutenant Colonel)
	SO2	Staff Officer Grade 2 (Major)

	SP	Service Person or Personnel
	Sp	Support
	SPA	Service Prosecuting Authority
	SSgt	Staff Sergeant
	SSCC	Sandhurst Staff Context Course
	SSU	Sandhurst Support Unit
	SVRM	Suicide Vulnerability Risk Management
	TOR	Term of Reference
	Trg Wg	Training Wing
	Tri-Service	Three Services – i.e. All three branches- Army, Navy and Air Force
	TRiM	Trauma Risk Management
	UHC	Unit Health Committee
	UWO	Unit Welfare Officer
	VRM	Vulnerable Risk Management
	VRMIS	Vulnerable Risk Management Information System
	VSI	Very Seriously Injured
	WISMIS	Wounded and Injured Soldiers Management Information System
	WO1	Warrant Officer Class One
	WO2	Warrant Officer Class Two
	WRVS	Women's Royal Voluntary Service (renamed Royal Voluntary Service in 2013)
	2IC	Second in Command

PART 1.2

Convening Order and Terms of Reference

OFFICIAL - SENSITIVE

From: Brigadier CMB Coles

Single Service Inquiry Coordinator (Army)
[redacted]

Telephone: [redacted]
Military:
MODnet: [redacted]

Reference: APSG/SI/[redacted]

Major General DF Capps CBE
General Officer Commanding
[redacted]

30th July 2019

Dear General Duncan

SERVICE INQUIRY (SI) INTO THE DEATH OF [redacted]

1. A SI is to be convened to establish the curcumstances surrounding the death of [redacted]

2. As General Officer Commanding Regional Command you will be the Convening Authority for the SI and are requested to issue the Convening Order. The Convening Order and Terms of Reference are to be approved by you and passed to the Head Army Personnel Service Group for approval together with an ndicative investigation plan and timeline. The conduct of this SI is to convene in accordance with guidance provided in Joint Service Publication (JSP) 832 and Land Forces Standing Order (LFSO) 3207.

3. The purpose of the SI is to:

   a. Establish the facts of the matter.

   b. Establish if policy and procedures were followed.

   c. Assess the relevant extant policies.

   d. Identify lessons and recommendations to prevent recurrence.

OFFICIAL - SENSITIVE

4. [redacted] Colonel [redacted], has been assigned as the President to this Inquiry. [redacted] Maj [redacted] will be one of the panel members, the other member is [redacted] Sgt [redacted] A medical offier is also required, due to medical in confidence, they will be required to assist with the medical element of the Service Inquiry. The President will engage with the Surgeon Generals department direct to discuss the requirement.

5. The Service Inquiry should provide its final report after being reviewed and signed off by the Convening Authority, no later than May 20.

ORIGINAL SIGNED

Copy to:

[redacted]
FTC- SO2 PPSI
APSG – DACOS Pers Svcs
HC – DACOS Legal
APSG – SO1 SI
APSG - SO2 Legal
APSG - BAS
DJEP - DIU
File

OFFICIAL - SENSITIVE

From: Brigadier CMB Coles

Single Service Inquiry Coordinator (Army)
[redacted]

Telephone: [redacted]
Military:
MODnet:

Reference: APSG/SI/[redacted]

Major General D J Eastman MBE
General Officer Commanding
[redacted]

02 November 2020

Dear General David

SERVICE INQUIRY (SI) INTO THE DEATH OF [redacted] ROYAL MILITARY ACADEMY SANDHURST ON 06 FEB 19.

1. Maj Gen Capps convened an SI on 30 Jul 19 to establish the circumstances surrounding the death of [redacted] on 06 Feb 19.

2. Due to change of General Officer Commanding Regional Command you will now be hold the role of Convening Authority for the SI and are requested to issue a revised Convening Order. The Convening Order and Terms of Reference have been approved by Maj Gen Capps, if you believe any amendments are required these must be passed to Head of Army Personnel Services Group for approval. The conduct of this SI is to be in accordance with the guidance provided in Joint Service Publication (JSP) 832 and Land Forces Standing Order (LFSO) 3207.

3. The purpose of the SI is to:

   a. Establish the facts of the matter.

   b. Assess the relevant extant policies.

   c. Establish if policy and procedures were followed.

   d. Identify lessons and recommendations to prevent recurrence.

4. The SI Panel comprises:

a. President: [redacted] –Col [redacted].

b. Member: [redacted] – Maj [redacted]

c. Member: [redacted] – Maj [redacted].

d. Member: [redacted] – Capt [redacted].

e. Legal advisor [redacted]– Maj [redacted].

f. Medical SME [redacted] – Surgeon Capt [redacted]

5. The Service Inquiry President will provide you monthly progress reports and will present the final report for your review and signature no later than Feb 21.

ORIGINAL SIGNED

Copy to:

APSG – [redacted]President & Panel
RC – Legad
APSG – DACOS Pers Svcs
APSG – SO1 - SI
APSG - BAS
APSG - SO2 Legal
DJEP - DIU
File

OFFICIAL SENSITIVE

CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL DG CAPPS CBE

GENERAL OFFICER COMMANDING REGIONAL COMMAND

1. A Service Inquiry (SI) is to be convened, in accordance with Section 343 of the Armed Forces Act 2006 (AFA 06), to investigate the circumstances leading to the death of [redacted] on 6 Feb 19. It is also to consider the policy and practice surrounding the identification and management of vulnerable Army personnel.

2. A SI is to assemble on 7 Oct 19. The SI is the Panel's priority task and takes precedence over any other duties.

3. The SI Panel President is [redacted] Col [redacted]. [redacted] Maj [redacted] will be a panel member as will [redacted] Lt [redacted]. A medical subject matter expert will be required for the Service Inquiry, the President will contact Surgeon General's office in due course. The medical subject matter expert will not be a member of the SI Panel.

4. The legal adviser to the SI is [redacted] Maj [redacted]. The legal advisor will not be a member of the SI Panel.

5. The Panel is to investigate and report the circumstances surrounding the incident, recording all relevant evidence and expressing opinions in accordance with the Terms of Reference at Annex A. The Panel is not to attribute blame, negligence or recommend disciplinary action.

6. The General Officer convening the SI directs that the evidence is to be taken on oath or by affirmation, as required, in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008. Any document or other matter produced to the Panel by a witness, for use as evidence, shall be made an exhibit and treated in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008.

7. Any person who, in the opinion of the President, may be affected by the findings of the Panel shall be treated in accordance with Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008. The President is to ensure that any such person is notified as early as reasonably possible.

8. The Panel may hear evidence from any such other witnesses or subject matter experts as it deems appropriate and may dispense with the attendance of any witness if it concludes that the witness evidence will not assist the SI. The President should note that a witness statement taken by the RMP/SIB may not be admitted as evidence to the SI, unless the express consent of the witness providing the statement has been obtained.

9. If it appears to the Panel at any time during the Service Inquiry that any person may have committed an offence against Service Law, including a criminal conduct offence contrary to Section 42 of the Armed Forces Act 2006, the President is to adjourn the Service Inquiry immediately and seek legal advice.

10. The President is to inform all witnesses that a transcript of the SI, whilst primarily for internal MOD use, may subsequently be released into the public domain. All such material accessible to the public would be released in a redacted form according to current Service policy on disclosure and adhering to current legislation, including the Data Protection Act 2018,

implementing the General Data Protection Regulation, and the Freedom of Information Act 2000.

11. The SI is to express its opinion with regards to any material conflict in the evidence, which may arise and give reasons for reaching that opinion. Any conflict in the evidence should be determined on the balance of probabilities.

12. The President is required to submit monthly progress reports to the Convening Authority and APSG Service Inquiry Branch in accordance with Appendix 4 to Annex G to CH 2 of JSP 832 and paragraph 27 (h) of LFSO 3207.

GENERAL ADMINISTRATION

13. Regional Command is to provide the following:

a. A professional Verbatim Court Recorder to be present to record evidence at hearings as required.

b. An orderly to assist at the hearings as confirmed by the President.

c. Stationery as required by the Panel.

d. Travel and subsistence for the Panel for SI related business away from their primary place of residence.

e. Travel and subsistence as required by any witnesses (for SI business).

f. Service Accommodation, as appropriate and if required, in the region where the hearings will take place, likely to be Andover.

g. Access to clerical support as required.

h. Appropriate office space and IT for the Panel members.

14. The costs of the Service Inquiry are to be charged to Regional Command UIN: [redacted].

DG CAPPS CBE
Major General
General Officer Commanding

Date: 7 Oct 2019

Annex:

A. Terms of Reference.

OFFICIAL SENSITIVE

ANNEX A to
Convening Order
Dated 7 Oct 19

SERVICE INQUIRY INTO THE DEATH OF [redacted]

TERMS OF REFERENCE

TERMS OF REFERENCE FOR THE SERVICE INQUIRY INTO THE CIRCUMSTANCES SURROUNDING THE DEATH AND PRIOR SELF HARM OF [redacted].

1. The Panel is to investigate the circumstances leading to and surrounding the death and prior self-harm of [redacted].

2. The Panel is to report on all relevant matters and, where the Panel thinks it appropriate, to comment on such matters, express opinions and make recommendations. In particular the Panel is to investigate and establish:

TOR 1 – Establish the facts surrounding the deliberate self-harm of [redacted] on 16 Jul 18

3. Determine the cause of the incident by examining the contributory factors and the events leading up to the self-harm of [redacted] on 16 Jul 18 to include, but not limited to:

a. A full chronology of the events leading up to the self-harm, concentrating on the period from the start of training at RMAS up to 16 Jul 18 and any subsequent events which are relevant to the Service Inquiry.

b. Details of [redacted] Service history; to include work performance and disciplinary record in the 12 months preceding her self-harm.

c. Establish, as far as is relevant to the scope of this Inquiry and can be disclosed without breaching relevant medical confidentiality restrictions, the personal circumstances including medical history which may have had an impact on [redacted] actions.

d. Establish to what extent the chain of command were aware of any welfare issues relating to [redacted].

e. Examine details of any welfare and/or medical organisation that may have been consulted, and any advice or treatment given, or action required, that would have assisted [redacted].

f. Examine whether the Chain of Command fully considered and applied sound military judgement to all the options available to [redacted] after her deliberate self-harm incident.

TOR 2 – Establish the facts surrounding the death of [redacted] on 6 Feb 19.

4. Determine the cause of the incident by examining the contributory factors and the events leading up to the death of [redacted], to include, but not limited to:

a. A full chronology of the events leading up to the death, concentrating on the period of 24 months before the date of death to include AOSB Briefing, AOSB attendance, Pre-RMAS courses and the Commissioning Course No182 to date and any subsequent events which are relevant to the Service Inquiry.

b. Details of [redacted] Service history; to include work performance and disciplinary record in the 12 months preceding her death.

c. Establish, as far as is relevant to the scope of this Inquiry, the personal circumstances including medical history which may have had an impact on [redacted] death.

d. Establish to what extent the Chain of Command were aware of any welfare issues relating to [redacted].

e. Details of the involvement of welfare and other relevant agencies that may have been consulted and any advice or treatment given.

f. Assess, with respect to the Chain of Command, the extent to which the level of support provided to [redacted] by the Chain of Command met the standard set by the extant policy; and express an opinion on, with respect to the relevant welfare services, the level of support they provided, in each case considering all the information available at the relevant time.

g. Examine the policy and procedures for the handover of OCdts between the RMAS Colleges at the end of each training term.

TOR 3 - Identify the relevant policies, procedures and other welfare provisions, and how they were applied at RMAS in relation to each case.

5. To determine RMAS approach to the relevant policies, procedures and welfare and other provisions including, but not limited to:

a. Identify what policies, procedures and regulations, both in the wider Army and within the establishment exist for the provision of welfare support in cases such as this, including but not limited to the implementation of AGAI Vol 3 Chapters 81 (Army Welfare Policy), 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy) and JSP 893 Policy on Safeguarding Vulnerable Groups.

b. Determine the level of understanding and application of AGAI 110 SVRM by the Chain of Command.

c. Consideration of Unit Health Committee activity and subsequent actions in relation to [redacted], concentrating on the application and management of her Care Action Plan.

d. Determine the extent to which policies and procedures have changed since Feb 19 and the extent to which any changes have been implemented within RMAS, at other training establishments and in the wider Army to prevent any recurrence of incidents of this type.

e. Express an opinion on the level of support provided to [redacted] by the Chain of Command and Welfare services in light of the information available and extant policy.

TOR 4 - Establish the relevant policies and procedures which apply to DCMH Aldershot and the extent to which they were implemented in each case, namely 16 Jul 18 and 6 Feb 19.

6. To determine DCMH Aldershot's understanding and application of the relevant SVRM Policy:

a. Identify the SVRM policy applied within DCMH Aldershot and how this integrated with AGAI 110.

b. Determine the extent to which policies and procedures have changed within DCMH Aldershot since Feb 19 to prevent any recurrence of incidents of this type.

c. Express an opinion as to whether the policies and procedures are appropriate in ensuring any risk is managed in cases such as these including the impact of the requirement for confidentiality.

TOR 5 – Investigate the extent to which RMAS and external medical agencies interacted in support of [redacted].

7. Examine the effectiveness of the multi-agency interaction, including but not limited to:

a. Determine any similarities in relation to each event and analyse in respect of the post-event care following the self-harm incident on 18 Jul 18 the action taken by the Chain of Command.

b. Analyse medical procedures and reports to determine the level of care and attention received by [redacted].

c. Determine the procedures in place at DCMH Aldershot for sharing of information and concerns with Units.

d. Identify whether sensitive and confidential information was appropriately shared between and within RMAS and DCMH Aldershot.

e. Express an opinion on whether the interaction between DCMH Aldershot, RMAS, medical agencies and welfare organisations was appropriate and sufficient in the circumstances known, or which could reasonably expected to be known, to those agencies and organisations at the time.

TOR 6 – Based on the evidence, make such findings and express opinions as are appropriate to support recommendations in order to prevent recurrence.

Procedure

8. The Panel is to include in the record of proceedings a clear and concise précis of the case in an easily readable form, addressing each of the Terms of Reference listed above. In particular the Panel should:

a. Set out the facts that, in the opinion of the Panel, have been established by the evidence, on the balance of probabilities.

b Set out any additional facts, relevant to the matter under inquiry, disclosed from the evidence, which have not been specifically referred to in the Terms of Reference.

c. Ensure that contained in the record are the transcripts of oral evidence, copies of witness evidence given to the Panel and any other evidence which the President decides should form part of the record.

9. The President is to forward one copy of the record of proceedings to the Convening Authority on completion of the Service Inquiry.

OFFICIAL SENSITIVE

CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL DG CAPPS CBE

GENERAL OFFICER COMMANDING REGIONAL COMMAND

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2. A SI is to assemble on 7 Oct 19. The SI is the Panel's priority task and takes precedence over any other duties.

3. The SI Panel President is [redacted] Col [redacted]. [redacted] Maj [redacted] will be a panel member as will [redacted] Lt [redacted]. A medical subject matter expert will be required for the Service Inquiry, the President will contact Surgeon General's office in due course. The medical subject matter expert will not be a member of the SI Panel.

4. The legal adviser to the SI is [redacted] Maj [redacted]. The legal advisor will not be a member of the SI Panel.

5. The Panel is to investigate and report the circumstances surrounding the incident, recording all relevant evidence and expressing opinions in accordance with the Terms of Reference at Annex A. The Panel is not to attribute blame, negligence or recommend disciplinary action.

6. The General Officer convening the SI directs that the evidence is to be taken on oath or by affirmation, as required, in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008. Any document or other matter produced to the Panel by a witness, for use as evidence, shall be made an exhibit and treated in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008.

7. Any person who, in the opinion of the President, may be affected by the findings of the Panel shall be treated in accordance with Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008. The President is to ensure that any such person is notified as early as reasonably possible.

8. The Panel may hear evidence from any such other witnesses or subject matter experts as it deems appropriate and may dispense with the attendance of any witness if it concludes that the witness evidence will not assist the SI. The President should note that a witness statement taken by the RMP/SIB may not be admitted as evidence to the SI, unless the express consent of the witness providing the statement has been obtained.

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10. The President is to inform all witnesses that a transcript of the SI, whilst primarily for internal MOD use, may subsequently be released into the public domain. All such material accessible to the public would be released in a redacted form according to current Service policy on disclosure and adhering to current legislation, including the Data Protection Act 2018,

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12. The President is required to submit monthly progress reports to the Convening Authority and APSG Service Inquiry Branch in accordance with Appendix 4 to Annex G to CH 2 of JSP 832 and paragraph 27 (h) of LFSO 3207.

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b. An orderly to assist at the hearings as confirmed by the President.

c. Stationery as required by the Panel.

d. Travel and subsistence for the Panel for SI related business away from their primary place of residence.

e. Travel and subsistence as required by any witnesses (for SI business).

f. Service Accommodation, as appropriate and if required, in the region where the hearings will take place, likely to be Andover.

g. Access to clerical support as required.

h. Appropriate office space and IT for the Panel members.

14. The costs of the Service Inquiry are to be charged to Regional Command UIN: [redacted].

DG CAPPS CBE
Major General
General Officer Commanding

Date: 5 Feb 2020

Annex:

A. Terms of Reference.

OFFICIAL SENSITIVE

ANNEX A to
Convening Order
Dated 5 Feb 20

SERVICE INQUIRY INTO THE DEATH OF [redacted]

TERMS OF REFERENCE

TERMS OF REFERENCE FOR THE SERVICE INQUIRY INTO THE CIRCUMSTANCES SURROUNDING THE DEATH AND PRIOR SELF HARM OF [redacted].

1. The Panel is to investigate the circumstances leading to and surrounding the death and prior self-harm of [redacted]

2. The Panel is to report on all relevant matters and, where the Panel thinks it appropriate, to comment on such matters, express opinions and make recommendations. In particular the Panel is to investigate and establish:

TOR 1 – Establish the facts surrounding the deliberate self-harm of [redacted] on 16 Jul 18

3. Determine the cause of the incident by examining the contributory factors and the events leading up to the self-harm of [redacted] on 16 Jul 18 to include, but not limited to:

a. A full chronology of the events leading up to the self-harm, concentrating on the period from the start of training at RMAS up to 16 Jul 18 and any subsequent events which are relevant to the Service Inquiry.

b. Details of [redacted] Service history; to include work performance and disciplinary record in the 12 months preceding her self-harm.

c. Establish, as far as is relevant to the scope of this Inquiry and can be disclosed without breaching relevant medical confidentiality restrictions, the personal circumstances including medical history which may have had an impact on [redacted] actions.

d. Establish to what extent the chain of command were aware of any welfare issues relating to [redacted].

e. Examine details of any welfare and/or medical organisation that may have been consulted, and any advice or treatment given, or action required, that would have assisted [redacted].

f. Examine whether the Chain of Command fully considered and applied sound military judgement to all the options available to [redacted] after her deliberate self-harm incident.

TOR 2 – Establish the facts surrounding the death of [redacted] on 6 Feb 19.

4. Determine the cause of the incident by examining the contributory factors and the events leading up to the death of [redacted], to include, but not limited to:

a. A full chronology of the events leading up to the death, concentrating on the period of 24 months before the date of death to include AOSB Briefing, AOSB attendance, Pre-RMAS courses and the Commissioning Course No182 to date and any subsequent events which are relevant to the Service Inquiry.

b. Details of [redacted] Service history; to include work performance and disciplinary record in the 12 months preceding her death.

c. Establish, as far as is relevant to the scope of this Inquiry, the personal circumstances including medical history which may have had an impact on [redacted] death.

d. Establish to what extent the Chain of Command were aware of any welfare issues relating to [redacted].

e. Details of the involvement of welfare and other relevant agencies that may have been consulted and any advice or treatment given.

f. Assess, with respect to the Chain of Command, the extent to which the level of support provided to [redacted] by the Chain of Command met the standard set by the extant policy; and express an opinion on, with respect to the relevant welfare services, the level of support they provided, in each case considering all the information available at the relevant time.

g. Examine the policy and procedures for the handover of OCdts between the RMAS Colleges at the end of each training term.

TOR 3 - Identify the relevant policies, procedures and other welfare provisions, and how they were applied at RMAS in relation to each case.

5. To determine RMAS approach to the relevant policies, procedures and welfare and other provisions including, but not limited to:

a. Identify what policies, procedures and regulations, both in the wider Army and within the establishment exist for the provision of welfare support in cases such as this, including but not limited to the implementation of AGAI Vol 3 Chapters 81 (Army Welfare Policy), 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy) and JSP 893 Policy on Safeguarding Vulnerable Groups.

b. Determine the level of understanding and application of AGAI 110 SVRM by the Chain of Command.

c. Consideration of Unit Health Committee activity and subsequent actions in relation to [redacted], concentrating on the application and management of her Care Action Plan.

d. Determine the extent to which policies and procedures have changed since Feb 19 and the extent to which any changes have been implemented within RMAS, at other training establishments and in the wider Army to prevent any recurrence of incidents of this type.

e. Express an opinion on the level of support provided to [redacted] by the Chain of Command and Welfare services in light of the information available and extant policy.

f. Express an opinion on the level of support provided by the Chain of Command and welfare services to the permanent staff and OCdts after the deliberate self harm incident on 16 Jul 18 and in the immediate period after [redacted] death on 06 Feb 19.

TOR 4 - Establish the relevant policies and procedures which apply to DCMH Aldershot and the extent to which they were implemented in each case, namely 16 Jul 18 and 6 Feb 19.

6. To determine DCMH Aldershot's understanding and application of the relevant SVRM Policy:

a. Identify the SVRM policy applied within DCMH Aldershot and how this integrated with AGAI 110.

b. Determine the extent to which policies and procedures have changed within DCMH Aldershot since Feb 19 to prevent any recurrence of incidents of this type.

c. Express an opinion as to whether the policies and procedures are appropriate in ensuring any risk is managed in cases such as these including the impact of the requirement for confidentiality.

TOR 5 – Investigate the extent to which RMAS and external medical agencies interacted in support of [redacted].

7. Examine the effectiveness of the multi-agency interaction, including but not limited to:

a. Determine any similarities in relation to each event and analyse in respect of the post-event care following the self-harm incident on 16 Jul 18 the action taken by the Chain of Command.

b. Analyse medical procedures and reports to determine the level of care and attention received by [redacted].

c. Determine the procedures in place at DCMH Aldershot for sharing of information and concerns with Units.

d. Identify whether sensitive and confidential information was appropriately shared between and within RMAS and DCMH Aldershot.

e. Express an opinion on whether the interaction between DCMH Aldershot, RMAS, medical agencies and welfare organisations was appropriate and sufficient in the circumstances known, or which could reasonably expected to be known, to those agencies and organisations at the time.

TOR 6 – Based on the evidence, make such findings and express opinions as are appropriate to support recommendations in order to prevent recurrence.

Procedure

8. The Panel is to include in the record of proceedings a clear and concise précis of the case in an easily readable form, addressing each of the Terms of Reference listed above. In particular the Panel should:

a. Set out the facts that, in the opinion of the Panel, have been established by the evidence, on the balance of probabilities.

b Set out any additional facts, relevant to the matter under inquiry, disclosed from the evidence, which have not been specifically referred to in the Terms of Reference.

c. Ensure that contained in the record are the transcripts of oral evidence, copies of witness evidence given to the Panel and any other evidence which the President decides should form part of the record.

9. The President is to forward one copy of the record of proceedings to the Convening Authority on completion of the Service Inquiry.

OFFICIAL SENSITIVE

CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL D J EASTMAN MBE

GENERAL OFFICER COMMANDING REGIONAL COMMAND

1. A Service Inquiry (SI) is to be convened, in accordance with Section 343 of the Armed Forces Act 2006 (AFA 06), to investigate the circumstances leading to the death of [redacted] on 6 Feb 19. It is also to consider the policy and practice surrounding the identification and management of vulnerable Army personnel.

2. A SI is to assemble on 7 Oct 19. The SI is the Panel's priority task and takes precedence over any other duties.

3. The SI Panel President is [redacted] Col [redacted]. [redacted] Maj [redacted] will be a panel member as will [redacted] Lt [redacted]. A medical subject matter expert will be required for the Service Inquiry, the President will contact Surgeon General's office in due course. The medical subject matter expert will not be a member of the SI Panel.

4. The legal adviser to the SI is [redacted] Maj [redacted]. The legal advisor will not be a member of the SI Panel.

5. The Panel is to investigate and report the circumstances surrounding the incident, recording all relevant evidence and expressing opinions in accordance with the Terms of Reference at Annex A. The Panel is not to attribute blame, negligence or recommend disciplinary action.

6. The General Officer convening the SI directs that the evidence is to be taken on oath or by affirmation, as required, in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008. Any document or other matter produced to the Panel by a witness, for use as evidence, shall be made an exhibit and treated in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008.

7. Any person who, in the opinion of the President, may be affected by the findings of the Panel shall be treated in accordance with Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008. The President is to ensure that any such person is notified as early as reasonably possible.

8. The Panel may hear evidence from any such other witnesses or subject matter experts as it deems appropriate and may dispense with the attendance of any witness if it concludes that the witness evidence will not assist the SI. The President should note that a witness statement taken by the RMP/SIB may not be admitted as evidence to the SI, unless the express consent of the witness providing the statement has been obtained.

9. If it appears to the Panel at any time during the Service Inquiry that any person may have committed an offence against Service Law, including a criminal conduct offence contrary to Section 42 of the Armed Forces Act 2006, the President is to adjourn the Service Inquiry immediately and seek legal advice.

10. The President is to inform all witnesses that a transcript of the SI, whilst primarily for internal MOD use, may subsequently be released into the public domain. All such material accessible to the public would be released in a redacted form according to current Service policy on disclosure and adhering to current legislation, including the Data Protection Act 2018,

implementing the General Data Protection Regulation, and the Freedom of Information Act 2000.

11. The SI is to express its opinion with regards to any material conflict in the evidence, which may arise and give reasons for reaching that opinion. Any conflict in the evidence should be determined on the balance of probabilities.

12. The President is required to submit monthly progress reports to the Convening Authority and APSG Service Inquiry Branch in accordance with Appendix 4 to Annex G to CH 2 of JSP 832 and paragraph 27 (h) of LFSO 3207.

GENERAL ADMINISTRATION

13. Regional Command is to provide the following:

a. A professional Verbatim Court Recorder to be present to record evidence at hearings as required.

b. An orderly to assist at the hearings as confirmed by the President.

c. Stationery as required by the Panel.

d. Travel and subsistence for the Panel for SI related business away from their primary place of residence.

e. Travel and subsistence as required by any witnesses (for SI business).

f. Service Accommodation, as appropriate and if required, in the region where the hearings will take place, likely to be Andover.

g. Access to clerical support as required.

h. Appropriate office space and IT for the Panel members.

14. The costs of the Service Inquiry are to be charged to Regional Command UIN: [redacted].

DJ EASTMAN MBE
Major General
General Officer Commanding

Date: 14 Feb 2020

Annex:

A. Terms of Reference.

OFFICIAL SENSITIVE

ANNEX A to
Convening Order
Dated 5 Feb 20

SERVICE INQUIRY INTO THE DEATH OF [redacted]

TERMS OF REFERENCE

TERMS OF REFERENCE FOR THE SERVICE INQUIRY INTO THE CIRCUMSTANCES SURROUNDING THE DEATH AND PRIOR SELF HARM OF [redacted].

1. The Panel is to investigate the circumstances leading to and surrounding the death and prior self-harm of [redacted].

2. The Panel is to report on all relevant matters and, where the Panel thinks it appropriate, to comment on such matters, express opinions and make recommendations. In particular the Panel is to investigate and establish:

TOR 1 – Establish the facts surrounding the deliberate self-harm of [redacted] on 16 Jul 18

3. Determine the cause of the incident by examining the contributory factors and the events leading up to the self-harm of [redacted] on 16 Jul 18 to include, but not limited to:

a. A full chronology of the events leading up to the self-harm, concentrating on the period from the start of training at RMAS up to 16 Jul 18 and any subsequent events which are relevant to the Service Inquiry.

b. Details of [redacted] Service history; to include work performance and disciplinary record in the 12 months preceding her self-harm.

c. Establish, as far as is relevant to the scope of this Inquiry and can be disclosed without breaching relevant medical confidentiality restrictions, the personal circumstances including medical history which may have had an impact on [redacted] actions.

d. Establish to what extent the chain of command were aware of any welfare issues relating to [redacted].

e. Examine details of any welfare and/or medical organisation that may have been consulted, and any advice or treatment given, or action required, that would have assisted [redacted].

f. Examine whether the Chain of Command fully considered and applied sound military judgement to all the options available to [redacted] after her deliberate self-harm incident.

TOR 2 – Establish the facts surrounding the death of [redacted] on 6 Feb 19.

4. Determine the cause of the incident by examining the contributory factors and the events leading up to the death of [redacted], to include, but not limited to:

a. A full chronology of the events leading up to the death, concentrating on the period of 24 months before the date of death to include AOSB Briefing, AOSB attendance, Pre-RMAS courses and the Commissioning Course No182 to date and any subsequent events which are relevant to the Service Inquiry.

b. Details of [redacted] Service history; to include work performance and disciplinary record in the 12 months preceding her death.

c. Establish, as far as is relevant to the scope of this Inquiry, the personal circumstances including medical history which may have had an impact on [redacted] death.

d. Establish to what extent the Chain of Command were aware of any welfare issues relating to [redacted].

e. Details of the involvement of welfare and other relevant agencies that may have been consulted and any advice or treatment given.

f. Assess, with respect to the Chain of Command, the extent to which the level of support provided to [redacted] by the Chain of Command met the standard set by the extant policy; and express an opinion on, with respect to the relevant welfare services, the level of support they provided, in each case considering all the information available at the relevant time.

g. Examine the policy and procedures for the handover of OCdts between the RMAS Colleges at the end of each training term.

TOR 3 - Identify the relevant policies, procedures and other welfare provisions, and how they were applied at RMAS in relation to each case.

5. To determine RMAS approach to the relevant policies, procedures and welfare and other provisions including, but not limited to:

a. Identify what policies, procedures and regulations, both in the wider Army and within the establishment exist for the provision of welfare support in cases such as this, including but not limited to the implementation of AGAI Vol 3 Chapters 81 (Army Welfare Policy), 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy) and JSP 893 Policy on Safeguarding Vulnerable Groups.

b. Determine the level of understanding and application of AGAI 110 SVRM by the Chain of Command.

c. Consideration of Unit Health Committee activity and subsequent actions in relation to [redacted], concentrating on the application and management of her Care Action Plan.

d. Determine the extent to which policies and procedures have changed since Feb 19 and the extent to which any changes have been implemented within RMAS, at other training establishments and in the wider Army to prevent any recurrence of incidents of this type.

e. Express an opinion on the level of support provided to [redacted] by the Chain of Command and Welfare services in light of the information available and extant policy.

f. Express an opinion on the level of support provided by the Chain of Command and welfare services to the permanent staff and OCdts after the deliberate self harm incident on 16 Jul 18 and in the immediate period after [redacted] death on 06 Feb 19.

TOR 4 - Establish the relevant policies and procedures which apply to DCMH Aldershot and the extent to which they were implemented in each case, namely 16 Jul 18 and 6 Feb 19.

6. To determine DCMH Aldershot's understanding and application of the relevant SVRM Policy:

a. Identify the SVRM policy applied within DCMH Aldershot and how this integrated with AGAI 110.

b. Determine the extent to which policies and procedures have changed within DCMH Aldershot since Feb 19 to prevent any recurrence of incidents of this type.

c. Express an opinion as to whether the policies and procedures are appropriate in ensuring any risk is managed in cases such as these including the impact of the requirement for confidentiality.

TOR 5 – Investigate the extent to which RMAS and external medical agencies interacted in support of [redacted].

7. Examine the effectiveness of the multi-agency interaction, including but not limited to:

a. Determine any similarities in relation to each event and analyse in respect of the post-event care following the self-harm incident on 16 Jul 18 the action taken by the Chain of Command.

b. Analyse medical procedures and reports to determine the level of care and attention received by [redacted].

c. Determine the procedures in place at DCMH Aldershot for sharing of information and concerns with Units.

d. Identify whether sensitive and confidential information was appropriately shared between and within RMAS and DCMH Aldershot.

e. Express an opinion on whether the interaction between DCMH Aldershot, RMAS, medical agencies and welfare organisations was appropriate and sufficient in the circumstances known, or which could reasonably expected to be known, to those agencies and organisations at the time.

TOR 6 – Based on the evidence, make such findings and express opinions as are appropriate to support recommendations in order to prevent recurrence.

Procedure

8. The Panel is to include in the record of proceedings a clear and concise précis of the case in an easily readable form, addressing each of the Terms of Reference listed above. In particular the Panel should:

a. Set out the facts that, in the opinion of the Panel, have been established by the evidence, on the balance of probabilities.

b Set out any additional facts, relevant to the matter under inquiry, disclosed from the evidence, which have not been specifically referred to in the Terms of Reference.

c. Ensure that contained in the record are the transcripts of oral evidence, copies of witness evidence given to the Panel and any other evidence which the President decides should form part of the record.

9. The President is to forward one copy of the record of proceedings to the Convening Authority on completion of the Service Inquiry.

OFFICIAL - SENSITIVE

AMENDMENT 2 CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL D J EASTMAN MBE

GENERAL OFFICER COMMANDING REGIONAL COMMAND

1. A Service Inquiry (SI) is to be convened, in accordance with Section 343 of the Armed Forces Act 2006 (AFA 06), to investigate the circumstances leading to the death of [redacted] on 6 Feb 19. It is also to consider the policy and practice surrounding the management of vulnerable Army personnel.

2. An SI assembled on 07 Oct 19. The SI is the Panel's priority tasks and takes precedence over any other duties.

3. The SI Panel comprises:

   a. President: [redacted] Col [redacted]

   b. Member: [redacted] Maj [redacted] (As required)

   c. Member: [redacted] Maj [redacted]

   d. Member [redacted] - Capt [redacted]

4. The legal advisor to the SI is: [redacted] – Maj [redacted], ALS

5. The Medical SME is: [redacted] – Surgeon Capt [redacted], RN

6. The Panel is to investigate and report the circumstances surrounding the incidents, recording all evidence and expressing opinions in accordance with the Terms of Reference at Annex A. The Panel is not to attribute blame, negligence or recommend disciplinary action.

7. General Officer Commanding Regional Command convening the SI directs that the evidence is to be taken on oath or by affirmation, as required, in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008. Any document or other matter produced to the Panel by a witness, for use as evidence, shall be made an exhibit and treated in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008.

8. Any person, who, in the opinion of the President, may be affected by the findings of the Panel shall be treated in accordance with Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008. The President is to ensure that any such person is notified as early as reasonable possible.

9. The Panel may hear evidence from any such other witnesses or subject matter experts as it deems appropriate and may dispense with the attendance of any witness if it concludes that the witness evidence will not assist the SI. The President should note that a witness statement taken by the RMP/SIB may not be admitted as evidence to the SI, unless the express consent of the witness providing the statement has been obtained.

10. If it appears to the Panel at any time during the SI that any person may have committed an offence against Service Law, including a criminal conduct offence contrary to Section 42 of the Armed Forces Act 2006, the President is to adjourn the Service Inquiry immediately and seek legal advice.

11. The President is to inform all witnesses that a transcript of the SI, whilst primarily for internal MOD use, may subsequently be released into the public domain. All such material accessible to the public would be released in a redacted form according to current Service policy on disclosure and adhering to current legislation, including the Data Protection Act 1998 and the Freedom of Information Act 2000.

12. The SI Panel is to express its opinion with regards to any material conflict in the evidence which may arise and give reasons for reaching that opinion. Any conflict in the evidence should be determined on the balance of probabilities.

13. The President is required to submit monthly progress reports to the Convening Authority and APSG Service Inquiry Branch in accordance with Appendix 4 to Annex G to Chapter 2 of JSP 832.

GENERAL ADMINISTRATION

14. Regional Command is to provide the following:

a. A professional Verbatim Court Recorder to be present to record evidence at Hearings as required.

b. An Orderly to assist at the Hearings as confirmed by the President.

c. Stationery as required by the Panel.

d. Travel and subsistence for the Panel for SI related business away from their primary place of residence.

e. Travel and subsistence as required by any witnesses (for SI business).

f. Service Accommodation, as appropriate and if required, for the nominated Panel members.

g. Access to clerical support as required.

h. Office space and IT including a Laptop, as appropriate and as required, for the Panel members.

15. The costs of the Service Inquiry are to be charged to Regional Command UIN: [redacted]

D J EASTMAN MBE Date: 02 11 20
Major General
General Officer Commanding RC

Annex: A Terms of Reference.

Annex A to
GOC RC
SI Convening Order
Dated

TERMS OF REFERENCE (TOR) FOR THE SERVICE INQUIRY (SI) INTO THE CIRUCMSTANCES SURROUNDING THE DEATH AND PRIOR SELF HARM OF [redacted]

1. The Panel is to investigate the circumstances leading to and surrounding the death and prior self-harm of [redacted].

2. The Panel is to report on all relevant matters and, where the Panel thinks it appropriate, to comment on such matters, express opinions and make recommendations. In particular the Panel is to investigate and establish:

TOR 1 – Establish the facts surrounding the deliberate self-harm of [redacted] on 16 Jul 18

3. Determine the cause of the incident by examining the contributory factors and the events leading up to the self-harm of [redacted] on 16 Jul 18 to include, but not limited to:

a. A full chronology of the events leading up to the self-harm, concentrating on the period of 18 months before the date of DSH to include AOSB Briefing, Pre-RMAS courses and the Commissioning Course No 182 up to 16 Jul 18 and any subsequent events which are relevant to the Service Inquiry.

b. Details of [redacted] Service history; to include work performance and disciplinary record in the 12 months preceding her self-harm.

c. Establish, as far as is relevant to the scope of this Inquiry, the personal circumstances including medical history which may have had an impact on [redacted] actions.

d. Establish to what extent the chain of command were aware of any welfare issues relating to [redacted].

e. Examine details of any welfare and/or medical organisation that may have been
consulted and any advice or treatment given, or action required that would have assisted [redacted]

f. Examine whether the Chain of Command fully considered and applied sound military judgement to all the options available to [redacted] after her deliberate self-harm incident.

g. Examine the policy and procedures for the handover of OCdts between the RMAS Colleges at the end of each training term.

TOR 2 – Establish the facts surrounding the death of [redacted] on 6 Feb 19.

4. Determine the cause of the incident by examining the contributory factors and the events leading up to the death of [redacted], to include, but not limited to:

a. A full chronology of the events leading up to the death, concentrating on the period of 24 months before the date of death and any subsequent events which are relevant to the Service Inquiry.

b. Details of [redacted] Service history; to include work performance and disciplinary record in the 12 months preceding her death.

c. Establish, as far as is relevant to the scope of this Inquiry, the personal circumstances including medical history which may have had an impact on [redacted] death.

d. Establish to what extent the Chain of Command were aware of any welfare issues relating to [redacted].

e. Details of the involvement of welfare and any relevant agencies that may have been consulted and any advice or treatment given.

f. Express an opinion on the level of support provided to [redacted] by the Chain of Command and welfare services considering all the information available and extant policy at that time.

g. Examine the policy and procedures for the handover of OCdts between the RMAS Colleges at the end of each training term.

TOR 3 - Establish the relevant policies, procedures and other welfare provisions, and how they were applied at RMAS in relation to each case.

5. To determine RMAS approach to the relevant policies, procedures and welfare and other provisions including, but not limited to:

a. Establish what policies, procedures and regulations, both in the wider Army and within the establishment exist for the provision of welfare support to a situation based on the facts of this matter, including but not limited to, AGAI Vol 3 Chapters 81 (Army Welfare Policy), 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy) and JSP 893 Policy on Safeguarding Vulnerable Groups.

b. Determine the level of understanding and application of AGAI 110 SVRM by the Chain of Command.

c. Consideration of Unit Health Committee activity and subsequent actions in relation to [redacted], concentrating on the application and management of her Care Action Plan.

d. Determine the extent to which policies and procedures have changed since Feb 19 and been implemented within RMAS and other training establishments and the wider Army to prevent any recurrence of incidents of this type.

e. Express an opinion on the level of support provided to [redacted] by the Chain of Command and Welfare services in light of the information available and extant policy. [redacted]

TOR 4 - Establish the relevant policies and procedures which apply to DCMH Aldershot and the extent to which they were implemented in each case, namely 16 Jul 18 and 6 Feb 19.

6. To determine DCMH Aldershot's understanding and application of the relevant SVRM Policy:

a. Identify the SVRM policy applied within DCMH Aldershot and how this integrated with AGAI 110.

b. Determine the extent to which policies and procedures have changed within DCMH Aldershot to prevent any recurrence of incidents of this type.

c. Express an opinion as to whether the policies and procedures are appropriate in ensuring any risk is managed in cases such as these including the impact of the requirement for confidentiality.

TOR 5 – Investigate the extent to which RMAS and external medical agencies interacted in support of [redacted].

7. Examine the effectiveness of the multi-agency interaction, including but not limited to:

a. Determining any similarities in relation to each event and analyse in respect of the post event care following the self-harm incident on 16 Jul 18 and the action taken by the chain of command.

b. Analyse medical procedures and reports to determine if [redacted] received sufficient care and attention.

c. Determine the procedures in place at DCMH Aldershot for sharing of information and concerns with Units.

d. Identify whether sensitive and confidential information was appropriately shared between and within RMAS and DCMH Aldershot.

e. Express an opinion on whether the interaction between DCMH Aldershot, RMAS, medical agencies and welfare organisations was appropriate and sufficient.

TOR 6 – Based on the evidence, make such findings and express opinions as are appropriate to support recommendations in order to prevent recurrence.

Procedure

8. The Panel is to include in the record of proceedings a clear and concise précis of the case in an easily readable form, addressing each of the Terms of Reference listed above. In particular the Panel should:

a. Set out the facts that, in the opinion of the Panel, have been established by the evidence, on the balance of probabilities.

b. Set out any additional facts, relevant to the matter under inquiry, disclosed from the evidence, which have not been specifically referred to in the Terms of Reference.

c. Ensure that contained in the record are the transcripts of oral evidence, copies of witness evidence given to the Panel and any other evidence which the President decides should form part of the record.

9. The President is to forward one copy of the record of proceedings to the Convening Authority on completion of the Service Inquiry.

Executive Summary

Issue

1.2.1 On 30 July 2019, Head Army Personnel Services Group (APSG), in their role as the Single Service Inquiry Co-ordinator, directed a Service Inquiry (SI) into the circumstances surrounding the death of a Service Person (SP) at the Royal Military Academy Sandhurst (RMAS) on 06 February 2019. Thereafter, General Officer Commanding Regional Command (GOC RC) convened a Service Inquiry on 07 October 2019.

1.2.2 This is an executive summary of that Service Inquiry, outlining what happened, what was learned and what action has taken place as a result of the recommendations. The SI involved 3 separate oral hearings which heard evidence from 46 witnesses, consisting of former Officer Cadets (OCdts), RMAS staff, Army Headquarter (HQ) policy experts, medical professionals and other individuals who knew the SP.

What happened?

1.2.3 The SP started Commissioning Course (CC) 182 at RMAS in May 2018 aged 20 yrs. On 16 July 2018, during a familiarisation visit the SP committed deliberate self-harmed[1] (DSH) in 5 different ways whilst heavily intoxicated. The SP was assessed by the Departments of Community Mental Health (DCMH) and the Chain of Command (CoC) returned the SP to training on 18 July 2018. At this point the SP was registered on the Vulnerability Risk Management (VRM) system and the College Risk Register, and a Care Action Plan (CAP) was created. The SP was also subject to a formal AGAI 67 (Army General Administrative Instruction) interview.

1.2.4 During the Intermediate term whilst on a battlefield study tour and after another incident involving excess alcohol the SP informed a fellow OCdt of allegations of [redacted] and a recent [redacted] the SP by the [redacted]. On the morning of 02 February 2019, after a Coy charity Ball, the SP drank to excess and awoke in the Sergeants (Sgts) and Warrant Officers' (WO) Mess in the room of their former Platoon (Pl) Colour Sergeant (CSgt). The SP missed first parade and an investigation commenced after the SP admitted to the CoC where they had been. Whilst being questioned about their whereabouts the SP [redacted] of the Company Sergeant Major's (CSM's) office. On 05 February 2019 the CoC was informed of the [redacted] but took no action, the SP attended an AGAI 67 interview and an Assisting Officer (AO) was appointed. The following day, 06 February 2019, whilst the investigation was ongoing, the SP was unaccounted for during training and was later found unresponsive in their locked bedroom.

[1] Defence changed the terminology from Deliberate Self harm (DSH) to Self Harm (SH) circa 2020, in line with the National institute for Health and Care Excellence (NICE) terminology.

What have we learned?

1.2.5 Key causal and aggravating factors – There are several aggravating and relevant factors in this case. A member of the Physical Training (PT) staff was conducting a relationship with the SP during the intermediate and senior terms. Despite agreeing to abstain from alcohol after the incident in July 2018 the SP had 2 further incidents involving excess alcohol which were known of by the Directing Staff (DS). There was a complete breakdown in welfare support during the SPs time at RMAS. In addition, there was extremely limited actual support or assurance of supporting staff activities which would have assisted the SP. There was exceptionally poor inter staff and departmental communications regarding the SP; albeit the SP was discussed at a variety of meetings, unfortunately no positive action took place thereafter to support the SP.

1.2.6 Details of behaviours at RMAS – This SI has identified several unacceptable behaviours and actions which occurred during May 2018 to February 2019. Of note, is that the SI findings are in complete contrast to the October 2017 Office for Standards in Education (OFSTED) report which commented positively upon welfare provision.

1.2.7 This SI has identified 61 recommendations. These are grouped into the following areas:

a. **RMAS**. 29 recommendations are specific to RMAS, covering the following areas.

(1) Policy reviews and educating staff on the requirement to use the policy
(2) Workforce management and selection
(3) Provision and staffing of Cadet facing welfare support
(4) Instructing staff on how to report abuse
(5) Management and assurance of VRM, CAP and Unit Healthcare Committees (UHC)
(6) Handover management of OCdts between Colleges and to Initial Trade Training (ITT)
(7) The Role of the Chaplaincy Department at RMAS
(8) Review the requirement for a Mental Health resilience trg programme
(9) Social media policy

b. **Policy and procedures.** 9 recommendations require current policy (AGAI's, Joint Service Publication (JSP) and Trauma Risk Management (TRiM) policy) to be reviewed and amended.

c. **Army Recruiting and Initial Training Command (ARITC)**. 14 recommendations focus on improving the training experience across Basic training establishments. Principally these recommendations are focused on tightening up procedures, pre-employment training, Trainee care during leave, female focus, staff education and refresher training, suitability of staff and UHC's for Basic training trainees.

d. **Military Secretary (Army Personnel Centre) (MS (APC)).** There are 2 recommendations to improve the staff selection, their responsibilities, and an additional increase in the workforce at RMAS.

e. **DCMH and Defence Primary Health Care (DPHC).** There are 6 recommendations specific to DCMH their procedures, policies and record keeping and 2 that related to DPHC.

f. **Chaplaincy.** There is 1 recommendation for the Chaplaincy department to review their training requirement for staff at a Ph1 trg establishment.

1.2.8 These recommendations, their associated progress and evidence of closure criteria being met are tracked in detail through APSG Lessons.

What progress have we made?

1.2.9 The recommendations have already been disclosed to the Senior Point of Authority and Support Action Manager ahead of the SI report, allowing recommendations to be actioned and closed. In addition, DCMH have already taken action to amend procedures. Of note there has been a significant increase in the welfare provision at RMAS, with the establishment of college welfare staff and "the huddle" welfare facility.

PART 1.3

Narrative of Events

TABLE OF CONTENTS – PART 1.3

PART 1.3 – NARRATIVE OF EVENTS

Synopsis

1.3.1 On 06 February 2019 the OCdts from Falklands Company (Coy), who were in the Senior term at RMAS, were conducting Skill at arms (SAA) training on the onsite training area. An OCdt from 33 Pl was due to undertake this training after finalising administration tasks set by the CoC. The tasks related to an ongoing disciplinary investigation that was being conducted following events at the recent Charity Ball, which was held on 01 February 2019. The OCdt did not attend the training event, her absence was noted by a member of Staff, and she was subsequently discovered in her room, unresponsive and was later pronounced deceased by the Senior Medical Officer (SMO). The OCdt had previously engaged in an incident involving DSH and the abuse of alcohol, during the junior and Intermediate terms of the Commissioning Course.	[redacted]
Background	
Officer Selection process	
1.3.2 Army Officer recruitment is undertaken in partnership with Capita. Once an Individual has registered their initial interest, Officer selection begins with a formal interview at a local recruitment centre. Potential Recruits are required to attend a medical assessment prior to progressing any further. Successful Officer candidates are required to attend a two-day Army Officer Selection Board (AOSB) briefing course. All Potential Officer (PO) recruits are provided with feedback and awarded a Category (Cat) relating to their performance. a. Cat 1 classifies the individual as a credible candidate for Main Board. The candidate is given advice and feedback on their strengths and weaknesses in order to assist them to prepare for the Main board. b. Cat 2 is a delay for either 3, 6, 12 or 24 months for development in one or more areas. c. Cat 3 classifies a candidate with one or more major areas of development where the board feel the candidate would find the Main board a significant challenge. d. Cat 4 classifies a candidate who the board believe is currently unsuitable to attend Main Board. Candidates may appeal citing a development plan to overcome their shortfalls.	[redacted]

1.3.3 The final stage for most recruits will be AOSB Main Board. This is a three-and-a-half-day selection event, which assesses physical, intellectual, practical and personality traits to determine if the individual has the potential required of an Army Officer. Successful POs are granted a pass to attend the RMAS, which is valid for five years. Those who are unsuccessful may attend AOSB Main board one final time. Individuals who are considered a risk pass may be required to attend and complete the Potential Officer Development Programme (PODP) prior to attending the CC. AOSB identifies areas of risk in their performance, this is shared with the Army School of Education (ASE), who deliver the PODP, in Worthy Down, Hampshire.	[redacted]
Potential Officer Development Programme	
1.3.4 The Potential Officer Development Programme is a 12-week residential course which includes individuals who have been selected by AOSB (Pre-RMAS (PRAMs)), as well as soldiers who are aiming to commission from Regular soldier service prior to attending AOSB main board.	[redacted]
The Commissioning Course	
1.3.5 The CC is one of a number of courses held at the RMAS, Camberley, Surrey. The purpose of the course is to train all OCdts in basic soldiering and leadership before joining their elected Regiments or Corps. The Regular CC is a 44 week long programme consisting of three 14 week terms, named Juniors, Intermediate and Seniors terms. a. The Junior term focuses on the basics of military skills, fitness and decision making. b. The Intermediate term develops command and conceptual thinking with the aim to develop professional, robust combat leaders. During this term, OCdts undergo a selection procedure for their future Corps or Regiment. c. The final, Senior term enables OCdts to practice their new military and Leadership skills through a series of complex and demanding training exercises in the UK and overseas. The focus of this term is on developing professional, agile thinking, ethical and robust leaders, who, with further pre-employment training, can take up their first Leadership position.	[redacted]

1.3.6 The RMAS timetable comprises of three Regular CC intakes throughout the year[2]. January and May intakes generally consist of 2 Coys equating to approximately 180 OCdts per intake. The September intake is often larger and comprises of up to 3 Coys, equating to approximately 270 OCdts. Each Coy is Commanded by a Major (Maj) and is made up of three Pl. Each Pl is Commanded by a Platoon Commander (Pl Comd) who is normally a Captain (Capt) assisted by a Colour Sergeant (CSgt) or Staff Sergeant (SSgt).	[redacted]
Regimental Selection and visits	
1.3.7 During the first six weeks of the Junior term, OCdts submit an expression of interest of the Regiments they are proposing to apply for at the Regimental Selection Board (RSB) process, which occurs in the Intermediate term. Throughout the CC there are several events hosted by the Regiments and Corps to gain an understanding of the unit roles and what a posting as a Pl Comd would involve. A familiarisation visit is conducted in the Junior term and another in the intermediate term. Typically conducted over two days, the Regiments host the OCdts, who have the opportunity to discuss their future role with Soldiers and view demonstrations of the unit activity. There is usually an evening social event during the visit. Permanent staff at RMAS are often Regimental representatives and can provide advice and guidance about the future roles for young Officers in their Regts or Corps. The RSBs occur during the final weeks of the Intermediate term. OCdts are normally interviewed by at least two Regiments that they have selected, ideally they are offered a Commission with one of them. OCdts who are not selected by either of their Regiments enter a clearing process which allocates them to a unit best suited to them.	[redacted]
Narrative of events	
1.3.8 In May 2018 the SP started the CC 182 at RMAS, where she joined 33 Pl of Falklands Coy. Prior to attending, she had completed the PRAMS course at the Army School of Education, where she was graded as the top student on her course.	
1.3.9 The Junior term is spent in Old College and then all cadets transfer to New College for the Intermediate and Senior terms. The SP was the youngest cadet on CC182 aged 20 yrs and prior to attending PRAMs she had lived at home with family members.	

[2] In addition, RMAS run the SNCO Selection Cadre, Lucknow Platoon (ongoing Rehabilitation Pl), the Late Entry Officers' Course (9 courses annually), Commissioning Course Short for the Reserves and Professionally Qualified Officers (3 courses annually) and the Leaders Development Course (3 annually).

1.3.10 In the Junior term, OCdts undertake familiarisation visits to Regiments or Corps, the purpose of which is to help them decide on a Choice of Arm. On 16 July 2018, the SP along with 42 other OCdts attended a familiarisation visit hosted by the Royal Engineers (RE) at Wyke Regis. At the end of a day of engineering activities there was a social event consisting of a barbeque, games and a free bar. The SP became intoxicated; she was accompanied to the accommodation, where she committed DSH. The DSH occurred in 5 different ways. All these attempts were prevented by fellow OCdts and eventually RE duty staff members who restrained her. These actions occurred during a 4-hour window early in the morning and a civilian ambulance was called. The paramedics agreed after assessing her, that due to the safeguarding measures that were in place, she would stay under the care of the RE staff and return to RMAS medical centre later that morning.	
1.3.11 The SP was escorted to RMAS by RE staff during the morning of 17 July 2018, she was handed over to the medical centre and referred to DCMH for an urgent assessment. One of the RE staff members visited the Old College HQ and told them of their concerns following the night's events. Academy HQ were informed of the event and the HQ staff directed the College to investigate the event. A Learning Account (LA) was prepared and submitted to APSG on 09 September 2018.	
1.3.12 The SPs assessment by DCMH on 17 July 2018 was based upon a limited knowledge of what actually happened at the RE visit, she was deemed "fit to return to training". The CoC discussed this guidance on 17 July 2018 and the SP returned to training on 18 July 2018. A case conference deemed to be a VRM risk assessment meeting occurred on 18 July 2018, this resulted in a VRM account being opened and a CAP was instigated. The case was referred to the Army Welfare Service (AWS), but their assessment was not passed to the CoC. The SP did not meet or receive any support from the RMAS Welfare Dept during her time at RMAS.	
1.3.13 During the latter weeks of the Junior term the SP was reassessed by DCMH and she attended 3 appointments in total the last one being a final assessment by a Consultant Clinical Psychiatrist. The SP was discharged from DCMH's care to the medical staff at RMAS on 09 August 2018, at which point she was classified as a Vulnerable Adult (VA), who's status was due to be discussed on a monthly basis thereafter. At no point during the Junior term were there any formal recording of discussions, appertaining to any supplementary information relating to the events of the night of 16/17 July 2018, being passed to the medical staff at	

RMAS or to DCMH. On 26 July 2018 the SP received a formal AGAI interview with the Old College Commander who explained that a "reoccurrence of such an event would make her future employability questionable". The event at the RE visit was recorded on the Company risk register and the SP was graded a red entry the risk being recorded as "suicide". In the Junior term she received pastoral support from the College Padre on 3 occasions. During this term she started a relationship with a civilian nurse who was also a member of the Royal Naval Reserves. The College Risk Register entry was handed over from Old College to New College CoC and the VRM and CAP were handed over to the Unit Welfare Officer (UWO) on 3 August 2018.	
1.3.14 In September 2018, the SP started the Intermediate term in New College, with new platoon staff. During a battlefield study tour to Normandy in November 2018, the SP became intoxicated in a bar in the presence of her Coy staff. Her behaviour was deemed to be inappropriate, and she was escorted back to her hotel room by fellow OCdts. Whilst being put to bed by a fellow OCdt, she disclosed that she had been subjected to [redacted] and that the alleged [redacted] The next day she told her Pl Comd she was struggling with the combat estimate and its application. The matters raised the previous evening were not disclosed to the CoC. The drunken incident in Normandy was recorded on the Coy risk register but was not elevated from the College to the Academy HQ it was referred to as a "crisis of confidence". This incident was not brought to the attention of the RMAS Medical staff.	
1.3.15 In November 2018, the SP started a relationship with a member of RMAS gymnasium staff, they spent time at various hotels and visited each other's accommodation at RMAS. The SP was successful at the Regimental Selection Boards and secured a place with the Royal Artillery (RA). She also took up boxing and won the prize for the "Most Courageous Boxer".	
1.3.16 On 01 February 2019 the Falklands Coy held a Charity Ball at RMAS. During the evening it snowed heavily and at the end of the Ball lots of guest were unable to disperse as taxis could not access the College. The consequence of this was that an after party developed in the accommodation lines where the SP drank to excess. The SP spent the night in a member of staff's bedroom in the WO and Sgts Mess. The following morning, the SP (who was the Duty Cadet) missed the morning parade, a search was instigated, and she was located whilst walking back to New College. During questioning to explain her whereabouts the SP self -harmed [redacted] admitted spending the	

night with a member of staff in their mess accommodation. The staff member was suspended. During the questioning she offered an explanation as to why she had spent the night with the staff member.	
1.3.17 Falklands Coy was stood down for the weekend and they were informed that a member of staff had been suspended. The OCdts were warned not to post anything on social media platforms. The SP stayed at RMAS that weekend, on Sunday 03 February 2019 she met with a Padre after the morning service for pastoral support. Later that day she wrote a statement outlining her version of events which was submitted to the CoC the following day. Training resumed on Monday 04 February 2019 and the SP was warned off for a formal interview with her Coy and Pl Comd on Tuesday 05 February 2019.	
1.3.18 The Panel understand that during the period 2-6 February 2019 the SP was under the impression she was going to be discharged.	
1.3.19 A fellow OCdt informed the CoC of the allegations of [redacted] on the afternoon of Tuesday 05 February 2019 before the disciplinary meeting. At the meeting the SP was questioned about the events of the Falklands Coy Ball, Witness 33 was appointed as her Assisting Officer (AO). After the meeting the SP was tasked with retrieving her phone log which would verify the details submitted in her statement and corroborate what she had told the CoC.	
1.3.20 On the evening of Tuesday 05 February 2019 the SP wrote a letter to her Pl Comd requesting to leave the CC and join the RE as a Soldier. This letter along with a log showing her phone records was handed to the CoC on the morning of Wednesday 06 February 2019.The SP was meant to be undertaking SAA training on the ranges at RMAS that day, she sent text messages to her fellow OCdts, her family, the CoC, and the Padre during the early morning.	
1.3.21 The instructor conducting the SAA training noticed that the SP was missing from the event at 1230hrs and alerted the Falklands CSM. The staff endeavoured to locate her and subsequently found her unresponsive in her locked bedroom at approximately 1400hrs. The CSM and an OCdt started resuscitation as directed over the telephone by the emergency services. A team of paramedics arrived soon thereafter and took over, the Senior Medical Officer (SMO) also arrived and declared the SP deceased at approximately 1440hrs. Thames Valley Police also attended thereafter at 1500 hrs and took statements from the individuals involved.	

1.3.22 The Joint Casualty and Compassionate Centre (JCCC) were informed and they instigated the notification procedures, the SPs family were informed of her death during the evening of Wednesday 06 February 2019. Her family members attended RMAS on Thursday 07 February 2019 when a memorial service was held in the Chapel. In the immediate aftermath, the SPs civilian partner became aware of a death at RMAS through social media sources. They had not been informed by JCCC as they were not listed as her Next of Kin or Emergency Contact. An OCdt, who was a close friend of the SP, confirmed her death by telephone to her partner. The SPs funeral took place on 01 March 2019 and was attended by fellow OCdts.

1.3.23 RMAS delivered a TRiM programme to the OCdts and staff during the remaining 9 weeks of the course. Unfortunately, the 2 first responders who dealt with the SP on 06 February 2019 did not receive any specific support during or after this time. CC182 completed on time and the OCdts Commissioned on 12 April 2019.

1.3.24 The following report provides a detailed response to the terms of reference and seeks to answer the outstanding questions following the SPs self-harm incident in July 2018 and her unfortunate death on 06 February 2019.

1.3.25 Service Persons Timeline

	[redacted]	The SP was born.
The SP began PO process by attending an Army Selection Interview.	10th Jan 2017	
	Feb 2017	The SP worked at [redacted] and [redacted]
The SP attended an Army Selection Medical.	9th Mar 2017	
	6th May 2017	The SP attended AOSB Briefing. Awarded a Cat 1.

The SP attended Army Air Corps (AAC) Aircrew aptitude testing at RAF Cranwell.	May 2017	
The SP attended AOSB Main Board.	26th Sep 2017	Considered a risk pass and directed to complete Pre RMAS course.
The SP attended the Royal Logistics Corps (RLC) Fam visit.	19th Nov 2017	
	8th Jan-30th Mar 2018	Attended Pre RMAS course, the SP is considered to be the top student on the course.
The SP began the Junior term of CC182 as a member of 33 Pl, Falklands Coy.	6th May 2018	
	16th Jul 2018	Attended a Regimental Visit with the RE, became intoxicated and Deliberately Self Harmed after an evening social event.
Returned to RMAS Medical Centre. Attended DCMH emergency assessment and cleared to return to unrestricted training.	17th Jul 2018	Senior elements of CoC discussed and agreed to return the SP to unrestricted training.
	18th Jul 2018	Individual case conference held by RMAS CoC, VRM and CAP produced. The SP returned to unrestricted training.

The SP attended follow up appointment with DCMH. The SP attended a disciplinary meeting in the form of a formal interview with the College CoC.	26th Jul 2018	
	3rd Aug 2018	Hand over, take over (HOTO) meeting occurs between the two Colleges, the SP is discussed, responsibility for CAP is transferred to Welfare dept.
The SP final assessment and discharged from DCMH care. No further DCMH support received. Classified as a VA.	9th Aug 2018	
PI CSgts informed that they would be moving Platoons, within the Coy. PI Comds also moved, some are new to the Coy.	10th Aug 2018	The SP completed Junior term and attended a week of Adventurous Training, hill walking in Scotland.
Intermediate term began .	10th Sep 2018	
	14th Sep 2018	The SP first entered in the Risk Register, she was graded red and it was classified as a suicide.
	6th-8th Nov 2018	The SP attended Ex Normandy Scholar.

A new entry was made on the Company risk register regarding the SP and it is recorded that she had a "crisis of confidence".	12th Nov 2018		
	27th Nov 2018	The SP competed in the RMAS boxing night, she is awarded most courageous boxer award.	
During RSB week the SP was offered a Commission with the RA and RLC.	26th-30th Nov 2018	the SP accepted a Commission with the RA.	
	14th Dec 2018	The SP completed the Intermediate term.	
The SP attended Adventurous Training Expedition, Skiing in Austria.	15th-22nd Dec 2018		
	7th Jan 2019	The SP began the Senior Term.	
The SP was downgraded from red to amber on the risk register.	14th Jan 2019		
	1st Feb 2019	The SP attended the Falklands Coy Charity Ball.	
The SP was missing from first Parade, a search was organised to find her. The SP was located returning from the WO and Sgts Mess	2nd Feb 2019	The SP was interviewed by a member of her CoC. Falklands Coy were informed a member of staff had been suspended, pending	

(an out of bounds area to cadets).		investigation, they were not to speculate or post anything on social media. The company was released for the weekend.	
The SP met with her intake Padre.	3rd Feb 2019	A member of the Coy CoC conducted a welfare check on the SP, via WhatsApp and in person.	
The SP was graded red on the risk Register.	4th Feb 2019		
	5th Feb 2019	The SP was interviewed by Company CoC regarding the events of the Falklands Coy Ball. The CoC were made aware of allegations of [redacted]	
The SP requested that a fellow OCdt take her weapon to the training area and she would follow, after completing her tasks for the CoC.	6th Feb 2019 0600		
	6th Feb 2019 0730	The SP handed in a letter to her CoC, addressed to her PI Comd requesting to leave the CC.	
The SP messaged a member of the CoC informing them that she was on route to the training area to conduct range activities.	6th Feb 2019 0805		

	6th Feb 2019 1230	Falklands Coy CoC received a message from staff on RMAS training area enquiring as to the location of the SP.
The SP was located in her room, unresponsive. Emergency services were contacted, first responders began CPR.	6th Feb 2019 1403	
	6th Feb 2019 1420	Civilian Ambulance arrived followed by RMAS medical personnel.
NOTICAS initiated.	6th Feb 2019 1425	
NOTICAS amended.	6th Feb 2019 1440	SMO declared the SP was deceased.
	6th Feb 2019 1449	INCREP sent.
Civilian police arrived and began taking statements from first responders.	6th Feb 2019 1500	

	6th Feb 2019 2005	NOK informed by Casualty Notifying Officer.	
The SPs family visited RMAS. A memorial Service was conducted in the chapel, all programmed training for Senior term OCdts was suspended.	7th Feb 2019		
	8th Feb 2019	Falklands Coy released for a college weekend. Training resumed, as planned on the Monday, along with TRiM.	
	1st Mar 2019	The SPs funeral was held.	
Service Inquiry Convened.	7th Oct 2019		

PART 1.4

Analysis

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Introduction

1.4.1 Section 1.4 contains the key elements of the Panel's findings, the analysis, and the resulting evidenced recommendations. It starts by outlining the approach taken by the Panel and explaining the terminology used to capture, discuss, and weight the findings of the Panel. It then seeks to address each of the Terms of Reference (TOR), and the relevant issues identified. Within each TOR the report answers the questions asked and evidences the various findings and avenues explored by the Panel. This includes where no issues were evidenced in order to demonstrate the breadth of study conducted and prevent uncertainty.

METHODOLOGY

Probabilistic Terminology

1.4.2 The probabilistic terminology detailed below clarifies the terms used in this report to communicate levels of uncertainty within the report. It is based on terms published by the Intergovernmental Panel on Climate Change (IPCC) in their Guidance Note for Consistent Treatment of Uncertainties. It is routinely used in Service Inquires and as such is the accepted benchmark used to describe the degree of confidence a Panel has in their stated opinion and conclusions.

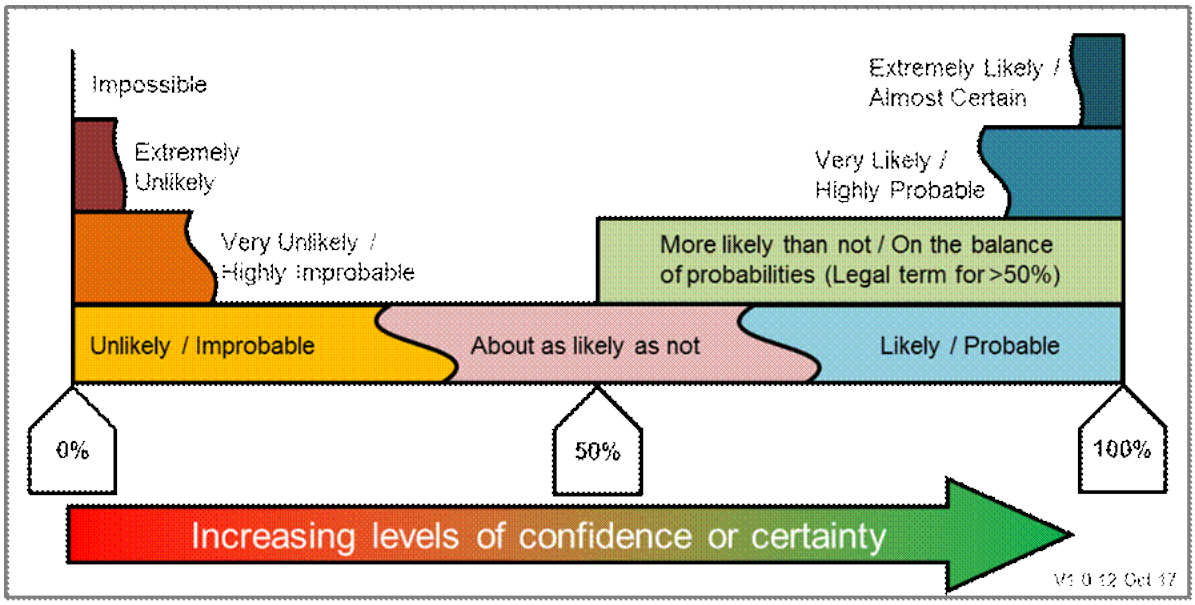

Figure 1 – Probabilistic Terminology

Available Evidence

1.4.3 The Panel had access to the following key evidence:

a. Learning Account and Learning Account Review.
b. Policy documents.
c. Written Witness statements.
d. Witness email responses.
e. Hearing interviews (and the supporting transcripts).
f. RMAS policy / governance documentation.
g. Ofsted Inspection reports.
h. Disc labs digital forensic report on SPs mobile phone.
i. The SP's DMICP medical record.
j. 3 independent medical reports produced after the 06 February 2019.

1.4.4 A full list of evidence used and referenced in this report can be found at Part 2.3, 2.5 and 2.6.

Other Investigations Relating to this Matter

1.4.5 Coroner's Inquest. The death the SP is due to be considered at a Coroner's Inquest in December 2022. Pre-Inquest hearings were held in October 2019, May 2021, and December 2021. The next Pre-Inquest hearing is scheduled for June 2022.

1.4.6 Civilian Police Investigation. As with all unexplained deaths the civilian police (Thames Valley Police) investigated this case and informed APSG that the matter had been closed.

1.4.7 Royal Military Police (RMP) Investigations. The RMP Special Investigation Branch (SIB) initiated an investigation, directed by Provost Marshall (PM) Army after the SI panel raised concerns following the analysis of the Oral testimonies and written evidence in March 2021. The investigation required a suspension of the SI for the duration of the Police Investigation. 7 SP were referred for charging decisions to be considered and upon completion of the investigation the case was referred to Comd 160 Brigade in July 2021. In addition, the panel became aware that information relating to this SI was shared with external media sources, as such, this inappropriate disclosure of information was referred for a further separate RMP investigation.

1.4.8 Service Prosecuting Authority (SPA) Decision. Comd 160 Brigade referred the case to the SPA in August 2021. The SPA considered the case and concluded in February 2022, not to direct trial by court martial against any of the accused. The family of the SP chose to request a victim's right of review of the SPA decision in February 2022. The review concluded on 30 March 2022 and agreed with the SPA decision not to direct trial by court martial.

1.4.9 West Midlands Police. The SI team have provided evidence to the Serious and Complex Crime Division of West Midlands Police for a separate investigation.

Analysis of Factors/Terms of Reference Exploration and confirmation of facts

1.4.10 As noted at para 1.4.1 this section captures all the facts, and or issues identified. The Findings element seeks to answer the questions / themes raised directly against the TORs. As such TOR 1 establishes the facts surrounding the DSH incident and relevant matters up to the end of the Junior term. TOR 2 establishes the facts surrounding the death of the SP. TOR 3 looks at the policies, procedures, and welfare provisions and how they were applied at RMAS. TOR 4 considers the policies and procedures that applied to DCMH Aldershot. TOR 5 considers the extent to which RMAS, and external medical agencies interacted, and TOR 6 outlines the Panel's subsequent recommendations. Where an issue is identified the degree of confidence the Panel have in their conclusion will be mapped against the probability language listed at para 1.4.2.

1.4.11 A number of learning accounts had already been produced before this Inquiry was convened, as a result some lessons and recommendations had already been captured by APSG.

SECTION 1 ANALYSIS OF FACTORS – TOR1 – Determine the cause of the incident by examining the contributory factors and the events leading up to the self-harm of the Service Person on 16 July 2018 to include, but not limited to:

SECTION 1 ANALYSIS OF FACTORS-TOR 1A.

A full chronology of the events leading up to the self-harm, concentrating on the period of 18 months before the date of Deliberate Self Harm (DSH) to include AOSB Briefing, AOSB attendance, Pre-RMAS courses and the Commissioning Course No182 up to 16 July 2018 and any subsequent events which are relevant to the Service Inquiry.

1.4.12 The SP attended AOSB briefing from 06-07 May 2017 and was awarded a Cat 1.	[redacted]
1.4.13 Following AOSB briefing, in May 2017 the SP attended AAC aptitude testing at RAF Cranwell, she was not successful in passing the aptitude testing. Joining as an AAC pilot would not be a viable career choice and this initial interest was no longer pursued.	[redacted]
1.4.14 The SP returned and completed the AOSB Main Board on 26-29 September 2017 and was graded a risk pass. The pass was subject to her passing the Pre RMAS course at the Defence College of Logistics, Policing and Administration, Worthy Down. Areas identified as risk were her academics, general knowledge, and history.	[redacted]
1.4.15 Capita recruitment records show the SP attended a RLC visit on 19 November 2017 in Deepcut, Surrey.	[redacted]
1.4.16 From 08 January 2018 to 30 March 2018 the SP attended the Pre RMAS course at Worthy Down. The end of course report was very positive, and the SP was graded as the top student on the course, enabling her to progress onto the Regular CC.	[redacted]
1.4.17 The SP attended a lunch at Minley Manor, hosted by the RE on the day they started at RMAS. She met other PO's also due to start at RMAS.	[redacted]
1.4.18 Thereafter she started CC 182 on 06 May 2018 aged 20 yrs. At the start of the course the SP was 1 of 4 females in a mixed, 30 strong Platoon namely 33 Pl which was one of 3 Pl's in Falklands Coy. The intake comprised of two Coy's; Falklands and Borneo, the	[redacted]

whole intake was 180 strong. The SP was the youngest on the course.

1.4.19 The CC is a 44-week initial training course that is designed to make effective leaders of soldiers. The first 14-week term at RMAS is a transitionary period, the training is devoted to basic military skills, fitness and decision making. The majority of instruction in the first term is undertaken by Pl CSgts. The pace of life is busy and OCdts are required to adapt to a military regime which may be a shock to some. It appears that the SP adapted well to this new regime and her DS had no concerns about her progress, in fact she was well regarded not only by her staff but also by her fellow OCdts. Witness 20 told the Panel "[the SP] always delivered to a better standard than everyone else". Witness 39 told the Panel "I thought [the SP] was doing well. She was a likeable individual. She was a grafter. I didn't have any issues with her."

[redacted]

Events of 16-17 July 2018

1.4.20 During the first term OCdts attend a Regimental visit, the main purpose of this is to inform the OCdts of the various roles within the Army, allowing the unit staff to get to meet the POs and the OCdts get a feel of the Regiment/Corps. It also gives the OCdts an opportunity to talk to soldiers and young Officers who are currently serving in different parts of the Army. Although there is not a selection element at this stage, it can cause self-induced pressure on the OCdts, who are, in essence having an informal discussion about future employment. On 16 July 2018 the SP along with 42 other OCdts attended a visit hosted by the RE at Wyke Regis Bridging Camp near Weymouth and of note there were no RMAS staff present during the visit. During the evening of 16 July 2018 there was a social event that included outdoor games, a free bar was provided, and alcohol was available. During the hearings the Panel heard evidence concerning the pre-visit briefing the RE Regimental Representative at RMAS (Witness 30) explained that they were unable to confirm the detail of what the OCdts were informed regarding their behaviour and what the specific instructions were regarding the consumption of alcohol. Witness 6, an OCdt, recalled the following "I think we were all aware of not embarrassing ourselves and not getting too drunk and messing up places at Regiment. I do not distinctively remember whether that was from a brief collectively or as a platoon, or what, I could not tell you." The Panel are of the opinion that a clear brief should have taken place to inform the OCdts of the standards expected of them during the visit.

[redacted]

1.4.21 The evening finished at around midnight and OCdts were transported by minibus to their accommodation. It is clear that the SP was drunk at this time as recalled by Witness 7 who helped the

[redacted]

SP out of the minibus. The SP vomited when she got out of the minibus. The two OCdts then attempted to find the accommodation block but were unable to do so, at this time the SP began saying [redacted] and was asking Witness 7 [redacted] and similar comments which concerned Witness 7 to such a degree that they recorded what the SP was doing on their mobile phone, (Witness 7 thought that their recollection of events might not be believed hence the recording). Witness 7 rang Witness 5 who, once they had arrived on the scene, helped return the SP to the accommodation block. Whilst they sat outside, she attempted to [redacted] during this period the SP also attempted [redacted] Initially the OCdts were unsure how to contact any staff out of hours whilst on a visit. The OCdts sought assistance from the RE Duty staff and Witnesses 51 and 48 duly attended, Witness 48 describes in their written statement how the SP also attempted [redacted]. During this period an NHS ambulance was called, and paramedics attended and assessed the SP. The following paragraphs give further details of the behaviour Witnessed on the night.	
1.4.22 Witness 7 explained to the Panel, in great detail, their recollection of the events of 16 July 2018. Witness 7 recalled the SPs behaviour came out of nowhere but that she was very distressed saying [redacted] As well as asking Witness 7 for [redacted] also attempted to [redacted], during which time her behaviour was described as “absolutely mental”. Witness 7 and Witness 5 took the SP back outside at this point the SP started “shouting saying constantly, over and over again [redacted] then attempted [redacted] Witness 11 was woken to come and assist Witnesses 7 and 5 outside and Witness 5 then went to seek help from the RE staff.	[redacted]
1.4.23 Witness 5 described to the Panel, that they had returned to camp on the minibus before midnight. Witness 5 returned to their accommodation but received a message from Witness 7 requesting help with the SP. Once they found the SP and Witness 7 on camp, [redacted], which I believe she intended to self-harm with them. At one point she asked us (Witnesses 5 and 7), [redacted] I think she even said that she was just going to [redacted] But it wasn't that she was upset, it was weird, because she was happy, and she was like [redacted] Witness 5 explained they were frantically trying to ring any member of (RMAS) staff but couldn’t get through to anyone. Once Witness 5 got the SP back to her accommodation and onto her bed they were about to leave when	[redacted]

[redacted] They restrained her and took her back outside (with Witness 7), where they had to continue to restrain her for quite some time because [redacted]. Once the RE staff had called for an ambulance, at about 0300hrs, Witness 5 was told to go to bed.	
1.4.24 During the events of the morning of 17 July 2018, Witness 5 (an OCdt) sent messages to Witness 39 (Permanent staff at RMAS) requesting assistance. This was not read until later in the morning and was in effect the first communication with RMAS.	[redacted]
1.4.25 Witness 11 described to the Panel the way the SP [redacted] They explained that once the SP had been put to bed, Witness 11 and 47 were in the room trying to get the SP to go to sleep but she kept [redacted] and Witness 11 had to lie next to her to restrain her until the ambulance arrived, around 0350hrs.	[redacted]
1.4.26 Witness 51, a member of RE staff gave a statement, in which they explain that on the night of 16 July 2018, an OCdt found them and requested help. On arrival at the SPs room, they asked the 2 OCdts assisting the SP to stand back so they could talk to the SP, at which point she attempted [redacted] so had to be restrained for 30 minutes. At one point during the evening, Witness 51 took her outside to try and calm her down, they explained that at this point she [redacted] which they then removed. Witness 48 continued to keep a close watch on her until the ambulance arrived, around 0350hrs.	[redacted]
1.4.27 Witness 48, a member of RE staff explained, they were alerted of an incident at 0130hrs on 17 July 2018 by a colleague. Witness 48 arrived at the SPs accommodation, where they remained to support her throughout the night. Before the ambulance arrived, Witness 48 explained the SP was talking to Witness 51 and that whenever the topic of [redacted] was raised it would cause an "anxious reaction" from her. Witness 48, witnessed the SP, try to [redacted] and use phrases to the effect of [redacted] Eventually Witness 48 and 51 felt the SP would be better back in her room, at which point Witness 51 explained "she continued to try to [redacted], when we restrained her, she would try to [redacted] It took a lot of force to restrain her".	[redacted]

The Return to RMAS

1.4.28 Between the RE Staff and the ambulance staff it was agreed that the SP should remain at the Camp and be returned to RMAS Medical Centre later that morning. Witness 48 remained with the SP who slept until early morning. They then escorted the SP to RMAS, and she was handed over to the medical staff at circa 1100hrs.

Witness 48 subsequently met with Witness 35, and explained their recollection of the events. Witness 48, retrospectively felt, the CoC focused heavily on the drinking side of the incident. In March 2020, when asked to provide a further statement, Witness 48 explained; "I considered this to be a serious suicide attempt. I believe if I left her in the room unattended that night, [the SP] would have killed herself. I think she was making a concerted effort to succeed" and that they thought alcohol was a red herring which emboldened her to behave in the manner she did," it was not drunken behaviour but a conscious thought".

The panel believe that, had an investigation commenced on 17 July 2018 as soon as the OCdts returned to RMAS, which involved the taking of detailed statements, then it is reasonable to assume that the seriousness of the various elements of self harm would have been known immediately by the CoC.

In addition, the fact that there was a video recording in existence, taken by Witness 7, who was so concerned by the SPs behaviour (whilst they were solely assisting the SP), that they decided to record the event as they didn't think that the CoC would believe their account alone. Due to this investigative omission, the entirety of this information was not understood by the CoC immediately and hence, the panel believe that it was not treated with the level of seriousness one would have expected.

The seriousness of this specific information should then have been shared immediately with the medical staff at RMAS who would have recorded the detail on Defence Medical Information Capability Programme (DMICP) where it would have been visible to the medical staff at the DCMH. Namely the 5 elements of self-harm; [redacted] along with her [redacted]

Unfortunately only limited information was disclosed to the medical staff and they were not fully appraised of the exact details of the events at the RE visit.

1.4.29 The Panel interviewed medical staff from RMAS as well as the mental health nurse and consultant psychiatrist who assessed

the SP at DCMH and it is clearly apparent that the full facts of the events of the morning of 17 July 2018 were not investigated. As a result, the full facts were unknown and unable to be shared with the healthcare professionals. At the oral hearing, when the facts of the RE visit were described to Witness 45, a medical professional who assessed the SP, they replied "Sir, this is the first time I am hearing this". In addition, Witness 40, another medical professional, explained; PRESIDENT: Were you aware of the fact that she had tried to [redacted] and that she had tried to [redacted] with her [redacted] WITNESS 40: No, no. No, I wasn't aware of that. PRESIDENT: Because that is the key. WITNESS 40: Yes, that would have made …I think that would have added on to the risk assessment or to a conversation that would have had with the -- what -- for her to then explain what had caused her to do that because it's not a common thing in terms of [redacted]… also given the fact that she's in an environment where she wants to do well, where she's keen to pass out as an Officer at Sandhurst. So, yes.	[redacted]
1.4.30 During the morning of 17 July 2018 Witness 20, explained they were informed the SP had "attempted to commit suicide" and spoke to their CoC, but at this point they had no further information. Witness 20 was categorical in their description of the deliberate self-harm incident in that it was an attempted suicide and in Witness 20's mind was a serious incident.	[redacted]
1.4.31 Upon arrival at the RMAS medical centre the SP was assessed by Witness 42 who recorded the findings electronically, which made them visible to the staff at DCMH that afternoon when the SP attended an urgent appointment. Of note was the fact that [redacted] Witness 42 also recorded that they had not ascertained as to what had caused the incident.	[redacted]
Attendance at DCMH Aldershot and Guidance to CoC **1.4.32** At 1400hrs the SP was assessed by Witness 40 at DCMH, the initial findings were discussed with Witness 45 before the decision was made to return the SP to training [redacted]	[redacted]

1.4.33 The SP returned to the medical centre at RMAS [redacted]	[redacted]
1.4.34 The interim assessment decision made by DCMH staff was relayed to Witness 31 at the medical centre who then shared that information with Witness 28, a senior member of the CoC. During the late afternoon and early evening, the decision to return the SP to training was taken by Witness 28 in consultation with Witness 36. The Panel are of the opinion that this decision was not fully informed. An assumption was made that all parties involved in this process were aware of the facts of the incident. That was not the case. A limited investigation and collation of facts had started, but unfortunately all the relevant information had not been shared with the medical chain.	[redacted]
Direction to Investigate **1.4.35** During the afternoon of 17 July 2018 Witness 35 informed Academy HQ of the details as known by the CoC, Witness 36 specifically requested further details of the visit. This was followed up by Witness 44 who provided direction and guidance to Witness 35 stating in an email dated 20 July 2018, "There is interest in the [Main Events List] MEL for the Visit and what actually took place during the evening in the lead up to the incident. I would suggest that you do as suggested please – produce an [Issue, recommendation, timing, background] IRTB providing the results of your investigation, along with a Learning Account. We may need to give some firm direction on Unit Visits, Alcohol consumption, Duty of Care and Reporting to both our Staff and Hosting Officers." The panel have seen evidence to prove Witness 35 sought advice and guidance on several occasions, to assist with completing the LA during July-August 2018.	[redacted]
1.4.36 Witness 36 clarified the understanding of the investigative process on 17 July 2018 as follows: President: What I am trying to determine is who directed whether an investigation was to take place, or did people assume that an investigation was going to take place? Witness 36: No, we would have directed an investigation to take place and there was a case file. So, I saw a case file with statements in it and the INCREPs [incident report] in it following the incident. So, they were directed, as is normal practice, to carry out an investigation. I didn't check whether they had asked all the	[redacted]

people who were at the incident. They were directed to carry one out."	
1.4.37 The Panel sought to understand the investigative process that occurred after the RE visit as it was apparent, following the hearings that none of the OCdts who Witnessed the behaviour of the SP were interviewed by the CoC. The panel would have expected that the OCdts involved in the incident would have been asked about what had occurred, and that this would have been recorded in writing. It was noted that's the RE staff were asked to submit statements in the aftermath but there were no statements taken from the OCdts who were the first responders. Witness 28 recalled discussing the incident with Witness 7 (the first responder), however Witness 7 had no recollection of this discussion. Witness 36 summarised the position when questioned about this area as follows; Witness 36: If the right people were not spoken to in terms of that investigation, then the right procedure wasn't followed. I mean, it is self-explanatory, isn't it? If we didn't get the right evidence into that folder and, therefore, the narrative that was read back into me and the Chain of Command and to the DCMH was wrong, then something didn't go right.	[redacted]
1.4.38 Late afternoon on 17 July 2018 the SP was visited in the medical centre by Witness 20, 28, and 30. It appears that she was exceptionally embarrassed by the position that she found herself in at this time.	[redacted]
1.4.39 During the evening of 17 July 2018 Witness 34 met with Witnesses 5,6,7,11 and one other OCdt in order to conduct "an initial assessment and requirement to hand off to TRiM practitioner", as requested by Witness 35. Thereafter, it appears that the TRiM process was considered by Witness 35 as outlined in their email however the informal approach provided by Witness 34 was deemed sufficient. Witness 43 who co-ordinated the TRiM process in February 2019 confirmed that there was no request for TRiM services in July 2018. Witness 46 explained there should not be a filter process for TRiM. No TRiM was conducted, no assurance sought from Witness 34 and no concerns passed back to the Chain of Command by Witness 34. Witness 8 was distressed as they were not invited to attend this meeting. The Panel are of the opinion that all those OCdts and staff members who Witnessed the DSH incidents that night should have received TRiM.	[redacted]

Return to Training and Case Conference **1.4.40** On 18 July 2018 the SP returned to unrestricted training. Witness 28 held a meeting to discuss the SP and the events of the RE visit. This was subsequently recorded as a risk assessment meeting and a VRM account was created along with the initiating of a CAP. The attendees are listed in the records, a significant omission that day was that UWO was not invited to that meeting albeit they were informed later. The Panel have found no evidence that the details of the CAP were ever discussed with the SP. On 18 July 2018 Witness 38 made a referral to the AWS the Panel has found no evidence that the services provided by the AWS were explained to the SP in July 2018. It seems likely that this did not occur as Witness 38 confirmed in their written statement that they never met the SP. The subsequent comments made by the AWS Initial Assessment team stated "there is risk that the SP may be dealing with unresolved issues, which may have manifested in self-harm in this seemingly isolated incident. There is also a risk that placing the SP back into a stressful training environment may cause her emotional and mental stress". These comments did not reach the CoC or feed into any decision regarding her future at RMAS.	[redacted]
1.4.41 The SP was also registered on the Falklands Coy Welfare tracker. This information was open source (within the Coy permanent staff) and the Coy CoC were supposed to be aware of this detail which states the following; "[the SP] attended the RE Regimental visit in junior term and, whilst drunk, made un-planned and half-hearted attempts to kill herself. She has been assessed by the medical, mental health and welfare teams as fit to continue training. She is being monitored closely by Pl staff and is now tee total. No risk to commissioning". At this time the SP would also have been included on the Old College Welfare tracker which would normally lead to her case being discussed at the monthly Commanders Welfare/Risk Register meeting. This meeting did not occur in July 2018 (the Panel have not received an explanation as to why this happened just that it was cancelled) and as such no higher-level meeting to confirm or clarify her ongoing care management occurred during the final weeks of the first term. The Coy staff and Pl Comd were aware of the details of the Coy tracker.	[redacted]
1.4.42 On the 18 July 2018 the SP was escorted back to the accommodation lines in Old College by Witness 34. Witness 39 explained that they had discussed her re-integration with the OCdts in 33Pl and that the SP was integrated "seamlessly" back into training.	[redacted]

1.4.43 Witness 20 and Witness 39 supported by Witness 34 were required in accordance with the CAP to "monitor" the SP. Witness 39 told the Panel they "can't recall any care action plan", and Witness 20 explained they "didn't fully understand what a CAP was". In the last 3 weeks of the junior term Witness 34 met with the SP twice on 20 July 2018 and again on 05 August 2018 to provide pastoral support. On 23 July 2018 a one-week review was recorded on the CAP, Witness 35 wrote: "An update on where she is a week following the incident. Appears to have moved back into training with no issues. Has a good support network around her due to being a popular OCdt. No immediate concerns"	[redacted]
1.4.44 The SP wrote a letter to Old College Commander apologising for her behaviour at the RE visit (dated 24 July 2018) and praising the assistance she received from her peers. She explained her behaviour was due to a "combination of alcohol and past events in my life". The Panel have seen no evidence that the past events in her life that she wrote of, were investigated or that she was offered specialist counselling to assist her with those wider issues. The RMAS medical Chain highlighted they were not sure why she had behaved as she did on the RE visit. This specific point was recorded in writing on the SPs medical records by Witness 42.	[redacted]
Disciplinary Interview with CoC **1.4.45** On 26 July 2018 the SP attended a disciplinary meeting with Witness 28, Witness 35 was also in attendance the details of the meeting are recorded as an AGAI 67 the formal guidance on disciplinary administrative action) entry which stated: "[the SP] stated she has given up drinking. She is also encouraged to mitigate/address the underlying family issues which-though the catalyst is alcohol -caused her to have a violent outburst threatening self-harm. Her letter of apology to Comd OC and praise and thanks for the handling of the situation by her peers all noted. A reoccurrence could lead to questions of her suitability of employment."	[redacted]
1.4.46 The consumption of alcohol and its adverse effects upon the SP were discussed in detail and the SP agreed to abstain from alcohol. On conclusion of the disciplinary meeting, the SP formally signed the AGAI paperwork. The CAP was also updated by Witness 35 the details recorded as follows:	[redacted]

"Interview with Witness [redacted] to inform [the SP] that the actions are unacceptable in this line of work. Acknowledgement and plan put in place by [the SP]."	
1.4.47 The Panel are of the opinion that the use of language which directly refers that a "reoccurrence could lead to a questioning of her suitability of employment" may have influenced the situation in February 2019, after the Falklands Coy Ball incident. As the SP assumed during the period 1-6 February 2019 that she was going to be removed from the CC even before the disciplinary investigation had concluded.	[redacted]
Return to DCMH and re-integration into training **1.4.48** The same day as the AGAI interview (26 July 2018) the SP attended a second assessment at DCMH with Witness [redacted], the outcome of which was confirmed with Witness 45 and the SP was again returned to training. The last 3 weeks of the junior term involved a week on exercise at Thetford and the SP impressed the DS. Of note is Witness 30 assessment of her performance recorded in their written statement as follows: "Under pressure to complete a platoon attack I witnessed her calmly directing her section and motivating them to complete their part in the action. [The SP] was clearly respected by those around [them] and [their] military skills were good"…."I later discussed what I had seen with [their] platoon staff and they agreed what I saw was typical of their interactions with [the SP]."	[redacted]
1.4.49 When questioned about the SP performance during the Junior term Witness 39 explained, "I would suggest that she was in the top third but definitely meeting the standard" and that she didn't give any cause for concern. In addition, Witness 20 stated "in the final 3 weeks of Junior term, she was still keen to get stuck in, still performed as well, if not above average with other individuals on course".	[redacted]
Final Assessment at DCMH and Handover from Old to New College **1.4.50** On 03 August 2018 a handover meeting occurred between the Old College staff to the New College (NC) Commander and their staff. The SP was discussed and the details that had been recorded on the Falklands Coy Welfare register were highlighted to the new CoC. The meeting was also recorded on the CAP as follows:	[redacted]

"Details of case handed over [redacted] also present". Witness 38 has highlighted an inconsistency in this recording and confirmed that they did not attend the meeting on 03 August 2018.	
1.4.51 On 09 August 2018 the SP returned to DCMH for a further assessment and was seen by Witness [redacted]	[redacted]
1.4.52 The CoC were not aware that the SP had attended [redacted] separate appointments at DCMH. At no point during the final 3 weeks of the junior term did any further detail of the event at the RE visit pass to Witness 40 and 45 at DCMH or to Witness 31 and Witness 42 at the RMAS Medical centre.	[redacted]
Welfare arrangements at the end of the Junior Term **1.4.53** The junior term finished on 10 August 2018 and the SP started a 3 week leave period. The responsibility for monitoring her during this time remained with the CoC from the first term. The CoC did not monitor the SP during leave. When asked about this aspect Witness 20 stated: "I don't know why I didn't other than at the time I didn't think of it as a thing I needed to do." Witness 39, from the SPs CoC, was also questioned about this element, their response is below: President: what I am trying to determine is who is looking after or checking up on her welfare during this three-week period whilst she is on leave? Witness 39: Well, it wasn't the Platoon Chain of Command. I believe at that point it may have been the professionals, DCMH who went through it but I'm unaware of who was responsible for her on leave.	[redacted]
1.4.54 JSP 822, Defence direction and guidance for training and education (March 2017) states the care regime must establish appropriate levels of supervision and welfare care at all times, including during leave. The staff had a lack of understanding of their duty of care, which extended over leave, this resulted in the SP	[redacted]

being left with no direct welfare support, 3 weeks after the DSH incident (see TOR 3a).	
1.4.55 During the last 3 weeks of the junior term Witness 28 discussed with Witness 30 that the SP should be encouraged to telephone home. The SPs mother stated that there was no communication whatsoever regarding the events that occurred at the RE visit or the subsequent DCMH appointments, the first time the family found out about the incident was after the SPs death when they visited RMAS on 07 February 2019. The guidance concerning this specific issue to the CoC at this time was to be found in Annex D AGAI 110 (Army Suicide Vulnerability Risk Management policy) where it outlines the approach to be considered when “engaging family support". The policy states; “Whenever possible, soldiers should be encouraged and persuaded to voluntarily tell their families about their problems and difficulties. If they will not, then if possible, they should be persuaded to allow the Chain of Command to speak to their families-even if it is only to tell them that the soldier is not happy.” The Panel have heard that numerous Witnesses felt that they couldn’t force this contact or engage directly. However, the policy does state the following: “In exceptional circumstances, the Chain of Command may approach the family without the soldier’s permission but in such a situation no personal information may be disclosed other than to say there is a concern about the individual’s welfare and it would be helpful if the family made contact”. The Panel are of the opinion, that if the CoC had conducted an investigation and therefore been fully aware of the situation, they would have had grounds to approach the family in the exceptional circumstances of the SP committing DSH in the form of attempted suicide.	[redacted]
OCdt Concerns for the Service Person **1.4.56** Witness 7 who dealt with the SP on the evening of 16/17 July 2018 confirmed that they were not asked to recount the events by a member of the CoC. This recollection is disputed by Witness 28, who informed the panel that they spoke to this Witness about the matter. Witness 7 described conversations with the SP during the last part of the junior term. WITNESS 7: I don't know if [Witness 5], was asked to make a statement, but I felt like they just left, they did not ever ask me	[redacted]

anything, it was really strange. I assumed it was kind of like to protect me, I don't know, but no one ever asked me about it.

PRESIDENT: Nobody ever asked you anything about it?

WITNESS 7: I told, like I had a bit of a bad moment one day and spoke to [named person unrelated to the Inquiry] for like 10 minutes about it and then I spent a bit of time speaking to the Padre, because I felt very responsible for her after that, so really it was very stressful, and especially because we had, so once she finally got out of the med centre, she was back in training, she was happy to talk again. It was the International Dinner Night thing, which was like a big outside event, and we were sat like on the big hill on Chapel Square chatting and I felt like every pair of eyes in the whole place was on us, like every Officer, and we were chatting up there and I said, you know, you can always talk to me, you know, if you feel like that, let's not let it get to that, you know, let's talk about it, and she said, "You know, [Witness 7], when I got back I thought maybe I should just do it because, you know, I've already fucked things up enough as it is," and I was like, "Oh, you don't mean that," and I completely brushed it off, like I seem upset all the time, and she sort of brushed it off as well and we carried on talking and she talked about [redacted]

1.4.57 At that point in time 4 OCdts had raised their concerns about the SP with Witness 34. Witness [redacted] described how there were "raised eyebrows when she was returned to training", when questioned further about the return to training of the SP Witness [redacted] offered the following perspective:

PRESIDENT: Albeit that DCMH said that she was fit to return to training in July 2018. Why did the Chaplaincy department not raise a red flag to the Chain of Command? If everybody was raising eyebrows … and you have the Officer Cadets saying, "I don't think she should be returning to training". …Why did somebody not grasp the nettle and say, "Do we really think this is a good idea?"

[redacted]

WITNESS [redacted] I was the person who could have done that so I'm happy to take that. But because the way the military works and the way Chaplaincy works within the military is that once they are into the medical Chain and the psychological Chain, the DCMH Chain, that is where that focus lies, and you've got a doctor doing that. I think it was [redacted] who's a great [individual], brilliant doctor. And it was with DCMH, who I had very little contact with when I was at Sandhurst. I've had more contact with them elsewhere, but not so much at Sandhurst. That was their -- I really don't think it's my

place to be challenging clinical judgements of health professionals who meet those qualifications…. Now, it's surprises me that you say that the Chain of Command didn't know what happened in that incident. It seems to me that half of these things have happened in my experience. People talk about it all the time and so -- I mean I'd heard about [redacted] and things like that. So, I didn't know everything, but I'd heard various parts.	
1.4.58 Witness 7 explained why they thought the investigation was not carried out thoroughly. Witness 7 felt Witness 39 "thought [they were] helping her out by massively brushing the whole thing under the carpet", and Witness 28 was giving the SP an "Officers don't behave like that speech…. let's just forget that ever happened because we can't have Officers who do that". The panel noted that Witness 28 recorded in their written statement that they had discussed the actions of Witness 48 with Witness 7 on 24 July 2018.	[redacted]
1.4.59 Witness 7 did raise concerns with Witness 34, about the SP behaviour at the RE visit but she was told "we are dealing with it". Witness 34 subsequently clarified their understanding of this comment, stating that it was made on the premise that the CoC would be fully investigating it and dealing with the matter.	[redacted]
1.4.60 The SP spent her summer leave based at the family home. She met up with Witness 10 for a 4 day break and also went on a foreign holiday with her [redacted]. She returned to RMAS to start the intermediate term on 10 September 2018.	[redacted]
1.4.61 Witness [redacted] informed the Panel that the SP had explained that sometime during the leave period that the SP met an individual whom she alleged had previously [redacted] and that during that meeting the individual [redacted] The SP also mentioned this matter to Witness [redacted]	[redacted]
Summary **1.4.62** There were five elements of self-harm that occurred at the visit at Weymouth, but when the Panel questioned DCMH staff, they were only aware of two of them. There was a clear break down in the Chain of communications about what actually happened at Weymouth. The Panel are of the opinion that this was a result of poor sharing of information, which would explain why the details of what happened at Weymouth, did not make it into the medical chain, which consequently wasn't able to inform the specialists at DCMH who assessed her. There was an incomplete picture of what	[redacted]

happened at Weymouth, that could have been clarified had somebody asked the questions of those OCdts present.	
1.4.63 A Learning Account was produced on 27 July 2018. The LA was reviewed by the Permanent President of Service Inquiries (PPSI) on 13 September 2018 and completed on the 29 September 2018. No wider investigation was conducted to determine the complete facts of the RE visit. Witnesses 36 and 44 both understood an investigation would happen. However, the collation of facts to inform the LA was limited in its scope. The Panel have identified key factors as follows: a. Statements were not taken from all personnel involved. Albeit, the RE staff provided statements, they were present for very little of the behaviour in question, no statements were taken from the OCdts immediately involved in the incident who were first responders. b. Key personnel involved in the incident were not identified in the LA, namely the OCdts including the SP. c. The Panel has seen no evidence to suggest the LA was shared with the Medical Chain, the Chaplaincy, the Welfare department, or the SPs CoC (if LA had been sent to the (senior medical Officer) SMO/DCMH they would have had a better understanding of the background of the event). The impact of these combined omissions were discussed with Witness 40 (see TOR 1, 1.4.29) who was not aware of all the forms of DSH that had occurred and, in the opinion of Witness 40, had they known all the facts [redacted]	[redacted]

SECTION 1 ANALYSIS OF FACTORS – TOR 1B

Details of the Service Persons Service history; to include work performance and disciplinary record in the 12 months preceding her self-harm.

1.4.64 The SP completed her A Levels during the summer of 2016, she decided not to continue her studies at university, she focussed on passing AOSB and in the meantime took part time jobs at [redacted]. References were submitted to the National recruiting centre which describe her as "very well motivated and extremely hard-working individual – nothing ever phases her". Her Head teacher describes her as showing maturity beyond her years, is in possession of enormous resilience" and demonstrates "enormous commitment and loyalty".	[redacted]
1.4.65 The AOSB report and her subsequent Pre RMAS course report provide a picture of an individual who relishes hard work and obviously wanted to succeed as an Army Officer. She impressed the staff and improved significantly over the 3 months of the Pre RMAS course so much so that she was classed as the Best Student. The Course Director's statement describes the SP as being "relentlessly positive and exceptionally keen to develop. Her level of application and diligence was second to none."	[redacted]
1.4.66 Witness 20 described the SPs performance in the Junior term, midterm report positively, highlighting a few areas for the SP to continue developing notably her "confidence in herself" and her navigation. This report was seen by the SP and dated 22 June 2018. The report produced at the end of the junior term was complimentary; "she showed a good amount of mental resilience and grit".	[redacted]
1.4.67 The SP completed several Command appointments whilst on exercise during junior term. The staff assess the OCdts' performance and complete Student Assessment Forms (SAFs). The SP received a SAF on Ex Long Reach, 27 June 2018, Ex Second Attack, 12 July 2018 and Ex Montgomery's Mark, 03 August 2018. Witness 20 commented on a SAF that the SP "grafted in appointment" and were "head and shoulder above others in the Pl". Her peers regarded the SP a hard worker and team player. Witness 1 said "she really does work hard". Witness 2 said "she was a really likeable person, a likeable character." Witness 3 described the SP as "Probably the most motivated person I can think of throughout Sandhurst. Nothing was too gopping, nothing too hard. She just worked so hard she was just nails". Witness 4 stated "She was the most enthusiastic person I had ever met. She was full of energy and	[redacted]

very positive". Witness 4's first impression of the SP was "Bubbly, young, a bit naïve, I would say. She was very enthusiastic about learning everything. Very excitable but it did feel that she was, yeah, quite naïve".	
1.4.68 In week 8 of junior term, the Cadets complete an open peer appraisal, providing development and sustainment points for one another. All sustainment comments, in some manner refer to her "resilience, robustness and that she is hard working" One third of the development comments refer to the importance of improving her military bearing and appearance.	[redacted]
1.4.69 There were no other disciplinary entries other than that related to the RE visit, or issues arising during the first term. The Panel are of the opinion the SP was performing well and was meeting the standards required to commission.	[redacted]

SECTION 1 ANALYSIS OF FACTORS – TOR 1C

Establish, as far as is relevant to the scope of this Inquiry and can be disclosed without breaching relevant medical confidentiality restrictions, the personal circumstances including medical history which may have had an impact on the Service Persons actions.

1.4.70 The SP started the Pre RMAS course in January 2018 and then flowed through to the first term at RMAS. She did not have a partner, boyfriend or girlfriend that was known to her family. Witness 10 confirmed that they met the SP through an online dating app sometime in May 2018. The SP subsequently introduced Witness 10 to other members of her Pl whilst they conversed on Facetime during the evenings. The SP did not disclose this new relationship with Witness 10 to her family.	[redacted]
1.4.71 The SP only mentioned her mother, Grandmother, and sibling in her personal statement and [Witness 53] confirms in their Witness statement that they were only aware of these three family members.	[redacted]
1.4.72 The SP had no entries in her military medical records prior to the DSH incident which would have a bearing on this Inquiry and no medical history concerns were identified during her application or on arrival at RMAS.	[redacted]
1.4.73 The Panel heard evidence from Witnesses [redacted] who were told by the SP that she had been the victim of alleged [redacted] There is no record of this having been mentioned to medical staff when she joined the Army, or to the Police. Although the facts of these allegations are outside the scope of the inquiry, the Panel are of the opinion that, if true, this would have been a contributory factor to the deterioration of the SPs state of mind.	[redacted]

SECTION 1 ANALYSIS OF FACTORS – TOR 1D

Establish to what extent the Chain of Command were aware of any welfare issues relating to the Service Person.

1.4.74 There were no recorded welfare concerns raised during the Pre RMAS course from January to March 2018.	[redacted]
1.4.75 Witness 20 conducted an initial arrivals interview in May 2018, which relies on the OCdt being open and having full disclosure, no concerns were noted. The SP was invited to share any welfare issues that may impacted upon her during her training, again no concerns were raised.	[redacted]
1.4.76 The SP wrote a letter of apology to a senior member of the Chain of Command, following the RE visit apologising for her behaviour and praising the assistance she received from her peers. She explains her behaviour was due to a "combination of alcohol and [redacted]". The Panel have seen no evidence that the [redacted] that she wrote of, were investigated or that a formal referral for specialist counselling via the AWS was made. Witness 28 explained to the panel, what was discussed at the meeting; Witness 28: I wanted to further reinforce that I got a strong sense from her still that the drunkenness was defining her performance and her potential at Sandhurst and I wanted to dissipate that and contain it and to say, "Don't fret, don't worry about that". It was looking towards end of term. She was going to go into the field exercise and that looked good. She was looking forward to that, it was her thing, it was good, and then have time away from Sandhurst, which appeared a good thing. "Go and relax, have fun, come back fresh" so I was checking the future looked good for her and she was able to tell me what that looked like. I wasn't picking on her.	[redacted]
1.4.77 The Panel believe that the past events in her life, that she refers to, may be corresponding to the disclosure made to Witness 8 during the Normandy visit in November 2018. This disclosure regarding allegations of [redacted], is covered in more detail in TOR 3E. The CoC was not aware of these allegations at that time.	[redacted]

1.4.78 The combination of alcohol and those [redacted] led to the attempted suicide event according to the SPs letter. The Panel are therefore of the opinion she should have been referred to AWS for specialist counselling support in July 2018. The Panel are also of the opinion that the expectation by the CoC that the pastoral support provided by the Chaplaincy Dept would be sufficient at this time, was a poor assessment of risk. The panel have come to this conclusion based upon the following 5 factors; a. No formal TRiM assessment was undertaken for either the SP or the individuals present. b. The decision to undertake TRiM assessment was requested by Witness 35, who was the CAP lead. This was dependent upon an assessment by Witness 34 who was not trained to deliver this function. c. Witness 34 was not aware of the reluctance by the SP to engage family support after the incident of DSH. d. Witness 34 was not fully aware of the multi-facetted nature of the DSH incident. e. Ultimately there was a poor assessment of risk (compounded by an incomplete investigation) by the CoC. The incident was recorded and classified within the written records as an "attempted suicide". The panel found that there was not the corresponding level of support, that they would have expected in an incident of such seriousness. The impact of this poor assessment of risk was further compounded by the poor management of the SP's CAP.	
1.4.79 The Panel are of the opinion that had the CoC conducted a full and thorough investigation following the DSH they would have been more informed of underlying welfare issues. In addition, references to "[redacted]" in her letter to Witness 28, were not followed up.	[redacted]

SECTION 1 ANALYSIS OF FACTORS – TOR 1E

Examine details of any welfare and/or medical organisation that may have been consulted, and any advice or treatment given, or action required, that would have assisted the Service Person.

1.4.80 The SP came to the attention of the Welfare Dept on the afternoon of 17 July 2018 at 1220 hours. There was no welfare representation at the risk conference which was convened to discuss the events of RE visit. Witness 38 confirms "There was an initial Vulnerability Risk Management Information System (VRMIS) meeting held on 17 July 2018. I was not invited to this meeting. This was unusual because... I should attend VRM meetings". They go on to say, "I was not informed of this incident by anyone in attendance", instead they heard about it through the WRVS member of their team. However, the Panel have seen evidence which shows on 17 July 2018, Witness 35, exchanged emails with Witness 38, who offered advice and guidance and was sent details of the situation.	[redacted]
1.4.81 Witness 21 had over 12 years experience in welfare departments, including 6 years working at a Phase 1[3] Training establishment (ATR Winchester) in a welfare role, they were not asked for their opinion by the CoC. When queried about the issue they gave the following pertinent observations; PRESIDENT: Because we know that [Witness 38] was not invited to that meeting [on 17 July 2018] for some reason or other. I was just wondering whether or not you had been invited. Witness 21: No. No, sir. We didn't even know about that. Me nor [Witness 38]. And that's why I say we found out about that I think a few days later about the whole incident. PRESIDENT: What would you have expected to have happened? Witness 21: I would have expected to have been told straightaway, sir, being Welfare anyway. And on an incident like that I would have definitely said to the Chain of Command that she should be obviously assessed by the doctors and that but released from the Army service.	

[3] Phase 1 training is now known as Basic training

PRESIDENT: If we just visit that last point that you made there. You have got significant amount of welfare experience in dealing with soldiers and trainees; can we just explore why you think that she should have been released? Witness 21: Why I say that, sir, is going back to Winchester, in Winchester any recruit trying to join the Army, if they've had an incident of trying to self-harm within five years of joining the Army they're not allowed to join. If on happening during being in the Army, and it did happen at Winchester, somebody trying to self-harm they were immediately assessed and released from the Army as being not fit for service.	
1.4.82 Albeit witness 21 had never met the SP, their comments are based upon their extensive experience and the policy applicable previously, in a previous role. The panel considered this perspective and further queried Witness 21's understanding of what should have happened regarding the SPs position after the DSH at the RE visit. Witness 21's response to the president is documented below for consideration. PRESIDENT: I am assuming they were assessed by the medical team? Witness 21: That's it, sir. PRESIDENT: Then they would be reassessed by the Chain of Command? Witness 21: That's it, sir, yes. PRESIDENT: And then a decision would have been made no doubt by the Commander. Witness 21: Commander, the Unit Health Committee meeting, sir, yeah. PRESIDENT: There would have been a Unit Health Committee meeting to discuss that individual -- Witness 21: Yes, sir. PRESIDENT: -- and a decision would have been made as to their future. Now, in the case of [the SP] you have suggested to us that after the incident down in Weymouth you think that she possibly should have been discharged? Witness 21: I definitely think she should have been discharged.	[redacted]

PRESIDENT: And you are basing that upon your significant welfare experience, I am presuming? Witness 21: Yes, sir. PRESIDENT: Were you ever asked to comment on her suitability or give any advice whatsoever to the Old College Chain of Command or the Commandant at that time? Witness 21: No, sir.	
Involvement of the Welfare Dept and the Army Welfare Service **1.4.83** Neither Witness 21 or 38 were invited to the meeting, they both received an email of the INCREP on 17 July 2018 and advice was sought regarding the recording of such incident, to which Witness 38 offered their SME knowledge.	[redacted]
1.4.84 The Welfare Dept did make a referral to the Army Welfare Service. As mentioned, (1.4.40) there is no evidence to confirm that the services offered by the AWS were explained to the SP or that she ever spoke to any member of the AWS or was aware there was a referral made to AWS about her. Therefore, no specialist counselling services, or advice was made available to the SP. Albeit, Witness 28 was of the opinion that these services would have been signposted to her by other members of staff. The specific note made by the AWS was based upon information relayed to them by the Welfare Dept however the following notes were made: "There is a risk that [the SP] may be dealing with unresolved issues which may have manifested in self -harm in this seemingly isolated incident. There is also a risk that placing [the SP] back into a stressful environment may cause her emotional and mental stress. DCMH monitoring and support may help manage these risk and support [the SP]. [the SP] has not requested AWS support now which may be due to embarrassment." The case was closed, and the above information was not shared with the CoC. The Panel are of the opinion that this information would have been shared at a multi-disciplinary UHC meeting, had there been one, because the AWS would have been invited to such a meeting.	[redacted]
1.4.85 The Panel are of the opinion that the SP was not advised of the referral and in addition she not informed by the Welfare Dept of the specialist services that would have been open to her through the AWS after the DSH incident.	

1.4.86 There was no engagement by the Welfare staff with the SP during the entirety of her time at RMAS. This is of particular relevance as one of the team became the lead for the SPs CAP after Witness 35 handed over the VRM responsibilities upon posting. The practical effect of this was that the New College CoC were unable to view the CAP, they were unable to confirm its requirements, add any changes or monitor its implementation. This is analysed further in TOR 3B.	[redacted]
Interaction between the Welfare Dept and the CoC **1.4.87** In order to determine the knowledge and understanding of the Welfare Dept and its role at RMAS the Panel asked Witness 20 about this aspect and received the following response: WITNESS 20: I didn't engage with them personally during my time... on the commissioning course…. My first port of call for the majority of people who wanted to talk about something was the Padres. They were much more accessible or they, as individuals, were much (more) accessible. They were present within the Colleges and could be contactable on a number and could meet an Officer Cadet in a matter of hours if they wanted a chat. I never referred anyone directly to the Welfare Officer. I didn't speak to [Witness [redacted]] directly at the time or [redacted]	[redacted]
1.4.88 Whilst it is evident that the role of the Welfare Dept was not well understood by the individuals who were closest to the SP in the CoC, it is also evident that there was some confusion as to who was meant to be monitoring her at this time. Witness 28, highlighted this fact as follows: PRESIDENT: So, the measures that are specifically referred to in the document [CAP], the Colour Sergeant and the Platoon Commander are primarily supported by the Chain of Command, and they are required to monitor her. WITNESS 28: …number one it is insufficient. Number two, … I wouldn't have put the onus on the Platoon Commander and Colour Sergeant, not least because… they might well be part of the problem. Thirdly, because actually they have got the other 29 cadets or however many in their platoon to look after and that is why you have a layer Chain of Command so it is clear who has responsibility for what and I wouldn't have wanted that on a Colour Sergeant [or] Captain. PRESIDENT: What were you expecting to actually happen?	[redacted]

WITNESS 28: I would have expected her, sir, to be - what's the right phrase - led to -- but not physically but made sure she knew she's in a place where she should seek conversations with the Padre. In the absence of anybody else, perhaps [Witness [redacted]] but I was never quite convinced of that. Whatever [Witness [redacted] could have found through AWS, but I keep referring back to this, I was pretty certain at the time I didn't have that key skill available for the behavioural psychologist who could make an assessment which would have helped me, but it would also develop her, [the SP] , and form an opinion about whether Sandhurst was the right place. But in the meanwhile, it was tracking her contentedness, her performance on a frequent formal basis and that's usually on the Monday morning through the College Co-ordination Group, Co-ord Group" The Panel conclude from this that Witness 28 expected the CoC at company level to closely monitor her, Padres to offer support and AWS to have been requested to provide support from the welfare department. Witness 28 would have expected the CoC to have reported back formally on a weekly basis. These expectations were not met.	
1.4.89 The Panel are of the opinion that as the role of the welfare Dept wasn't fully understood and there was confusion over who was meant to monitor the SP, it is unsurprising but extremely regrettable that she did not receive any support from this Dept.	
1.4.90 The Panel investigated why there appeared to be a break down in the provision of welfare support and poor communication between the welfare Dept and the CoC.	
1.4.91 Witness 28 explained that (despite the monthly welfare meeting not taking place in July 2018) at their weekly co-ordination meetings various departments, including AWS would have had the opportunity to raise the issue of not having seen the SP. WITNESS 28: I would have very much hoped if Witness 38 or others you were expecting to see [the SP], hadn't seen her I'd have been made aware either on the day and I could have engaged, and if it's a simple physical medical appointment there's a well-rehearsed line of getting a cadet help and seeing somebody. We're not in that space, but I would have looked to be engaged to find out why [the SP] wasn't going there, what can we do, because it's a group thing, that I can see they're reticent. I would certainly have expected on the Monday mornings, the weekly co-ords, to be told, "No, she hasn't come down, I haven't seen her". So as far as I was allowed to believe, she was being seen by Unit Welfare Office and AWS, if that was appropriate.	[redacted]

PRESIDENT: My next question was did welfare department staff back brief you in the final three weeks of term about what engagement they had with her? WITNESS 28: No, certainly ... they had the opportunity to. I don't remember them saying, "She is not engaging, The SP is not engaged, and we haven't seen her" otherwise I'd have done something about it. PRESIDENT: [The] closely monitoring action that is meant to be happening appears to me that it is actually not happening, and it is not being co-ordinated by the Chain of Command. What are your thoughts to that assessment? WITNESS 28: I think ... especially in retrospect, which is dangerous, I'm disappointed at how much new information is coming out now about, "[The SP] didn't go to this" or -- for instance. I do understand her reticence, but I think we needed to work on that, and if, frankly -- and I relate it to a physical injury, if she twisted her knee and she wasn't going to the physio I could well have taken her out of training to say, "Ultimately I'm responsible for your health and welfare during training and if you're not engaging having your knee repaired, you're stopping, you're pausing", same with a psychological issue. I would have done that, but it's just -- but it's not fact, but it is proof. If I had known she wasn't engaging then the Chain of Command would have stopped her training and paused and gone around the buoy again, as it was, I, as a part of the Chain of Command, I knew she wasn't engaging". The Panel are of the opinion that although Witness 28 was not told of the lack of engagement, there was a requirement of Witness 28 to request the information.	
Engagement with the Chaplaincy Dept **1.4.92** The Chaplaincy Department, consisting of a Senior Padre and 2 assistant Padres, were engaged by the CoC to support the SP after 17 July 2018. Witness 34 escorted the SP back to the accommodation lines and met with her on 20 July 2018 and again on 5 August 2018 to provide pastoral support.	[redacted]
1.4.93 There is a specific reference to the Padre in the SPs CAP where it is stated that "the Padre is a key person to assist as required"	[redacted]
1.4.94 Witness 34 statement describes meetings with the SP as follows:	[redacted]

"In my initial meeting with [the SP] and in subsequent ones her overwhelming demeanour was one of huge embarrassment for how she had behaved, and a deep sense of shame at the fuss she had caused everybody."	
1.4.95 When questioned on access to welfare provisions, Witness 8 was asked if they would have approached the Padre, they explained, "I am not religious and also [Witness 34] was very close, like, to the Chain of Command". Witness 8 also referred to discussions she had with the SP regarding the meetings that occurred with Witness 34. "She went to see [them] for the first time and [they] took notes and she asked [them] not to take notes and [they] basically just carried on taking notes and she felt that it was all going to the Chain of Command, and she thought that that was more like a place where she could just talk. So, she didn't like [them] for that".	[redacted]
1.4.96 The Panel also asked Witness 3 if they would approach the chaplaincy; "I just wouldn't go to the Padres. I think they are part of the Army and, therefore, they have still got a responsibility to then push that up the Chain of Command".	[redacted]
1.4.97 A number of OCdts have explained to the Panel that they would not seek help from the Chaplaincy Dept because they were not religious. The Panel understand the position of the Chaplaincy Dept is that OCdts do not have to be of any faith to receive the pastoral care that is available. The key issue is that there is a perception among the OCdts that pastoral care is linked to having religious beliefs. The Panel therefore conclude that there is a misunderstanding by the younger generation of OCdts as to what the Padres role is, and what support they are available to offer (this is echoed in Witness 18 transcript). OCdts who have been to College or University are now used to having access to Student Welfare Officers who provide counselling and support services, who have no direct link with religion	[redacted]
Monitoring by Medical Staff and importance of family support **1.4.98** In addition to the welfare and Chaplaincy Depts the SP was meant to be monitored by the medical staff at RMAS. Witness 31 described how she was monitored at the monthly Primary Healthcare meetings, the senior medical staff also attended the Academy level welfare meetings where the SP was discussed, no concerns were raised to the RMAS medical staff. The Panel are of the opinion that the SP was discussed in meetings, but no one was actually talking to or engaging with the SP.	[redacted]

1.4.99 The medical Chain, consisting of both the Medical Reception Station (MRS) at RMAS and DCMH placed significant importance on the SP having a supportive family network, which she openly expressed to Witness 31:

PRESIDENT: you seem to think that she spoke to her mother. Why do you think that?

[redacted]

PRESIDENT: We now know that she did not actually speak to her mother at all and that the Old College Commander asked her Company Commander to suggest that she might want to have that conversation with her mother to determine whether there is, you know, some support there from family at home, et cetera, et cetera. But you have regarded that as being a key protective factor.

[redacted]

1.4.100 Witness 45 was also of the belief that the SP had an open dialog with home regarding the RE visit and that they were supportive.

[redacted]

[redacted]	
1.4.101 Senior members of the CoC had identified the requirement to ensure the SP engaged with her family, however this didn't happen, and no assurance took place, this is discussed further in TOR 3.	[redacted]
Summary **1.4.102** The Panel are of the opinion that the CoC should have placed a greater importance on ensuring the SP was getting the family support DCMH believed she was getting. Given the fact the CoC was aware the SP had unresolved family issues, the Panel would have expected a reasonable amount of assurance from the CoC in the form of establishing contact with the SPs NOK to highlight this welfare concern. The manner in which this could have been undertaken was outlined in AGAI 110 and assessed in TOR 3B. The SPs family remained unaware of the DSH incident and were therefore unable to provide any additional support.	[redacted]
1.4.103 Witness 31 explained that they advised the SP "be supported in her return to training by the CoC considering the option of involving further work with the RMAS Communications and Applied Behavioural Science (CABS) Team to develop her coping mechanisms and psychological resilience" Witness 31 continued noting that "Plan agreed with ongoing informal pastoral support delivered at Platoon level with Padre / CABS input as required and any further concerns flagged to the medical Chain." This was advised to the CoC during the risk management meeting on 18 July 2018.	[redacted]

1.4.104 The Panel heard from Witness 18, a member of staff within the CABS department, who is a psychologist employed as an academic who volunteered to provide psychological coaching support for staff and cadets. They confirmed that, with regards to the SP, “I didn’t get any referral”, she did not receive any support as outlined above, due to the fact the CABS department were unsighted to this recommendation and the details of the RE visit incident. In addition, Witness 20 stated they “(weren’t) aware that CABS gave support to the SP on one-to-one basis”. Witness 18 would not be made aware of details discussed in a welfare meeting and no referral was requested, as a result the SP didn’t receive any support from the CABS department.	[redacted]
1.4.105 In summary, the Panel are of the opinion that the level of support afforded the SP as a trainee, specifically from the CoC, welfare department and Chaplaincy Dept fell below the standard that should have been expected when considering all the circumstances. The CoC did not conduct a thorough investigation, the details of which should have passed to the medical Chain. The Chaplaincy department did not report concerns from the OCdts who Witnessed the incident and highlighted the seriousness of the events that occurred. Finally, the welfare Chain did not appear to offer any effective support, directly or from the AWS. The welfare dept had no contact with the SP at all during her time at RMAS.	

SECTION 1 ANALYSIS OF FACTORS – TOR 1F

Examine whether the Chain of Command fully considered and applied sound military judgement to all the options available to the Service Person after their deliberate self-harm incident.

1.4.106 On 18 July 2018 the SP returned to the Commissioning Course, Witness 36 explained in detail the options for discharging an OCdt that were considered in this case: a. Discharge, on medical grounds, this would require a diagnosis. b. Discharge, if the individual requests it. c. Discharge, due to unsuitability to military experience. d. Discharge, services no longer required. e. Discharge, due to not meeting training standards. f. Mutually agree for the SP to leave, with an understanding they can return to training where they left off, once they return. Additionally, they considered the options of putting her training on hold or returning her to training. The CoC felt the most appropriate outcome was to return her to training.	[redacted]
1.4.107 The Panel heard that a number of the OCdts and members of staff had concerns about the SP returning to training, Witness 36 was asked to explain if discharge was considered in July 2018 WITNESS 36: it is always an option but again you have to think of why, why are you discharging somebody, and I won't sort of going into the personal investment that people have put into their time at Sandhurst in order to get there and all the rest. That is self-evident. But why would I discharge her? She is a young individual who has got drunk and has done something stupid. She would not be the first or indeed the last. She has come back from DCMH with a clean mental bill of health, so why would I discharge? It is a rhetorical question back to me. (a) I don't have grounds for discharging her, so if it was ever contested, she would win, and (b) it wouldn't be the right thing to do. There was insufficient evidence to discharge her and if we discharged everybody who had -- and I know this term will sound wrong given the context of what she subsequently did, that had a mental health wobble during their time at Sandhurst, we would lose a lot of people because it is a very stressful environment. So, it was a consideration. Did I take it seriously at that point? No, but if this continued to be a trend, as tracking and other things came to the fore, then we would in the way that we have, sadly, with other people.	[redacted]

1.4.108 From the above excerpt, it is clear to understand why the SP was not discharged. However, the Panel has established that on the balance of probabilities that all the decisions taken in July 2018 were based upon an incomplete evidential basis. It was however, noted by the panel, that on the basis of the information that had been acquired at that time, why the decision to return her to training with her Platoon was regarded by the CoC as safe choice.	
1.4.109 The decision was also based heavily on the positive performance of the SP to date. Her performance was highly thought of by her Pl staff and fellow cadets as indicated by Witness 30: WITNESS 30: based on what was presented in front of us, a Cadet who is incredibly highly performing, somebody who I had been led to believe at that time expressed extreme remorse for what had happened, and embarrassment, for somebody who it seemed was overly happy, rather than overly sad, and with an SMO saying that she was of low risk of reoccurrence, I am assessing that that was what the decision was made on. But having not written down the bullet points of why the decision was made, I'm afraid I cannot give you a verbatim, "This is why I made the decision"…I probably had a bias, having seen her performing so well, and heard so many good things about her, that I -- that the medical Chain bit was what was my, as I said, red light/green light.	[redacted]
1.4.110 Concerns raised by OCdts about the SP returning to training were not given sufficient consideration because there were investigative errors in the immediate aftermath of the RE visit in July and August 2018.	
1.4.111 Her Junior Term SAFs indicated that she was performing comfortably at the standard expected. The panel are of the opinion that military judgement was side-lined for an over reliance on this positive performance, coupled with the medical risk of reoccurrence, when making the decision to return the SP to training.	[redacted]
1.4.112 The Panel came to this finding because it is apparent from the evidence that there was not a thorough investigation into the events of the night of 16/17 July 2018. The OCdts, who witnessed the event were not asked to provide statements describing the totality of the evening. Therefore, the details collated and considered by the CoC were not a full, true and accurate representation of the event.	

The impact of missing Information and the return to training decision making process

1.4.113 Witness 36 was not informed by the staff in the Old College CoC (because they were not aware) of the severity and protracted nature of the incident. They were ignorant of the full extent of the facts that had occurred. In addition, the following other items of information were not brought to the attention of Witness 36:

a. the reservations that the OCdts who witnessed and were involved in safeguarding her during the DSH incident, had about her returning to training.

b. the concerns that the AWS Initial assessment team had recorded.

c. the requirement directed in policy (AGAI 110) to inform the RMP SIB of any DSH incident.

The Panel found that this ignorance flowed from the initial inadequacies to fully investigate the matter, coupled with an assumption up and down the CoC that the matter had been fully investigated.

[redacted]

1.4.114 The Panel explored the absence of an investigation with Witness 36 who candidly offered the following observation:

Witness 36: If the right people were not spoken to in terms of that investigation, then the right procedure wasn't followed. I mean, it is self-explanatory, isn't it? If we didn't get the right evidence into that folder and, therefore, the narrative that was then read back into me and the Chain of Command and to the DCMH was wrong, then something didn't go right.

[redacted]

1.4.115 Witness 36 clarified their position and their understanding of the position appertaining to the SP after 18 July 2018 as follows:

"Post her DCMH assessment, her behaviour was always described to me as 'stupid drunken behaviour' or, at most, a minor attempt at self-harm induced by excess drink and immaturity. Throughout, it was made very clear to me by the CoC (of both colleges) and medical Chain that she was not deemed at serious risk of self-harming again, let alone suicide. It is in that context that I read and understood those comments and made my decision".

The panel noted that there is a discrepancy between Witness 28 and Witness 36's recollection of how the SP's behaviour was described.

[redacted]

1.4.116 The overall assessment of the situation was candidly described to the Panel by Witness 44 states;

"this is in no way my own opinion perhaps, but that it wasn't a deliberate attempt and actually it was -- my impression at the time was that -- the general consensus that it was a foolish and quite silly action in order to, you know, perhaps draw attention to herself or -- it was seen at the time, I think, to have been very little more than a bit of drama after drinks, to be frank, sir."

[redacted]

1.4.117 One aspect of the evidence presented to the Panel has been that, individuals in the CoC felt that as DCMH had said that the SP was fit to return to training then that could not be challenged and as such was direction to be followed rather than one aspect of a decision which should include various other factors. Witness 27 described this perspective as follows:

WITNESS 27: if DCMH has assessed an individual to be suitable, then these -- you know, I've got to respect the [subject matter experts] SME's decisions within that, sir.

PRESIDENT: If there has been no new investigation to determine what actually went on and DCMH have to go on what [the SP] tells them and not on a wider understanding of what happened, then we all know now that [the SP] was returned to training, but what do you think really would have happened or should have happened?

WITNESS 27: In hindsight, looking at it sort of objectively after the fact, sir, potentially moved into Lucknow Platoon [the rehabilitation platoon] where she will have been afforded the duty of care and such like still within the military areas, allowing a full investigation to go on or further investigation to go on and affording her the support and continued DCMH help to give them a longer time to assess her and assess deeper into her personality and thought processes before returning her back to mainstream training.

[redacted]

1.4.118 The initial decision to return the SP to training was taken after only one assessment had been completed by DCMH on 17 July 2018. There were no further reviews before the end of the Junior term or during the month of August to properly consider the details of Witness 45's report which was visible on DMICP to the medical staff at RMAS. Albeit Witness 28 had discussed the SPs abstinence from alcohol and the fact that she had agreed to this, the importance with which Witness 45 placed upon this agreement did not filter into the CoC's understanding of the position as the SP was returned to training.

[redacted]

Investigative Process and assessment matters

1.4.119 Witness 17 has 10 years' experience in mental health and wellbeing policy. They explained the level of investigation that should have been conducted and the multi-disciplinary attendance at the risk conference.

WITNESS 17: It's in a training establishment, so any investigation would have needed to be more thorough than would have -- because of duty of care guidelines that were put in place following Deepcut (deaths), which applied not just to soldiers but to all Officer training.

So, I would have expected a more detailed investigation as to the incident, that they would have looked at records of her behaviour since she had arrived at Sandhurst. They would have looked at any other known factors. The Welfare Officer would have been asked to provide input, for example, as to whether either had seen The SP, the same as the Padre. The doctor should have been involved in the initial risk conference.

[redacted]

At that point, the individual had already seen the DCMH, so the DCMH should have been asked to attend and provide input along with, clearly, the OC and anybody else in her immediate Chain of Command should have been there at the meeting and they should have had a discussion about all of those factors and teased out any other known factors or factors that could be identified.

PANEL MEMBER 2: you said immediate Chain of Command. So, should that in this instance for an Officer Cadet include her Platoon Colour Sergeant and Platoon Commander?

WITNESS 17: I would have thought so, yes.

PRESIDENT: So, it is an information-gathering exercise. It is a multi-agency discussion, almost. We have got lots of different people who are involved in this initial assessment as to whether or not she should be on the VRM or there should be a VRM entry for her. This is not just determining her future treatment.

WITNESS 17: No.

1.4.120 One aspect which the Panel considered was whether the SPs keenness to return to the course overshadowed or influenced the whole decision-making process. Witness 31 was questioned about this aspect and offered the following perspective:

[redacted]

PRESIDENT: So, if we move on, the Panel could conclude that you and your colleagues were naïve and that you just believed the SP

and did nothing to verify her versions of the events or corroborate what she was saying, her version of the incident. I put that to you and please come back to me and explain to me why it is not the case? Witness 31: I think that, that's a fair, probably a fair proposition or allegation to make. I think… [redacted]	
1.4.121 The Panel believe that there was sufficient time from 17 July to 10 August 2018 for an investigation to occur including taking of statements from the OCdts who attended and assisted the SP. Witness 48's assessment of the events should have formed part of the investigation as it offered a different perspective from an individual who was not only a first responder but also outside of the RMAS CoC.	
1.4.122 The Panel have seen evidence that the CoC did not have a full and comprehensive understanding of AGAI 110, the Army Suicide Vulnerability Risk Management[4] (SVRM) policy in place at the time. This lack of knowledge and application of the policy is one of the causal factors of the SPs mismanagement and is acknowledged in the following excerpt: PRESIDENT: Your meeting on the 18th in effect was a risk conference, is it not, to discuss a way forward? WITNESS 28: Yes. I would agree with that.	[redacted]

[4] AGAI 110 Suicide Vulnerability Risk Management (SVRM) was renamed AGAI 110 Vulnerability Risk Management (VRM) in 2020

PRESIDENT: That is basically actually what it was? WITNESS 28: I think that's entirely what it is, sir. I think that was the intent. Perhaps more an understanding conference, but very much part of that is a consequence about understanding what are the risks. I don't think we had the right people there and I see that's the merit in knowing that AGAI [AGAI 110], its existence in this detail, and sticking to what it formulates, which is best practice. It is not only best practice; it is the practice to follow. The lack of training and awareness of AGAI 110 is covered in detail in TOR 3.	
Summary **1.4.123** The Panel are of the opinion that the CoC did consider all options for the SP as described by Witness 36 however the basis upon which the decision to return her to training was made was an incomplete one. There was no thorough and in-depth investigation into the events of 16/17 July 2018 and as a result the CoC had to rely upon a limited understanding of the position when making their decision regarding the SP future at RMAS. In addition, the CoC placed disproportionate weight on the views of medical professionals whilst giving little consideration to other factors.	

SECTION 1 ANALYSIS OF FACTORS – TOR 1G

Examine the policy and procedures for the Handover for Officer Cadets between the RMAS colleges at the end of each training term.

1.4.124 No formal handover policy existed for the handover of OCdts between colleges in August 2018. The procedure that should be followed is evidenced by the head of administration within the College. **a. Continuity.** Firstly, the Coy CoC remains the same. The OCdts will have a new Pl Comd (almost always from within their Coy, so a 'known'), their SNCO Instructors remains the same, their CSM and OC remains the same. This continuity means that issues are tracked. **b. Transfer of Risk Register.** All Training, Medical, Welfare and Discipline risks are recorded on Coy Risk Registers, updated regularly by CoC and reviewed weekly by College HQ. At the end of term, we have a co-ord conference with NC HQ, involving the Coy CoC and welfare stakeholders. In this we go through each Coy Risk register in detail to ensure there is a thorough HOTO with NC.	[redacted]
Staff Personnel Changes within Falklands Coy and passage of DSH details. **1.4.125** The procedure, outlined above, was not adhered to, for Falklands Coy CC182. Witness 30 was the only member of the SPs CoC not to change. The CSM changed, due to assignment posting. The Pl Comd and Pl CSgt both changed in internal Coy moves. The decision for internal staffing was only shared with the staff on the final working day of the term.	[redacted]
1.4.126 Witness 33 explained they (Witness 20 and 33) had a thorough handover, they "talked at length", and they had the "full picture of what happened on the visit". The Panel have heard evidence which contradicts Witness 33's assessment and suggests that Witness 20 did not have the "full picture" in order to conduct a thorough handover as they [redacted] told the full facts relating to the RE visit.	[redacted]
1.4.127 Further handovers at Platoon level did not happen. The Company CSgt's were not informed until the final working day of the term, which Platoon they would be assigned. This did not allow the	[redacted]

time for a handover. This late publication of moves by Ac HQ led to reduced time being available for proper HOTO to take place.	
1.4.128 Witness 39 explained there was "no formal handover/ takeover" but that they had a chat about performance (of the Cadets) with Witness 23.	[redacted]
1.4.129 Witness 26 commenced their position with Falklands Company at the start of the Intermediate term. They also informed the Panel they did not get a handover.	[redacted]
1.4.130 Witness 26 was not aware the extent of the DSH in July 2018, as they were not informed. They discussed whether knowledge of the DSH would have caused them to do anything differently in the aftermath of the Falklands Coy ball: LEGAD: We have already spoken about the fact that she had ...self-harm[ed] before you were the [Witness 26] and also the lack of handover, the fact that you were not aware of this at the time. Had you been aware of it, what would you have done in those circumstances knowing that she was effectively committing self-harm again? WITNESS 26: Like I said before, sir, I probably would have informed different people. LEGAD: Who would you have informed? I am interested in where the welfare/medical Chains of Command go because when we speak to different people, they are telling us different things. Who would you have informed? WITNESS 26: I would have got hold of the Padre straight away and I would have seen if there was anyone in the med centre, but on the Saturday, we would have probably known that's not going to be the case. But I would have seen if I could get somebody in. The importance of this excerpt is that Witness 26, an individual with significant military experience who had worked at RMAS previously understood the significance of the missing information when questioned at the hearings; and more pertinently stated that they would have acted upon it had they been made aware of the details.	[redacted]
College Handover Meeting 3 August 2018 **1.4.131** The inter College handover meeting took place on 3 August 2018, the purpose of the meeting is to handover welfare and training concerns to the new Chain of Command within New College. At the	[redacted]

handover meeting the individual chairing the meeting, directed that the SP be taken off the VRM (3 weeks after DSH incident). One of the reasons this was recommended was due to the SP having not consented to being on the VRM and that she might see, being on the VRM, as “unhelpful when trying to progress her career”. This shows a misunderstanding of the AGAI 110 policy. In addition, her permission was not sought, this is discussed further in TOR 3B & C.	
1.4.132 The Panel saw evidence to suggest the handover meeting was not a thorough handover. Witness 27 attended this meeting on 03 August 2018 but was not aware of the VRM or CAP being handed over, and they weren’t really aware of what a CAP or VRM was.	[redacted]
1.4.133 In attendance at the College handover meeting was Witness 37, a member of New College CoC, who explained that the CAP was handed over to the welfare department rather than them, as they did not have access to VRMIS. As a result, Witness 37 didn’t become aware of all the facts of the DSH until after the death of the SP. Witness 35 was of the understanding that the full facts of the DSH incident were handed over to the NC CoC at the meeting.	[redacted]
1.4.134 The effect of this action was that the individuals who should have managed, monitored, and assured it did not have visibility of the electronic record and as such were unsighted to it and its requirements. The specific details and requirements of the CAP were not discussed with sufficient rigour, at the College HOTO meeting and effectively became dormant thereafter.	[redacted]
1.4.135 Measures made by the medical Chain (DMICP readout) [redacted], as a result this information was not handed over or acted on.	[redacted]
1.4.136 The panel believe, that the importance that the Old College CoC placed on the SPs commitment to abstain from alcohol was not fully understood by the CoC in New College. The panel made this assessment because after the alcohol related incident on Ex Normandy Scholar and again after the Falklands charity ball, there was limited positive intervention by the CoC.	
1.4.137 The SP demonstrated a strong performance on the final exercise in Junior term, this was used to strengthen the case that she was doing well in training and may have overshadowed the requirement for any further investigation.	[redacted]

Other Influencing Matters at the end of the Junior Term

1.4.138 The Panel were made aware that during the last week of the Junior term there was a serious disciplinary incident, unrelated to the SP, which resulted in a court martial trial, Witness 30 described it briefly as follows:

WITNESS 30: Because there was so much… We had the incident [which resulted in a CM trial]. That was right at the end. I was dealing with that after the Sovereign's Parade on that Friday because it was in the press and all. You can imagine that soaked up a hell of a lot of time. No excuse, but just to bring the context that those kinds of weeks are crazy.

The incident occurred on 07 August 2018. Whilst Witness 30 stated that this did not affect or unduly influence the SP position; however, the very fact that some of the CoC, in particular, Witness 20, did not know that she visited DCMH on 09 August 2018 [redacted] and was subsequently discharged from DCMH's care undermines Witness 30 understanding of the situation. This increased disciplinary related activity during the final days of the term may explain the lack of attention towards the SP and explain why there was no plan in place to monitor her over the summer leave period.

[redacted]

Summary

1.4.139 The inconsistencies in staff change over, lack of thorough handovers, combined with a view of the event as "drama after drinks" rather than a mental health presentation, resulted in an incomplete knowledge of the problems facing the SP at the beginning of the Intermediate term. The Falklands Coy and New College staff were not fully appraised of the seriousness of the RE incident nor of the measures that should have been actioned to fully support the SP when she returned to training in September 2018.

[redacted]

1.4.140 The Panel believe there was a combination of causal factors. The SPs inability to come to terms with deep rooted personal issues, that remained unresolved, coupled with the further factors of the added pressures of being in a military training environment, transitioning from civilian to military life, being away from home for the first time and trying to prove to herself and others that she was worthy of being at RMAS, (where she desperately wanted to be). This accumulation of perceived pressure exacerbated by excess alcohol, which removed barriers and inhibitions, resulted in this uncharacteristic first known incident of self-harm in the form of attempted suicide.

1.4.141 The Panel believe that the CoC did not fully understand or investigate the deep-rooted issues nor sufficiently investigate the incident of DSH on 16/17 July 2018. As a result, this information did not inform the medical Chain, where it was also recorded that they didn't feel they had fully ascertained why it happened.	

SECTION 2 ANALYSIS OF FACTORS – TOR 2 Establish the facts surrounding the death of the Service Person on 6 February 19.

Determine the Cause of the incident by examining the contributory factors and the events leading up to the death of the Service Person, to include, but not limited to:

SECTION 2 ANALYSIS OF FACTORS – TOR 2A

A full Chronology of the events leading up to the death, concentrating on the period 24 months before the date and any subsequent events which are relevant to the service inquiry.

1.4.142 See Tor 1, 3a, for chronology up to the end of Jnr term, 10 August 2018.	[redacted]
1.4.143 During summer leave (11 August to 10 September 2018), The SP undertook a week's adventure training activity in Scotland. She also met up with Witness 10, which her family were unaware of. Fellow OCdts were aware, as was the CoC in the form of Witness 23, but she had confided in them and explained that she did not want her family to be informed of the relationship with Witness 10.	[redacted]
1.4.144 The Intermediate term resumed on 10 September 2018. The Inters term focuses on "Command and conceptual development to be professional, robust combat leaders". The Cadets spend more time on exercise, in the first 8 weeks of that term the Cadets complete the following; Ex Marlborough's Attack, Ex Allenby's Advance, and Ex Slim's Stand. The term culminates in the Regimental Selection Boards (RSBs) a period of added pressure, determining the future career stream of all OCdts.	[redacted]
Regimental Selection Board Process November 2018 **1.4.145** The RSBs consist of 2 interview Panels with senior Officers from the Regiments/Corps the OCdts aspire to join. The OCdts choose 2 (or very occasionally 3) Regiments/Corps they wish to join, with guidance from their CoC and usually after visiting the unit. The interview Panel receive a report on the OCdt based on their performance on the CC. An OCdt may be offered a place in one or two Regts/Corps (in which case they choose), if they are not offered either Regt/Corps they go through a clearing process to ensure everyone finds a unit that they are suitable for. Witness 36 explained this in detail.	[redacted]
1.4.146 The SPs Midterm review was on 19 October 2018, she wrote "An achievement I am proud of is actually being at Sandhurst.	[redacted]

Sometimes I look at my surroundings and the people that are next to me and I can't believe I am here and am able to call this my home. I want to keep this mindset for the rest of my career because being part of the Army and being an Officer, to me, is a privilege." Her Platoon Commander describes her as "An enthusiastic and motivated individual who has maintained a strong work ethic and upbeat character throughout the term". This is echoed in her end of term report.	
1.4.147 Prior to 15 October 2018, the SP changed her RSB choices to RA and RLC. Witness 30 tried to persuade her to keep her first choice of the RE but following the events at the RE visit in July 2018, she removed RE from her choice of arm preferences.	[redacted]
Exercise Normandy Scholar – Battlefield Study Tour Application of Alcohol Policy **1.4.148** The SP deployed on Ex Normandy Scholar (Ex NS) during week 9 of the intermediate term (05-08 November 2018). The exercise is a 2-day battlefield study allowing cadets to apply the combat estimate in a historical context. During the evening of the 06 November 2018, Falklands coy were accommodated in a hotel. The Company and College CoC informed the cadets and staff of a restricted alcohol drinking policy in that no more than 2 alcoholic drinks should be consumed per person (2 can rule). Some Cadets and Platoon staff ignored the drinking restrictions and during the evening both groups ended up socialising in the same bar. Witness 39, a member of staff, was aware the SP had given up alcohol but during the evening they became aware she was drinking: Witness 39: I could see that she was drunk. And having been told that -- we were well aware that she had given up the alcohol. She became quite -- not forceful but animated at which point I told her to leave and one of the Cadets took her out and sent her back to the hotel or went back with her to the hotel.	[redacted]
1.4.149 Witness 24, a member of staff, told the Panel that they were aware there was a restriction on drinking alcohol (2 can rule) but that they "didn't abide by it". They were aware OCdts were also not abiding by the rules and didn't do anything to prevent it. Witness 30, from the CoC, explained they felt let down by this behaviour, once they became aware of it.	[redacted]
1.4.150 Witness 1 describes an incident between the SP and Witness 39 in the bar. The SP was trying to hold onto Witness 39, whilst they had to physically try and pull themselves away. Witness 1 described the SP as "manic" and that they and another OCdt had to remove her from holding Witness 39 before she was taken outside.	[redacted]

1.4.151 Witness 2 described the SP as being drunk and trying to tell Witness 39, from her CoC about something. Witness 39 was not interested in engaging in conversation which was causing the SP some frustration. Witness 2 took the SP outside as she was getting emotional and kept saying " I just need to speak to [them]. I need to tell [them]." At which point Witness 2 advised the SP to leave and go back to the hotel.	[redacted]
1.4.152 The higher elements of the Coy CoC were not aware that staff and OCdts were drinking together, and Witness 39 did not report that the SP was drunk.	[redacted]
Disclosure of [redacted] **1.4.153** The SP was returned by fellow OCdt's to her hotel room at which point she disclosed the following information to Witness 8 who she was sharing a hotel room with: Witness 8: She basically told me that the last time she had gone home she had bumped into [an individual known to the SP], and [they] told her [redacted].....She basically told me that [they] [redacted]	[redacted]
Academic Stresses Surface and additions to Coy Risk Register **1.4.154** The following morning the SP was hungover as described by Witness 8, who was asked to support her during the morning's activities. Witness 33 was aware she was hungover and reminded her of her decision to be tee-total.	[redacted]
1.4.155 The SP discussed with her immediate CoC her concerns about her perceived lack of academic ability and that she felt better suited to be a Soldier, the panel understand that this was because she was struggling with the combat estimate process. Witness 33 discussed with her the role of a soldier and the roles of an Officer and said they could discuss it further (another time).	[redacted]
1.4.156 The significance of the stress that the SP was experiencing during her time in Normandy appears not to have been appreciated by the CoC. The Panel have been made aware of an additional disciplinary event involving the disappearance of an OCdt on Ex Normandy scholar which may have over shadowed concerns about the SP.	[redacted]
1.4.157 Data subsequently recovered from the SPs phone showed, from 08 November 2018, she entered search terms into google on the subject of suicide. On this date she researched "committing suicide [redacted]	[redacted]

1.4.158 The incident in Normandy was recognised by Witness 33 as serious enough to warrant an entry on The Falklands Weekly Welfare Register and was summarised as a “Crisis of confidence” and entered register on 12 November 2018. The full entry is as follows:

Risk Register entry; 12 November 2018 -Crisis of confidence issues, due to academic pressures, and some home life [redacted] issues reappearing, causing overwhelming pressure on Cadet. Currently managing and given CABS support/tuition assistance talk. Padre informed and signposted. Did drink on Ex NS and has been spoken to about the negative impact this has on her. Remains manageable and unrelated to previous issue.”

[redacted]

1.4.159 This information was not uploaded onto the College level Monthly Welfare Register return where it would have been visible to Witness 36 and Witness 31 at the monthly meeting. As a result, no one outside the College CoC other than the chaplaincy department, were aware of the incident in Normandy. Witness 23 wasn’t aware of the incident. In addition, no referral was made for CABS support/ tuition assistance.

[redacted]

1.4.160 This breakdown of communication and lack of understanding of the RE visit events in July lead the Panel to conclude that the incident in Normandy was not given the level of seriousness it deserved. Although the incident in Normandy was recorded onto the Coy risk register it was not added to the CAP and it was also not brought to the attention of the medical staff.

[redacted]

Monitoring and declassification as a vulnerable adult by PHCT

1.4.161 During this term the SP was removed from the Primary Healthcare Team (PHCT) register (6 November 2018) and as such was no longer categorised as a vulnerable adult. The Panel asked Witness 31 about the details concerning the events in Normandy and how they would have interpreted this event had they been made aware of the crisis of confidence. The follow-on effect of not informing the medical staff at RMAS was that DCMH were also not made aware of this relapse. Witness 31, explained their thoughts below:

[redacted]

[redacted]

[redacted]	
1.4.162 Immediately following Ex Normandy Scholar the SP wrote a letter to Witness 39 apologising for her behaviour in Normandy which was acknowledged by a WhatsApp message on 14 November 2018, “letter received, much appreciated.”	[redacted]
Start of relationship with member of Staff **1.4.163** On the evening of 17 November 2018, the SP went for a night out in Windsor with fellow OCdts following a sporting competition. She got a taxi home with Witness 25, a member of staff, and exchanged phone numbers.	[redacted]
1.4.164 The RSB interviews and the Academy boxing night fell in the same week, 26-30 November 2018. The RSB process is a stressful time for all OCdts involved, which is understood by the Academy CoC.	[redacted]
1.4.165 The SP was interviewed by the Royal Artillery (RA) and Royal Logistics Corps (RLC) and was offered both Choice of Arms. She sought advice from her CoC and specifically Witness 39 and chose to accept a place with RA, evidence suggests she was very happy with her choice.	[redacted]
1.4.166 During this term the SP took up boxing, she passed the mandatory medical assessment in order to compete in the Academy boxing competition. On 27 November 2018, she fought at this prestigious event and was presented with the most courageous boxer award. From this point onwards the SP was now well known throughout the Academy. The boxers were invited to the WO & Sgts Mess, following the event to celebrate their achievements.	[redacted]
1.4.167 The SP continued to communicate with Witness 25. As their relationship was not allowed (against Army Recruiting Initial Training Command (ARITC) policy; Relations between PS and Recruits and trainees undertraining, or potential candidates for enlistment, (April 2018) policy), Witness 25 advised her that she should be discreet, not to tell anyone about them communicating or meeting and that she should delete her messages from them.	[redacted]
1.4.168 The panel are aware that this inappropriate behaviour was previously seen in 2017 when Witness 25 came to the attention of	[redacted]

the CoC. [redacted] ” at RMAS.	
1.4.169 On 29 November 2018, Witness 25 invited the SP away for a weekend. She agreed and they subsequently made plans to meet at a hotel, during Christmas leave.	[redacted]
1.4.170 On 07 December 2018, the Company Risk Register was updated to the following entry: “07 December 2018- Nil further impact and back on track with academic and RSB selection. No risk to commissioning”.	[redacted]
1.4.171 On 08 December 2018, the data recovered from the SPs mobile phone shows she went to Guildford for an evening with Witness 25, on their return to RMAS they returned to her accommodation where they spent the night together.	[redacted]
1.4.172 The following day, the SP messaged and phoned Witness 10 in a distressed state to say, she might be pregnant. The Panel are of the opinion, that this was the SPs perspective as a consequence of having had sexual intercourse with Witness 25, a member of staff, which contravenes the RMAS Standing Order Book Part 2.	[redacted]
1.4.173 On 14 December 2018, evidence from WhatsApp messages suggests, the SP visited Witness 25 in the WO & Sgts Mess at RMAS. This is an out of bounds area to OCdts. Following a night together she left at 0230hrs on 15 December to take part in an AT expedition, skiing in Kaprun.	[redacted]
1.4.174 On return from the AT expedition the OCdts and staff commenced their Christmas leave period. The SP spent most of leave at the family home in the West Midlands.	
1.4.175 From 28-30 December 2018 the SP met with Witness 25 at a hotel in Nottingham. They met again on 5 January 2019 at a hotel near Oxford.	[redacted]
1.4.176 At a New Year’s Eve party, Witness 6 became aware the SP had started a relationship with Witness 25.	[redacted]
Staff Values and Standards **1.4.177** The Panel have heard evidence to suggest some of the Falklands Coy staff were not always setting the right example, Witness 13 who had been back termed during training and as such had experienced staff from different training teams offered the following perspective:	[redacted]

PRESIDENT: So, during the time that you were in Falklands Company were you aware of any? [Relationships] WITNESS 13: No, apart from [the SP] whatever happened then on that ball night. I mean the Colour Sergeants sort of were very overly friendly, from what I saw, like going out drinking with people, taking them out to Camberley, which we were barred from doing, going into the bars in Camberley. They were like, "Oh yeah, do not worry, we will give you top cover, just come out with us." PRESIDENT: And was that quite a regular thing? WITNESS 13: As far as I could tell, yeah. It was usually, not everyone, but there was a few people that always go out with them. PRESIDENT: And was that in complete contrast to your first course for want of a better word? WITNESS 13: Yeah, one hundred percent and the one afterwards. It was very much just the Falklands Company from what I saw.	[redacted]
Senior Term January to 06 February 2019 **1.4.178** The Senior term began on 07 January 2019. The focus of the term is on developing Professional, agile thinking, ethical and robust leaders.	[redacted]
1.4.179 On 10 January 2019, the SP was downgraded from Red to Amber on the College risk register and consequently was downgraded on the Company risk Register on 14 January 2019	[redacted]
1.4.180 On 19 January 2019, the SP spent a night in Newbury with Witness 25. She told Witness 25 she was worried that Witness 23, another member of staff, was aware of their relationship, she had also had conversations with Witness 8 about her concerns. The Panel are of the opinion that the SP was feeling an increased pressure to keep her relationship with Witness 25 from being disclosed and was concerned of the consequences.	[redacted]
Falklands Coy Charity Ball Fri 01 February 2019 **Events up to midnight** **1.4.181** In the Senior term, each company plans and organises a Charity Ball. The Falklands Coy Ball was on Friday 01 February 2019. The SP invited Witness 10 with a few days' notice. Witness 10 could not attend, and the SP did not have a guest to accompany them.	[redacted]
1.4.182 The aim of the Ball was to enable some OCdts to gain experience planning a social event and raise money for Charity,	[redacted]

members of the wider Academy staff are invited. However, Witness 25 did not attend. WITNESS 25: Yes, so we were actually invited as Falklands… staff but in a rare rational thought of mine it was not a good idea to go just in case we did or people sort of clocked that we were speaking on more friendly or personal terms than the norm. So, I just stayed away from it really. I think I saw the Colour Sergeants in the NAAFI gearing up. Lots of chat about blowing off steam, getting absolutely drunk and having a good night, basically. But apart from that, I met my siblings, went for a meal and I was in bed at a normal time. I didn't have any involvement with the dinner night at all really.	
1.4.183 Prior to the Ball the OCdts who helped to organise the event gave a brief to Witness 32, a member of their CoC, on the format of the evening. At this briefing, Witness 32 gave the OCdts some direction on the consumption of alcohol during the event; that alcohol is permitted but only to a level where you remain in control of your faculties. Witness 32 explained the alcohol direction for staff at the event was, "the permanent staff are not permitted to drink more than is appropriate and what I deem to be appropriate is again they behave in a professional and responsible manner". During the evening the guidance relating to the consumption of alcohol was not strictly adhered to or enforced by the wider CoC.	[redacted]
1.4.184 Most of the Company staff attended the function. There were 2 staff members on duty. Witness 33 was on "shark watch" a system whereby a member of staff does not consume alcohol in case they are required to deal with incidents. The shark watch system is also designed to ensure that OCdts who have over indulged are advised to stop drinking. At one point during the evening Witness 26, a member of staff who was not drinking and was on duty that night, explained they had to pause the charity auction in order to regain focus because "they had lost focus on the charity and gained focus on the drinking. They were all in the bar area and not participating in raising money for charity. So, I had to have a pregnant pause during it".	[redacted]
The events after midnight and the after party **1.4.185** The Ball was due to finish at midnight and guests would normally have arranged for taxis to return them to their accommodation or take them into the nearby towns to continue their partying unfortunately it snowed heavily that night and as such taxis were unable to access New College to disperse the guests. WITNESS 30: At about 11 o'clock, I think I had a conversation with [Witness 33] and with the Lead Cadet. I think it was [Witness 1], I'm not sure, to say that, given how difficult the conditions were, we probably should start getting taxis in now or they're not going to	[redacted]

make it. And then I could sort of see looming on the horizon a scenario where we had a couple of hundred Cadets and nowhere to go although accommodation was available at Victory. And some of the taxis were able to make it and it sort of petered out and, from my view, it sort of -- it finished in terms of formal -- everybody left before the band finished. I left. It looked like it had sort of stopped. [Witness 26] was one of the people sort of keeping an eye on things and I know that [they were] going to go and just check that stuff was -- that people were doing as they were supposed to. But I think we underestimated the effect of the sudden curtailment at 12 o'clock of all organised fun, and the fact that that was clearly going to continue. If it was off campus, great, as intended, but if they couldn't get off the campus, it was going to happen somewhere else and sort of didn't quite realise that was going to continue in the way it did.

1.4.186 As a direct consequence of the inability of guests to disperse the Falklands Coy Ball essentially moved into the accommodation lines. OCdts where aware that drinking alcohol in the lines is against RMAS policy but felt that as the CSgts were leading the way, this meant it would be allowed. Witness 4 explains this factor as follows:

[redacted]

WITNESS 4: I was with my girlfriend at the time and we, because I was quite nervous about breaking rules essentially especially at Sandhurst, I was uncomfortable about taking her up to the lines. So, we just were unsure and then I remember saying, "If the staff go up, we will go up, if not I will take you back to --", she was at Victory College at the time. And I remember two staff, I believe it was, yeah, [Witness 39] and [Witness 24], went up and seemed to be encouraging people, I do not know how much they were encouraging but they seemed to be encouraging people to continue the party upstairs. People were holding drink as they went up. So, we went up into the lines. Once there it became a big party essentially, most of the company and their guests drinking in the lines. It was quite a rogue event throughout the lines in all areas in the corridor and in the two social rooms at the end people were drinking, speaking loud and, yeah, it just became a big party for everyone.

[redacted]

1.4.187 A number of the OCdts who gave evidence were open about the nature and extent of the after party:

WITNESS 1: It was just chaos. It was just music going, it was just like everyone's rooms were open and all that. There was a lot of drink going around. People were having a good time and all that.

[redacted]

WITNESS 3: [the SP] was probably the most drunk I have ever seen her. So, I was actually -- I was coming back from splitting up two other people when I heard her shouting and I went down to my room. She was in my room shouting at my guests. Like my guests

were waiting for me to take them to Victory Building and she was duty bod the next day, so she was just yelling about timings and they are not meant to be up in the lines, that 0900 they had to be out. And I walked in and at first, I was really quite shocked because I have never, bar on a Command appointment, I have never heard her shout and I have never seen her in such a state. WITNESS 6: It was just really raucous, and everyone was hammered. There were loads of people's bedrooms open. It was not just Officer Cadets in the lines, it was guests. People were really drunk, and it did not look like a fun place to spend the rest of the night to be honest with you. I just thought my guests are mature people anyway, they do not want to run around with drunk kids being sick on the floor. Like go to a club.	
1.4.188 Witness 26 was the only member of the CoC who attempted to police the after party. Witness 26 mentioned that they persuaded guests to disperse after the Ball and that they also saw Witness 39 present in the lines after the Ball. Other members of the CoC didn't assist with this task. Witness 33 was involved with tidying up and securing the monies collected at the ball and the bar. Witness 30 left after the event and was unaware of the after party until the next day. WITNESS 26: We had some horrendous weather. The snow had been quite bad, so the event was collapsed around about 1100 hours or 2300 hours, I believe, but we couldn't get the guests gone because they couldn't get the taxis. So, we had a little bit of an issue and then the normal thing for them to do is to follow their partners into the Lines where I had to then get them out of the Lines in a nice, polite manner. They left. There was a couple of guests that tried sneaking back into other peoples' rooms, but we got them out. I can only recall myself doing it. I didn't see any of the other Colour Sergeants at that point. I did see [Witness 39] in their office. We made eye contact, but [they] didn't help me out and that was the thing I was going to chase up the next morning. But I didn't [see] anyone, member of staff-wise, that looked like they were intoxicated to the point they couldn't do their job, so I just remained getting everyone out. I think at around about 12.30am I made my way back to my own room in the Warrant Officers' and Sergeants' Mess and got my head down before going in at 0600 the next morning, sir. The Panel are of the opinion that although Witness 26 was content when they left at 1230 this was not the end of the after party which continued with vigour until approximately 0300hrs.	[redacted]

The influence of alcohol upon OCdts and Staff

1.4.189 The extent to which alcohol clouded the judgement of staff is explained by Witness 1 who explained the actions of one of the members of staff as follows.

PRESIDENT: And who went back to your lines with you? When you got there who was there?

WITNESS 1: So first of all, I know the Colour Sergeants, they were in [their] office, [Witness 23] was in [their] office with a few people, guests specifically. And, yeah, there was definitely a few guests there. [Witness 23] slept with one of them that night. I was then in to -- I went into --

PANEL MEMBER 1: Sorry, can I just take a step back? [Witness 23] slept with one of the guests that night?

WITNESS 1: Yes.

PANEL MEMBER 1: You are obviously aware of that?

WITNESS 1: Yes.

PANEL MEMBER 1: Is that because it was in the lines or--

[redacted]

WITNESS 1: Well, you could hear it, so.

PRESIDENT: Okay.

PANEL MEMBER 1: So, it was in the lines?

WITNESS 1: Yeah, because obviously it was a guest of an Officer Cadet who was in the platoon, which made it a bit awkward as well. It was is like, ah.

PRESIDENT: It was not [their] guest?

WITNESS 1: No, (indistinct) as well.

And Witness 4 described further events

WITNESS 4: Yeah. So, there were other guests around. I do not know if [the SP] was drunk arguing or something but she was getting really agitated against the guests. She was holding on to a bottle of wine. She would not let anyone take the bottle of wine off her at all, quite aggressively.

So, I remember [Witness 39] was there at the time. [They were] also very drunk. [They] tried to kind of calm her down, but it was,

you know, weird. Kind of put two arms over her shoulders. Nothing inappropriate in the touch apart from a Colour Sergeant touching an Officer Cadet. It seemed as a kind of to calm her down. PRESIDENT: Did that have the right effect? WITNESS 4: It contained her. She no longer moved. I think it probably did actually. But it was just a bit odd and it did strike me as odd because it was a very, very drunk Colour Sergeant and a very drunk cadet and [Witness 39] was like, oh, calm down, calm down, and holding her from behind.	
1.4.190 During the early hours of Saturday morning the SP entered Witness 39 office, they were drunk; fellow OCdts Witnessed this and were concerned for the SP and Witness 39. Witness 4 explained that along with another OCdt they tried to intervene but were rebuffed by Witness 39 as follows: WITNESS 4: So, we opened the door, went in and tried to get [the SP] to leave and I cannot remember the exact words I said but it was essentially it was not a good situation, get out. [The SP] was very drunk. Did not seem to respond properly but I believe [the SP] was sitting on a chair at this point. So, [the SP] was in, at this point, in a corridor beyond the main corridor not in [Witness 39] actual office. Their actual office was round to the side and then when we initially opened the door [the SP] was in that secondary corridor, not in the office with [Witness 39]. [The SP] was not leaving, the door shut again. We then thought right, no, we need to just get [the SP] out. So, we went in said, "Right, The SP , you need to come." Went to grab [the SP]. [The SP] was resisting. No, no, no. And then Witness 39, who I believe at this point was -- I think [they] had started taking off [their] mess dress at this point, so [they] was getting changed. That was a normal thing. That is where [they] would get changed. [Witness 39] said, "No, no, leave [the SP]. [The SP] is fine. [The SP] is fine," and then started to usher us out. So, [Witness 39] was walking towards us and we essentially were backing off towards the door. [Witness 39] said, "No, [the SP] is fine." "Witness 39, we need to get her out." "No, [the SP] is fine." And then as at this point, I was going through the door I said, "Witness 39, it is for your protection as well. It is for your protection as well essentially." And then [they] kind of laughed to that and was like, "Fuck off, I don't need protection," or protecting or something like that. And then [they] closed the door, got us out, closed the door and locked the door. This was bad essentially is what we were thinking. This then led to what do we do?	[redacted]

1.4.191 Witnesses 3 and 4 were the last people to see the SP that morning, they waited in the corridor for the SP to leave Witness 39's office until about 0300hrs before leaving the scene. WITNESS 3: Myself and Witness 4 just sat in the corridor and I was like, "Well, we will just wait for her to come out." I think we waited probably about an hour or so. It was to about 3.00 to 3.30 thereabouts when both of us just looked at each other and we were just chatting all night basically. But one of us turned around and said, "It is getting really late. Like we have got to be up at seven for nominal roll. At this stage I am not getting out of bed."	[redacted]
1.4.192 Due to their level of intoxication Witness 39 could not be clear in their recollection of events. They told the Panel: WITNESS 39: Yes, so after leaving, I went up and found a large number of Cadets from different -- and guests from different Platoons, I think, in my lines. I wasn't particularly concerned initially. I was having a chat with a few people and guests. Then I recall speaking to one of my Scottish Cadets from 32 Platoon who liked the whisky. I had a whisky in my room -- sorry, in my office, and we had a discussion over whisky or something like that. I've seen -- I do recall seeing some Cadets from different Platoons up in my office. One of them was [the SP]. Everyone, including myself, was excessively drunk. Then I believe there was -- I'm just referencing my previous statement here, just to be clear. There was -- I believe there was an altercation with some other Cadets and then a possible altercation with [the SP] and someone else. I had -- in the offices, there's like an alcove but it does have a closed door that goes right into my office, forward into Platoon Commander's office, left into the changing room, New College. I had her in there. And then I left, I believe I left alone. I've read a lot of the statements that said -- and it is possible that I left with her. I don't believe I left with her. I've heard the ones that the people have been telling you.	[redacted]
1.4.193 The SPs written statement prepared on Sunday 03 February 2019 describes her explanation of what happened that evening/early morning. In her statement the SP explained that she had had a telephone call from her [redacted] after which she was [redacted] at which point she went to the cash point (in the vicinity of the WO & Sgts mess). Whilst she was there Witness 39 heard her, realised she was distressed and called her into the WO and Sgts mess to get her out of the inclement weather, at which point she fell asleep in their room (see para 1.4.237-243 for specific details).	[redacted]

The events on the morning of Sat 02 February 2019 **1.4.194** On Saturday 02 February 2019 the SP was the Coy Duty Cadet and should have conducted the first parade. Witness 8 stood in for her and it became apparent that the SP and another Cadet were absent. Witness 26 co-ordinated a search known as OP WIDEAWAKE this involved all the members of Falklands Coy searching the buildings and grounds of the Academy. At approximately 0930hrs the SP returned to the rear of New College wearing her Ball gown and effectively walked into Witness 26 and 27.	[redacted]
First Meeting with Staff in CSM Office- gathering of facts by the CoC. **1.4.195** The SP was escorted into Witness 26 office to explain where she had been. She was distressed, crying and upset. Witnesses 2,6,8 and 14 had to assist the SP in getting changed prior to returning to Witness 26 office.	[redacted]
1.4.196 The SP was visibly distressed, she proceeded to trash her room, kicked her iron, threw a picture, scratched the wall, and [redacted]. PRESIDENT: Were you under the impression that [the SP] was in a lot of trouble? WITNESS 8: Oh, yes. Like I was trying to convince her that she wasn't going to get kicked while also thinking I really hope she doesn't get kicked out. PANEL MEMBER 1: And with the shouting from an observer looking in if you had been The SP how would you have felt? WITNESS 8: She was already resigned to it. She knew that it was coming. She just knew that you had no chance of getting out of that in my opinion, like they had already made their decision. She hadn't even seen anyone yet and, you know, they had already made their decision. She then tried to stamp crush her phone in front of them. She put her phone on the ground and started stamping on it. She's very small and didn't make any impact on the phone, but she tried. [redacted] WITNESS 8: [redacted] And then I pinned her arms down to her, she still was doing it, so I, like, picked her up and moved her and she's really strong, I mean small but strong, and they told me to take her away. So, I took her away.	[redacted]

PRESIDENT: What did they say? WITNESS 8: Like, take her out. PRESIDENT: And was it said in a low volume, you know, normal talking volume, or was it a bawl and a scream and a shout? WITNESS 8: Not a scream and shout, just like just get her out, just kind of, like, dismissive.	
1.4.197 The Panel heard from all the individuals who were involved with the SP during this period and Witness 26 explained their position as a member of the CoC who was endeavouring to determine what had gone on overnight and why the SP was late for the morning parade: WITNESS 26: Thoughts and observations, sir, she was never shouted at once. If anything, we were more lenient towards her welfare and asking her if she was all right. She didn't get shouted at, not once. We didn't overly question her. We just wanted to know where she was. When we started to paint the picture and things didn't start to add up, her natural panic state went up. There was nothing we could do about that. We couldn't stop. She knew that we knew that something was amiss. She didn't get shouted at once, sir. That's not what we do. No.	[redacted]
1.4.198 The Panel concluded that the SP [redacted] in the CSM's office, there are various recollections of what happened Witness 26 explained that they asked the 3 OCdts to stop the SP from [redacted] Witness 2 explained that the SP [redacted] but only once the staff had left the room.	[redacted]
1.4.199 Witness 2 was one of the OCdts who escorted the SP out of the office and returned her to her room where she was to get changed. It appears that the SP was panicking about the next steps Witness 2 describes this specific interaction below: WITNESS 2: So, as I say, I said to her, you know, because she was flapping about what she should say and that she was in trouble. I said, "Well, you have got two choices, you either lie or you tell the truth but if you lie you need to be really good at lying because you have just had a whole company looking for you." PRESIDENT: Yeah, what happened next? What did she say? WITNESS 2: So, all I said to her was, "If you are going to lie or tell the truth, of which the truth might be damning depending on what	[redacted]

has happened, you should text [them] and let [them] know." And the first thing is she got her phone out, [Witness 39], and texted [them].	
Second Meeting in CSM Office and initial explanation **1.4.200** Upon returning to the CSM's office the SP admitted that she had spent the night in Witness 39 room in the Warrant Officers and Sgts Mess. Witness 39 was effectively suspended at this point, pending an investigation.	[redacted]
1.4.201 Witness 26 and 27 confronted Witness 39 in the Warrant Officers and Sgts Mess where Witness 39 admitted that the SP had spent the night but denied that anything inappropriate had occurred.	[redacted]
1.4.202 The SP spent the remainder of the morning helping to clear up after the Ball.	
Suspension of Staff member and Social Media direction to OCdts **1.4.203** Prior to dismissing the Coy for the remainder of the weekend the OCdts were informed that Witness 39 was no longer part of the Coy staff and that they should not post anything on social media about the events that had occurred. The SP was not present at this final parade. Witness 8 explained the position: WITNESS 8: The platoon has just lost their Colour Sergeant; she has just lost her favourite member of staff. I liked [them], other people liked [them], it wasn't just their platoon that had lost [Witness 39], like, we also lost [them]. And at that time nothing had happened to her, but [Witness 39] had been RTU'd already. We had [an OCdt] going [to the same Regt as Witness 39] in our platoon that would never have said so, but [they were] really upset at both situations, like [they] got really, like, grumpy about it, which was kind of understandable because that was [their] contact before [they] went to unit. No-one would say they were blaming you, but you get that sense anyway don't you when you muck up on a Command appointment, you just feel that you have let other people down.	[redacted]
Social Media Breach and its impact **1.4.204** Over the weekend Witness 13 posted information regarding to the events of 02 February 2019 on social media. WITNESS 13: "Update. Someone tried to break into the kitchen. [They have] told the staff to fuck off and ran away. Whole company's been held here until they admit it. We also had a female cadet go missing. We had a full OP WIDEAWAKE to find her. She's just been found exiting the Sergeants' Mess in last night's	[redacted]

clothes and has been told by [Witness 27] she can be expected to be kicked out of Sandhurst." PRESIDENT: Why did you put that last part of the message in that says, "... and has been told by [Witness 27] she can expect to be kicked out of Sandhurst"? WITNESS 13: Because someone from one of the other companies had said it in the corridor when we were sort of all chatting after we had been told, oh, she has been found and here is what happened. PRESIDENT: Do you know anything about the circumstances in which she was found? WITNESS 13: I have no idea. This is all just what I was told from some [one]--	
1.4.205 Witness 13 was aware that the Op MINIMISE (restrictions on external communications) protocols were in place and that they should not have posted messages on social media relating to the evenings' events. Witness 13 was subsequently disciplined.	
1.4.206 Data recovered from the SP phone showed at 1410 hrs on 02 February 2019 she researched suicide.	[redacted]
Welfare provision and duty of care towards the Service Person **1.4.207** Witness 33 was also asked about the welfare provision for the SP and gave the following assessment: PRESIDENT: Okay. So, did you put anything in place for The SP (the SP) welfare over the weekend? WITNESS 33: Not specifically, no, other than speaking to her and just ascertaining if she needed anything specific and again, I signposted her towards the Padre and offered her if she needed to get home at all, but she said she didn't need to. Reassured her from a welfare and discipline perspective that we just need to understand what happened and then things will take its course …. But other than that, I don't recall any special measures that were in place for that Sunday.	[redacted]
1.4.208 During the weekend leave the SP chose to stay at RMAS. WITNESS 8 explained "the SP stayed at Sandhurst. She didn't want to go home that weekend. She didn't want to tell her mum".	[redacted]
1.4.209 Witness 26 checked on her and had no concerns. No other Coy staff members or members of the RMAS Duty team checked on the SP over the weekend. Witness 26 inquired as to the SPs welfare	[redacted]

by sending her 7 WhatsApp messages on 03 February 2019, telling the SP “Don’t worry”.	
1.4.210 On 03 February 2019 the SP researched [redacted] suicide at 1548 hrs, and at 2238 hrs.	[redacted]
Interaction with Chaplaincy Dept **1.4.211** The SP met with Witness 34 on Sunday 03 February 2019 after the Chapel service, which her CoC were unaware of: PRESIDENT: Just explain to us what that interaction was. WITNESS 34: Well, again, I suspect I followed her up and I suppose again it was just to touch base with her, just to make sure that she was okay. Again, she had the same kind of demeanour, where she’d had -- you know, after the previous incident, hugely embarrassed. And, you know, as I say in my statement, you know, she expressed that nothing had happened, but realised that she was in a bit of a pickle, basically. PRESIDENT: Did she understand the seriousness of the position she was in? WITNESS 34: Yeah, I believe she did.	[redacted]
1.4.212 On the balance of probabilities, the panel believe that a relevant factor at this time was that the SP had been told by Witness 28 in July 2018 that any repeat of a similar natured event to that of the RE visit (with regards to excess consumption of alcohol not self-harm) would result in questions being asked about her “suitability for future employment”.	[redacted]
1.4.213 Witness 34 described the nature of the meeting and the assessment of the position when it closed, of note is that fact that the SP believed that she had got the member of staff into trouble, her perception altered in the following days when she found out that the member of staff had amended their original statement. The SP messaged Witness 10 stating “he’s sorta screwed me” and “he has played on my [redacted] meaning I’ll be fucked”.	[redacted]
The isolation of the Service Person and the impact of gossip. **1.4.214** During the weekend and into the following week the Panel believe that the SP was allowed to isolate herself, her door remained shut, and she refused people entry into her room. Witness 2, 5 and 8’s transcripts provided evidence of this withdrawn behaviour: WITNESS 8: She refused to come to breakfast.	[redacted]

PRESIDENT: Why do you think she did not attend? WITNESS 8: She didn't want anyone to talk to her, she didn't want anyone to ask her questions. So, she just didn't want to be there, as in a situation where people would be asking her questions. Witness 2 also described how she was isolated during this time: PRESIDENT: Do you think that people were ignoring her? WITNESS 2: Oh yeah, massively because how do you approach somebody that we do not know -- the problem is that you do not know the facts, you only know the gossip. So, people were avoiding. They want to find out information, but you cannot gossip about that person in front of that person. She was isolated. Who could she speak to because all the people around her she knows are gossiping about her. I am sorry but it is hard to ignore how toxic the gossip is and the fact that she was very well aware of it. You could hear people in the other rooms next to you. She was not stupid, and she had heard what people were saying. She had heard about the fact that this person has gone and sent a text message saying that she had done this and now the wider Field Army have got wind of it. She knows people are talking about her.	
1.4.215 Witness 2 explains how the SP said she was feeling on 04 February 2019: WITNESS 2: Because her career was ruined. That is the way she saw it. Any possible career, regardless of discipline, was now ruined. She will never get a job; she will never be perceived as a woman that is a professional. Her career was over. Everything was done.	[redacted]
The events of Mon 4 February 2019- Upgrading on the Coy risk register **1.4.216** On Mon 04 February 2019 the SP was considered at the Falklands Coy Welfare meeting and her status was upgraded from an amber to red (see para 1.4.309 for explanation), on the Coy Risk Register. The College Risk Register was not updated at this time. The impact of this was that Witness 36 and their G1 staff were unsighted to the formal recognition of increased risk that was being held at Coy level. The panel believe that the CoC should have shared this with Academy HQ and the Medical staff at this critical junction. Had this occurred then it is reasonable to consider that the medical staff may have reconvened a case conference or called the	[redacted]

SP in for a review. As highlighted by Witness 31 and Witness 45s comments at their respective hearings.	
1.4.217 Mon 04 February 2019 Witness 34 arranged to meet the SP. Witness 34 message, 0914; Good morning [SP] r u around for a brew today? SP message, 0959; Yeah, I'm just in room sir Witness 34 message, 1013; ok can you get to my office in new college at 1400 SP message, 1133; Ack Albeit this was arranged it didn't happen and the SP did not meet with anyone from the Chaplaincy or welfare department during 04, 05 or 06 February 2019.	[redacted]
1.4.218 The CoC sought to determine what had occurred after the Falklands Coy Ball and the SP prepared a statement over the weekend, the content of which she discussed with Witness 34: WITNESS 34: She did say that she'd been asked to write a statement and I simply asked to view her statement, if she had it, and if she was happy for me to do so, which was on her phone. That was the only occasion I ever asked her to look at her statement. PRESIDENT: Why did you do that, [Witness 34]? WITNESS 34: I think because she was trying to explain ... trying to explain why she was where she was and she mentioned that she'd been trying to write a statement of her recollection of it and I guess I asked would she mind if I had a look at it. So, I suppose I was trying to work out in my own mind, you know, what the situation was from a pastoral perspective, you know, I guess to better support her. PRESIDENT: Whilst I can understand your best intentions there, the Panel could conclude that you had overstepped the mark and that you were getting yourself involved in a disciplinary situation. What is your observation to that comment I just made? WITNESS 34: So, my response to that comment would be that [the SP] was already trying to explain to me, you know, the situation and why she found herself where she did. I was not asking leading questions, but in the context of a pastoral interview, some context of perspective is always useful or helpful. And so it would have been in the -- in those terms, it was in no way an attempt to, you know,	[redacted]

prejudice any discipline and it wasn't in the context of, you know, "You're going to be disciplined, you'd better let me see your statement". You know, there was nothing of that whatsoever. It was a pastoral interview. She was trying to explain what happened.	
Welfare/Medical considerations for the Service Person by the CoC **1.4.219** Witness 33 described the events of Mon 04 February 2018 as follows: PRESIDENT: So, the question I am going to ask you is we have now got three incidents on the tracker that involve [The SP] and alcohol. What action was considered on 4th February in relation to [the SP]? WITNESS 33: So, from my perspective I believe it was just understanding and investigating the incident that happened over the weekend, to get to the bottom of that. I don't know of any specific meetings, or I certainly wasn't involved in any, that related to her overall welfare, whether it be alcohol-related or not. Obviously, it implies that outside of the fence the cadets don't -- aren't drinking generally because of the busy days, but I'm not aware of any specific meeting, sir. PRESIDENT: Okay. Let me just be clear, what I am trying to determine is we know that there was another meeting in relation to [the SP] and the detail is quite clear and evident to me there, but this is another incident involving [the SP] and alcohol, but nothing has happened. There is no action. Nobody appears to me to have twigged to the idea and thought, "Well, why do we not send her to the med centre for review?" Was that discussed? Can you recall? What options were considered for [the SPs] welfare on the afternoon of Monday, 4th February? WITNESS 33: So other than I believe that I fed back to the OC that I'd spoken to her, asked about her [redacted], and offered her several days at home if it was required to decompress or to support family, which she elected not to take, I don't know of any others. I don't know if she was ordered up to the med centre for alcohol-related information or whether that was deferred because of the investigation that was ongoing. Apologies, sir.	[redacted]
Continuation of harming behaviours and actions by CoC **1.4.220** Witness 33 excerpt confirmed to the Panel that no consideration was given to referring the SP to the medical centre and it is fact that at no point between Sat 02 February and Wed 06 February 2019 did the CoC refer the SP to the medical centre for review. Witness 26 as identified in TOR 1, explained that had they	

been made aware of the full details of the RE visit then after the [redacted] incident in the CSM's office they would have involved the medical staff. Of note is Witness 31 assessment which was referred to in TOR 1 regarding the harming behaviours continuing after July and November incidents which both involved alcohol. In light of these facts the Panel conclude that during the period 01 - 06 February 2019 scant regard was paid to the vulnerability of the SP and the fact that she had agreed to abstain from alcohol.	
Changes to social media accounts **1.4.221** The SPs mother explained, that on the 03 February 2019, "I had noticed that The SP had taken down her photograph from her WhatsApp home page, and I asked her why. She replied, "I just didn't fancy one". I also noticed that her WhatsApp timeline has disappeared."	[redacted]
1.4.222 At some point over the weekend she also deleted many of her friends off Facebook and changed her name and picture on Instagram. Witness 7 explains "I assumed it was because …she had been caught up in that incident with Witness 39 and didn't want it to get in the paper and her picture be on there". The Panel believe that the SP may have felt there was no way out of the situation and had concluded that the outcome was more serious than it was likely to be.	[redacted]
Events of Tue 05 February 2019 **1.4.223** On 05 February 2019, Witness 23, a member of staff, made a comment about the SP in front of her peers during a classroom lesson stating: "stay away from her, she's had enough male company". This throw away remark had a profound effect upon the SP and was subject to further discussion later that evening when she messaged Witness 8.	[redacted]
1.4.224 The Panel investigated this matter and Witness 23 offered their assessment: PRESIDENT: Okay. So, we know that on the Tuesday, [the SP] had to give a lecture and that supposedly you said to her words to the effect of "Stay away from her she's had enough male company," Do you remember making that comment? WITNESS 23: I do remember making that comment, sir, yeah. I just thought, because everyone knew [comment relating to SP sexuality], she's obviously not done it type thing and it was just an off the cuff bad attempt at banter, I suppose.	[redacted]
1.4.225 The panel sought clarification of this event and Witness 22 corroborated Witness 23's recollection of the event. Albeit the	

remark was meant in jest the Panel are of the opinion that the SP (who was subject to a disciplinary investigation and the main topic of gossip at this specific time) may have taken it's meaning in completely the wrong manner to that in which it was made.	
1.4.226 The SP also expressed her upset at the incident when she messaged Witness 10; "having a lesson with the staff that spread all the rumours".	[redacted]
The building pressure and increasing rumour activity **1.4.227** One aspect which is of significance is that Witness 25, a member of staff, heard gossip and rumours which resulted in Witness 25 messaging the SP at 0146 hrs on 05 February 2019, "what's constantly getting to you though, The rumour mill or Witness 39 or what? I understand bc I felt awful just thinking about it yesterday with everyone's comments." This demonstrates that the wider rumour mill and gossip about the situation was commonplace at RMAS not only with OCdts but also with staff and may offer an explanation as to why the SP felt under growing pressure on 04 and 05 February 2019.	[redacted]
1.4.228 Witness evidence suggests the SP was feeling the pressure building. This is explained by Witness 10, in that she felt she needed to take the blame for the situation and that she was getting abusive messages on Facebook. The SPs Facebook account has been deleted so we have no further evidence of this. The excerpt below explains why the Panel believe that the perceived pressure of the situation was building for the SP. WITNESS 10: So, she -- I started getting frustrated with her at this point because she's adamant that -- and I know she respected [Witness 39] and had a lot of time for [them]. She's adamant that she's not going to get [them] in trouble. She was, like, saying on the phone to me, "It's all right if I go but we both can't go. I need to take this. It's my fault". She was starting to, like, really blame herself and she was, like, "And he's put it on me now anyway" and I was saying, "[SP], that's not fair. Women in these situations always get thrown under the bus. It takes two to tango or whatever happened, I don't care what's happened" but she was adamant that she was going to take all the blame. Over the 4th is now -- what day of the week? PRESIDENT: The 4th is the Monday. WITNESS 10: So, then on the Monday things start -- I suppose pressure mounting on her as well because that's when she goes -- I'm sure it's on a Monday she goes to class, yes, and they all started talking about it. She says that some of the staff members in class start saying things to her and she starts getting messages on Facebook from staff members saying that she's a slag and a slut	[redacted]

and it's her fault, everything's her fault and she starts getting messages from them. The Panel have seen no evidence of these alleged derogatory messages that were posted on Facebook. This is due to the fact that the SP's Facebook account had been closed down some time after 06 February 2019.	
Lack of perceived support by the Service Person **1.4.229** Witness 10 also explained the isolation and perceived lack of support the SP felt over 04-05 February 2019 as follows: WITNESS 10: She didn't have anybody. She said to me on the phone she didn't have anybody to go with and I say, "Is that because you're not allowed?" and she was, like, "I'm not allowed anybody. I have to go on my own. I have to do this on my own. It's my fault". She was just, like -- on these two days she was just piling on the blame, and it was just getting, sort of, thicker and thicker of how she was having to deal with everything on her own. So, in terms of support, I would have then said with her conversations, "Have you spoke to the [Witness 34]?" and she says that [Witness34] was away, or she couldn't get hold of [them]. So, she had nobody. And I say, "Have you spoke to [Witness 8]?" She was, like, "No, I can't speak to [Witness 8]. They're all in classes. I've not speak to anybody about it".	[redacted]
1.4.230 Witness 8 explains that other than themselves the only person she saw going into the SP room was Witness 24, a member of staff, she felt Witness 24 was there to ensure the SP didn't divulge details of the relationship between Witness 24 and an OCdt. Witness 8 also recalls their own Pl CSgt didn't visit the SP. The Panel addressed the issue of visits by Witness 24 during their hearing, Witness 24 stated that they were hastening the SP to finalise her written statement. The Panel believe that Witness 24 was the only member of staff to visit the SP in her room between 04-05 February 2019.	[redacted]
1.4.231 On 05 February 2019 at 0007 the SP messaged Witness 25 saying "this is the worst thing I have ever felt" and "feel broken".	[redacted]
Disclosure to the CoC of alleged [redacted] and [redacted] **1.4.232** On 05 February 2019 at approximately 1500hrs Witness 8 disclosed to Witness 30 the details which the SP had explained when she was returned to the hotel in Normandy. Witness 30 described in the written statement:	[redacted]

"At some point before [the SPs] death, [Witness 8] disclosed to me something that [the SP] had said about [a personality from her past]. I am not absolutely certain when [Witness 8] told me the details of this, but I believe it was in-between the events of the Charity ball [1 February 2019] and her death [6 February 2019]. I believe I was questioning [Witness 8] on the events of the charity ball when she mentioned that [the SP] had been [redacted] It was difficult to hear this information, but I could not verify its accuracy. I discussed the matter briefly with [Witness 33] before the discipline interview but I would not have thought it appropriate to raise it in the discussion because it would have only caused her more stress. Up to that point, nothing has alerted me to any concerns relating to stresses or pressures on The SP from outside the Academy. At that moment I did not act further on this information. I cannot remember exactly what my thought process was, my initial concern was dealing with the discipline investigation at hand, and I probably saw this as a further reason to be careful in my questioning of the SP."	
1.4.233 When the Panel asked a Witness with significant welfare experience what could have been done if Witness 30 had acted on the information received, they explained. WITNESS 16: So, if there had been -- if AWS had referred the information about [redacted], the information with regard to what the [personality from her past] had said linked with the previous referral that we had received, so we would have had that information on file, we would have encouraged the SP to either seek support from ourselves or again seek some form of therapeutic input, be that from services within Sandhurst, be that the Padre, or from DCMH. I think the key issue would still be if the [SP] refused that service, we couldn't enforce it, so we couldn't -- we wouldn't force her. It's the bit about … there's ways that we could have got a service to [the SP] in my view. So, if the Unit Welfare Officer or the Chain of Command had said, "Look, there's an organisation, our Welfare Service, they're either military or civilian so you can choose to have a military or civilian Army Welfare Worker. We can arrange for you to actually see them off camp so you can go to their team office in Aldershot, or you can see them on camp, if that's your preference".	[redacted]
1.4.234 When the Panel asked a senior member of the CoC what they would have expected Witness 30 to do with this information they explained	[redacted]

PRESIDENT: So, to summarise, we have allegations of [redacted] that have been passed to a member of staff just before a disciplinary interview. What would you have expected to have happened?

WITNESS 36: For [the SP], it is a game changing piece of information because it then lights up a whole series of things in the VRM, and I used that, but it lights it up for you anyway. It's pretty obvious but when you look at the risk factors, it lights a whole load of things. It also alludes to the fact that there is probably a whole lot more going on outside Sandhurst than we actually know about. So, I would have expected that information to have been delivered straight up the Chain of Command into the medical services and I would have expected her to be treated as significantly at risk. That is the point at which I would have expected DCMH to go into overdrive.

LEGAL ADVISOR: …[Witness 30]. … became aware of it the afternoon, ..., before The SP died. [the] question to [them] was, "Why did you not do anything immediately?" and [they] said [they] wanted to have a bit of a think about it. The question to you is, do you think, given what you now know, that is the sort of thing that should have been acted on immediately?

WITNESS 36: Yes. I don't think, just sorry to come back on your phraseology, I don't think it's, given what I know now, I think it's the moment [they] had that piece of information, it is a critical piece of information in the whole pattern of her behaviour and what is going on and in particular the stresses that she is under at that time. So, it is not something I think requires any "go away and think about it". [Their] first port of call should be to ring, in this case the College Commander, and get [them], and then I would have expected the whole of the welfare team and the G1 team and the medical team; that's our job is to then start managing this with that piece of information.

AGAI Meeting with CoC and appointment of Assisting Officer

1.4.235 At 1600hrs on Tue 05 February 2018 the SP attended an interview with Witness 30, in attendance was Witness 33 who was appointed her assisting Officer. The SPs assisting Officer was in her CoC the Panel do not believe that she would have disclosed the truth of the events to this individual due to the very fact that they were part of the CoC. Witness 30 described the meeting as follows:

[redacted]

LEGAD: We have heard from various members of the Chain of Command that [the SP] was to be treated as a victim, not a co-accused, so I am wondering whether you ever received specific direction on that.

WITNESS 30: No, I don't think I did. The only direction I formally got was that I was the originating Officer for the SP, which would, sort of, indicate the opposite of what you just said. But I -- but we absolutely were not treating her as a co-accused and I would hope that the fact that she remained in training, she was offered the opportunity to go home and see her family if, as we understood, that was the cause, the kick-start if you like, the trigger, the spark for what happened on the Saturday night, if she needed to sort that out she could go home and do so. She was Company Duty Cadet. I don't think that indicates somebody who is being treated as an accused at that time, coupled with which when we did have a chat with her [Witness 33] and I, I led it as a sort of -- under the auspices of what is termed as an, I'm going to forget this, initial interview, but I changed it more into a, "Can you tell me what happened?" and the fact that in -- opposite to that [Witness 39] had been suspended, I was happy that we were not treating her if you like as a co-accused. At this point we were trying to work out what happened, whereas [they] absolutely was being investigated for wrongdoing. LEGAL ADVISOR: So, I will just paraphrase my understanding of that, so perhaps not a co-accused but not a victim either. Is that fair? WITNESS 30: Yes, I think that's fair. I think that's fair. LEGAL ADVISOR: Then I am bound to say this, because having read your handwritten notes about the meeting, you have been quite clear over the last couple of days of hearings of explaining to The SP at that meeting that you thought she was doing well. Did you actually speak to her and tell her that you did not think she was going to be discharged at that meeting? WITNESS 30: I'm pretty sure I did, but I for some reason didn't write it down, but I'm pretty sure I did because I was aware of her feeling delicate about it and [Witness 33] was in that interview too and we chatted before that interview to say, "We need to be careful in how we approach this." And that's probably all I can say on that.	
1.4.236 Witness 33 explained their perspective of the meeting with the SP as follows: WITNESS 33: So it was myself and [Witness 30] and [The SP] in the room and again there was a discipline tone to it because, you know, she had broken some of the AGAI regulations over the weekend, so there was that element, but I remember again more fact-finding questions, so [Witness 30] trying to understand her turn of events over the weekend and also corroborating some of it…,	[redacted]

PRESIDENT: So, what was said to reassure [the SP] on the afternoon of Tuesday, 5th February? WITNESS 33: So, in the same vein that I spoke to her, in the sense of, you know, "No conclusions have been made yet based on what's happened and therefore obviously no outcome" … "We're still understanding exactly what happened and the facts of the case." to counter as well -- to counter the rumours that obviously we were starting to hear around what happened and what was the outcome. PRESIDENT: What were those rumours that were starting to circulate, [Witness 33]? WITNESS 33: So again, linked to immediate dismissal, removal from Sandhurst, et cetera, where I got the impression that that decision had not been made yet. PRESIDENT: But my understanding of this afternoon's activities is that [the SP] left that meeting knowing that she had to provide some information and screenshots to back up her story, but my other observation is that she left that meeting thinking that she was going to get kicked out of Sandhurst. How do you counter what you have just told me really, or how do you explain what you have told me? Because she left that meeting with a very, very different perception as to possibly how you did, which is going to lead the Panel to have to consider what actually happened. WITNESS 33: Of course, sir, that is the perception I had. I mean, I suspect with the pressures of the rumour mill and perhaps some of the lack of awareness of the discipline process in the military that she was not, sort of, as confident in what [Witness 30] was telling her and I think she was very emotional in the sense of the welfare and also perhaps that she knew she had, sort of, stepped wrong, but, yeah, I can't, sort of, counter why her perception was that, other than speculate.	
1.4.237 Whilst it was a reasonable request of the SP, to produce her phone log the fact that she now had to corroborate her previous statement must have added significant pressure to the position that she found herself in.	
1.4.238 The SP sent a WhatsApp message at 1716 hrs telling Witness 8 "I'm fucked mate". This communication demonstrates that her understanding of the outcome of the meeting with Witness's 30 and 33 was very different to their recollection.	[redacted]

Events of the evening of Tue 05 February 2019 **1.4.239** At around 1900 Witness 1 entered the room of the SP, they recalled "she had a wild look in her eyes, like a rabbit caught in headlights. I had never seen her like this before. I went into the room and shut the door behind me, she was dressed in her MTP and was pacing back and forth repeating "I'm fucked, I'm fucked, I'm fucked", "they've fucked me and thrown me under the bus". After further conversation, she hugged Witness 1 and said, "love you".	[redacted]
1.4.240 On 05 February 2019 at 2236, the SP phoned her mother. She recalls "During the call she seemed quite flat and that she can't stay for long as she was busy...I felt that [the SP] was distant and didn't seem herself."	[redacted]
1.4.241 Following the conversation with her mother, the SP phoned a contact in her phone 3 times. The contact was the SPs nickname.	[redacted]
1.4.242 On the morning of 06 February 2019, the SP made several outgoing calls to unidentifiable numbers at the following times; 00:30, 00:32, 01:49, 01:49, 03:02, 06:41. The Panel believe that the SP was attempting to recreate her phone log, in an effort to show that she had in fact been in communication with a family member on the evening of 01 February 2019. The Panel have made this conclusion because Witness 30 had requested details of her phone log at the disciplinary meeting the previous day.	[redacted]
1.4.243 The SPs brother confirmed his understanding of communications with his sister in his statement. The Panel note that the SP did not actually communicate with her brother on 01-02 February 2019.	[redacted]
The chronological sequence of events of Wed 06 February 2019 **1.4.244** c0730, the SP handed a letter to Witness 26, addressed to Witness 33, requesting to transfer from RMAS to be a soldier in the RE.	[redacted]
1.4.245 0734, the SP messaged Witness 26, "Sir, the letter I gave to you can you tell [Witness 33] it is the letter that we spoke about the other day just wanted [them] to look at it, and I'm going down to the exercise now on Barossa now just for your information."	[redacted]
1.4.246 0742 the SP messaged Witness 33, "Sir, its [the SP] heading down to the exercise now, I have given my letter that we talked about to [Witness 26] just so you have it for now."	[redacted]
1.4.247 0748 the SP messaged Witness 34 "Are you free to talk this afternoon?", they replied at 0919 "I am on ex till tom late afternoon if it can't wait till then [Witness 29] around?" the SP had never met	[redacted]

with Witness 29 previously and didn't arrange to meet them after receiving this reply from Witness 34. Albeit Witness 34 sent a message to Witness 29 regarding the SP at 0915 hrs they did not follow up the matter with the SP.	
1.4.248 0751, the SP messaged her mother "have a good day love you loads".	[redacted]
1.4.249 1230, Witness 26 received message from training staff asking if the SP would be attending, Witness 26 replied to say she should already be there.	[redacted]
1.4.250 1355, Witness 26 messages training staff to check if the SP has been found. They reply, no.	[redacted]
1.4.251 1355, Witness 26 phoned the SP, the medical centre, and the training staff to try and find the SP.	[redacted]
1.4.252 1400, Witness 26 talked to Witness 8 to try and confirm location of the SP.	[redacted]
1.4.253 c1401, Witness 26 told Witness 15 to get the spare key for the SPs room.	[redacted]
1.4.254 c1402 Witness 26 phoned Witness 27 and informed them the SP is unlocated and that they intend to force entry into her room to help locate her.	[redacted]
1.4.255 c1403, the facilities manager arrived with the spare key to the SPs room.	[redacted]
1.4.256 c1403 the SP was found in their room.	[redacted]
1.4.257 The Cadets were ordered to clear the lines immediately and 999 Emergency services were called. Witness 22 moved the SP, and the emergency operator gave advice to begin resuscitation. Witnesses 26 and 22 commenced with CPR until they handed over to the paramedics.	[redacted]
1.4.258 c1420 a civilian ambulance arrived, and the paramedics were escorted to the SPs room where they took over from Witnesses 22 and 26.	[redacted]
1.4.259 c1422 the SMO and DMSO arrived at the scene.	[redacted]
1.4.260 c1425 NOTICAS was initiated, at this point listed as Very Seriously Injured (VSI).	[redacted]

1.4.261 c1440 the SP was confirmed as deceased by the SMO and NOTICAS was amended.	[redacted]
1.4.262 c1500 Civilian Police arrived and took control of the scene; they began taking statements from those who had found the SP.	[redacted]
1.4.263 During the afternoon of Wed 06 February 2019 the CoC corralled the OCdts into one of the ante rooms in New College whilst the Police and emergency services attended to the SP.	[redacted]
1.4.264 The news of the SPs death was re-laid by members of staff to the OCdts that afternoon.	[redacted]
1.4.265 33Pl lines were cordoned off and the OCdts were accommodated elsewhere overnight in the College, the female OCdts all congregated together in one of the rooms.	[redacted]
1.4.266 During the late afternoon Witness 25 learnt of the death of the SP and approached their own line manager to explain their relationship with her.	[redacted]
1.4.267 During the afternoon the Bereavement and Aftercare Support team appointed a Notifying Officer and a Visiting Officer. The Notifying Officers attended the SP 's mother's address early evening and collected her from a local gym, returned her to the family home and then informed her and her immediate family that the SP had died. Soon thereafter the SP's mother along with the SP's [redacted] and the Notifying Officer informed The SP 's [redacted]	[redacted]
1.4.268 Prayers were said by Witness 29 in the SPs room at 2115hrs before the SP was moved to [redacted] Hospital, [redacted]	[redacted]
Events following the death of the SP **1.4.269** On the morning of Thu 07 February 2019 Witness 32 addressed the whole intake and explained that the SP had died. A memorial service was held at the Chapel that day and the SPs family attended RMAS and met with selected OCdts and members of staff.	[redacted]
1.4.270 The same day Witness 10 became concerned that there had been no communication from the SP. As Witness 10 was not listed as the next of kin for the SP, she was not automatically informed. Members of the CoC knew of the existence of Witness 10 but this information was not re-laid to JCCC. The OCdts had been ordered by the CoC not to discuss the matter with anyone, however, Witness 10 was informed of the SPs death by Witness 5. Witness 19 who has significant experience of SP deaths offered the following perspective in their hearing:	[redacted]

WITNESS 19: … this Officer Cadet probably appreciated that if she didn't know now, she should know. I can't remember how long after the incident it was, but I understand the decision was probably based on an extremely good analysis and judgement. That is my personal view.	
1.4.271 Witness 34 spoke to Witness 10 by telephone after they had requested that someone from RMAS should contact them. The exact nature of this conversation is detailed in the transcript J10 pages 37-40.	[redacted]
1.4.272 Witness 34 described their discussions regarding this matter in transcript J34 Pg31-37.	[redacted]
1.4.273 The whole intake was released for a scheduled long weekend at 1230hrs on Fri 08 February 2018	
1.4.274 The Trauma Risk Management (TriM) process started on 11 February 2019 after an initial planning meeting on 07 February 2019 at 1500 and is dealt with in detail in TOR 3.	[redacted]
1.4.275 The SPs funeral took place on 01 March 2019, Witness 25 was advised against attending.	[redacted]
1.4.276 On 22 March 2019 the SPs mother and close family attended a meeting with Witness 36 at RMAS.	[redacted]
1.4.277 CC 182 completed their training and commissioned on 12 April 2019.	
1.4.278 A learning account was drafted on 18 February 2019, this included statements from OCdts and staff. This was submitted to APSG PPSI team by Witness 36, the initial PPSI review did not recommend a SI be convened. This was overruled by Head APSG who directed a SI to be convened.	[redacted]
1.4.279 The General Officer Commanding (GOC) Regional Command (RC) signed the Convening Order on 30 July 2019. This identified the President, Panel Members, Legal and Medical advisors. The Order directed the Panel to investigate the TORS and produce a report along with accompanying evidence. The panel assembled on 07 October 2019.	

SECTION 2 ANALYSIS OF FACTORS – TOR 2B

Details of the Service Persons service history; to include work performance and disciplinary record in the 12 months preceding her death.

1.4.280 Service history and work performance from February 2018-August 2018 has been addressed in TOR 1.	
1.4.281 The SPs junior term, end of term report, dated 06 August 2018, stated "[the SP] is a team player and is determined to do well, with a good work ethic and full involvement in PI activities".	[redacted]
1.4.282 The Panel have seen several Student Assessment forms (SAFs), the latest being that on 17 September 2018 on Ex Marlborough's attack, the SP is at the standard in all respects. Showing the DS had no concerns with regards to her military performance.	[redacted]
RSB Report details **1.4.283** The SPs RSB report, dated 15 October 2018, had input from her Platoon and Company Commander. Her Platoon Commander wrote "a hardworking and enthusiastic individual who has developed her skill and has pushed herself throughout the term and is now working at the standard in all respects". They do comment on her academic skills; "although struggled initially academically she continues to work hard and is beginning to understand the combat estimate". Her Company Commander echoed this in their comments; "she is, however, less confident on the more conceptual aspects of the training and initially with the combat estimate too."	[redacted]
1.4.284 The SP work performance had been such that the RE representative continued to persuade her to seek a commission with the Corps: WITNESS 30: She was embarrassed by what had happened on the Engineer visit and wanted to leave the Engineers as a Choice of Arm but… I wanted her to be a Troop Commander in the Royal Engineers and I tried to persuade her to stick with the Royal Engineers as a choice of arm. I wouldn't have taken that choice lightly because I held -- I took very seriously my role as selecting the best possible Officers to lead soldiers that I had the privilege to Command as well. And in that regard, I did speak to her one -- to one in my office more than I would any other of the Cadets necessarily at that time, and so I did have a personal view on her as well. It wasn't all second-hand	[redacted]

information, and this was backed up by what I had continued to see of her on exercise and reports from her staff of her performance to.	
1.4.285 The SP appeared to her fellow OCdts and Directing Staff to be coping with the practical pressures of the second term. In her Midterm review dated 19 October 2018, her Platoon Commander describes her as “An enthusiastic and motivated individual who has maintained a strong work ethic and upbeat character throughout the term”. This is echoed in her end of term report.	[redacted]
1.4.286 The SPs academic midcourse report for CABS states “[the SP] is currently the strongest member of the class with her “very good” mark in the group presentation demonstrating this”.	[redacted]
1.4.287 Her report from Defence and International affairs (DIA) made the following assessment “she has impressed from the outset with her enthusiastic and professional approach to the wider subject matter. Although not possessing either the breadth or depth of knowledge of some of her peers.”	[redacted]
Peer Reviews **1.4.288** A peer review has comments from her platoon members who perceive the SP as hardworking and enthusiastic but tends to depend on others and at times lacks confidence. Throughout the duration of the course, the SP completed and was subject to 6 peer reviews, which provided sustainment and development points. Of these 6 documents, one required the SP to identify the top 5 and bottom 5 performing Cadets in her Pl, she did not include herself in this ranking, and grade every Pl member on a scale of 1-5 based on their performance, where 1 is poor and 5 is excellent. In this, the SP graded herself a 2. In another peer review, the SP was required to rank her entire Pl form top, number 1, to bottom, excluding herself.	[redacted]
1.4.289 27 November 2018 the SP participated in the prestigious RMAS boxing night. Despite losing the fight, she received the “most courageous boxer” award.	[redacted]
1.4.290 During RSB week, the SP was interviewed by RA and RLC and was successfully offered the opportunity to commission into either Corps. She selected RA.	[redacted]
1.4.291 By senior term the SP had continued to impress her training team, Witness 30 said of her performance thus far on the course: WITNESS 30: …the training team view of The SP at this stage was one of satisfaction. She outwardly was brilliant and everything that we saw of her was of an enthusiastic, engaging, polite, humble OCdt who was popular. She seemed to have a lot going for her.	[redacted]

1.4.292 The only evidence of disciplinary action the Panel have seen is an AGAI 67 interview following the DSH incident in July 2018. Witness 28 explained to the panel "I got a strong sense from her still that the drunkenness was defining her performance and her potential at Sandhurst and I wanted to dissipate that and contain it to say "Don't fret, don't worry about that". During this interview the SP agreed to abstain from alcohol. The record of the formal interview states "a reoccurrence could lead to questions of her suitability of employment".	[redacted]
1.4.293 The Panel has not had sight of the RMAS Minor AGAI folder this has been recorded as missing by RMAS and as such the Panel are not able to comment upon any minor disciplinary matters that may have affected the SP.	[redacted]

SECTION 2 ANALYSIS OF FACTORS – TOR 2C

Establish, as far as is relevant to the scope of this inquiry, the personal circumstances including medical history which may have had an impact on the Service Persons death.

1.4.294 In November 2018 the SP disclosed to a peer [redacted] This information was subsequently disclosed to Witness 30 on 05 February 2019. The Panel noted that this [redacted] was only mentioned by the SP to her closest friends Witness 8 and 10 respectively.	[redacted]
Impact of alcohol and assessment by the CoC. **1.4.295** There are effectively 3 incidents involving excess alcohol and the SP, after each event she expressed remorse and embarrassment. In the aftermath of the Normandy incident, Witness 33 even discussed with her the fact that she had agreed not to consume alcohol after the RE visit. Witness 30 was questioned by the Panel about this aspect and did not seem to recognise the warning signs that the SP was displaying after the Normandy incident, and which were repeated again in February 2019. LEGAD: The President read to you a paragraph from your statement where you said you were not made aware of an incident involving [the SP] while she was in Normandy and you reiterated that this morning. But then in the follow-up questions, we have then discussed this entry in the Company Risk Register where, clearly, there is a discussion about an incident involving [the SP] or of this crisis of confidence. So, I am just trying to reconcile in my mind the statement that, "I did not know anything had happened to [the SP] in Normandy" and this entry. Could you explain that to me, please? WITNESS 30: Well, I think the crisis of confidence doesn't leap out to me as being as a result of Normandy. The crisis of confidence, to me, is through academic pressures on the course. I didn't see it as an incident, if you see, in Normandy. I don't think I made the leap that her perhaps going out with friends in Normandy led to a sort of degradation of her functioning at that stage so, yeah, I potentially didn't read enough into it. And as it says on there, "I have spoken to her about the negative impact on her and remains manageable. Unrelated to previous issue". So, I don't think it's as clear-cut perhaps as you said there. Yes, she was having confidence issues about her academic ability to cut it but not necessarily that that was linked to an incident in Normandy. The Panel are of the opinion that certain elements of the CoC viewed the event in Normandy very differently, however of	[redacted]

significant relevance is the fact that Witness 33 updated the Coy welfare register with specific details. These were effectively warning signs that no one actually identified or chose to act upon at that time. Both Witness 31 and 45 medical professionals commented upon the significance of the behaviours demonstrated by the SP at this time, and this is dealt with in TOR 5.	
1.4.296 During the AGAI interview in July 2018, it was made clear to the SP that a "reoccurrence could lead to questioning of her suitability of her employment". She would have been aware of this in February 2019, when she was involved in the Falklands Ball disciplinary investigation. This fact may explain why she felt so certain that she was likely to be discharged in February 2019, when no final decision had been made regarding her future. The Panel have seen no evidence to suggest the CoC in New College, other than Witness 30, were aware of the details of the interview.	[redacted]
1.4.297 The Panel understand that the SP had limited experience of relationships prior to joining the Army. In May 2018 she started a relationship with Witness 10, whom her family were unaware of. In November 18, she became involved with Witness 25 whilst still in touch with Witness 10. She then spent the night in the room of Witness 39 on 01 February 2019, an individual whom she admired but felt that she had compromised the career of. The SP described the events of Friday 01 February 2019 to a civilian friend during a telephone conversation as recorded in their police statement. It is apparent to the panel, that from 02 February 2019, the SP was in the midst of a complex personal situation, which will have contributed to the stress they were experiencing at that time.	[redacted]
Relationships between members of Staff and OCdts. **1.4.298** During 2018 -19 relationships occurred between staff and Cadets. This was known amongst the OCdt cohort but not known by the CoC. There were also other examples of inappropriate behaviour; a. A CSgt boasting on parade of sexual relations with an OCdt on the night of their commissioning. b. OCdts formed the opinion that Witness 23 was having sexual relation within the Platoon lines, with an OCdts' guest/sister after a Company social event. c. Witness 7 confirmed their relationship with a member of the Lucknow Platoon staff. d. Witness 6 confirmed their relationship with a member of staff, Witness 24.	[redacted]

e. The SP's relationship with Witness 25.	
1.4.299 The panel have heard from 7 of the witnesses who were all under the impression that Witness 26, a member of staff, was in a relationship with Witness 2. The President questioned both Witnesses at the hearing and the allegations were denied by both witnesses. Whilst plausible explanation was provided it does not fully explain how this perception could have been so widely misinterpreted by the OCdt cohort.	[redacted]
1.4.300 This behaviour undermined the CoC and was completely unacceptable within a training establishment, the rules and guidance in place at RMAS are designed to safeguard OCdts and staff alike. The Panel are of the opinion that more than one relationship and numerous examples of inappropriate behaviour occurred within this intake. This adequately demonstrates that the staff were prepared to take the risk and contravene the rules and regulations. In addition, the Panel believe that this risk-taking behaviour could have been misinterpreted as being an accepted norm by the OCdts and may explain, why there was such an involvement with Staff members at this time. There was ultimately a complete misunderstanding of the values and standards, by the individuals concerned.	
Summary **1.4.301** The Panel believe that the concern over her personal reputation, possible mental health stigma that may have followed her into the Field Army and the gossip associated with having spent the night in the room of a member of staff, all combined to give an understanding of the position that the SP found herself in, after the 01 February 2019.	
1.4.302 The Panel have seen evidence to suggest the SP applied self-induced pressure and guilt around damaging the reputation or career of a member of staff. Messages she sent to Witness 39 after spending the night in their room on 01 February 2019, "I've said it was all me because it was and said anything that happens should come to me because I caused the situation". Later she messaged them, "I'm so sorry" and "any problems just say was me".	[redacted]
1.4.303 The rumours circulating amongst OCdts, and staff were likely to be causing the SP to feel exposed and isolated. She messaged Witness 25, "I really wanna leave", "all the rumours", "hate it". During the SP time at RMAS the Panel believe that she was juggling a complex personal life as well as dealing with the rigours of the	[redacted]

Commissioning Course. The rumours circulating about her misdemeanours combined with her requirement to justify her version of events after the Falklands Coy Ball indicate that there was an increasing degree of pressure within her life between 01-06 February 2019.	

SECTION 2 ANALYSIS OF FACTORS – TOR 2D

Establish to what extent the Chain of Command were aware of any welfare issues relating to the Service Person.

1.4.304 At the start of the Intermediate term the senior elements of the CoC were aware but not fully cognisant of the welfare concerns relating to the SP. Her case had been discussed at the handover meeting on 03 August 2018 between the Old College and New College staff, unfortunately the actions outlined in the CAP were not reaffirmed with the new members of Pl staff who were required to provide support. Thereafter the Panel believe that the internal communications between New College and Academy HQ were lacking in detail especially after the incident in Normandy, Witness 36 (who was aware of the previous DSH), was not made aware of the Normandy "crisis of confidence" issue because the information inputted on the coy risk register was not transferred to the college risk register where it's importance may have been identified.	[redacted]
Knowledge of the Service Person's external stressors by the CoC during the Junior term. **1.4.305** Whilst Witness 28 who dealt with the AGAI interview with the SP and who wrote the LA dated 27 July 2018 was aware of "past events in her life" because the SP had referred to these in her letter of apology to them. Witness 35 who also stated: "[the SP] stated she has given up drinking. She is also encouraged to mitigate/address the underlying family issues which-though the catalyst is alcohol - caused her to have a violent outburst threatening self-harm". The importance of these 2 separate factors does not seem to have been fully appreciated by the staff in New College. The Panel have seen no evidence to suggest the CoC investigated the "underlying family issues" or provided support to assist the SP in dealing with these issues.	[redacted]
Service Persons "Crisis of Confidence" whilst in Normandy **1.4.306** In November 2018 after the Normandy Scholar Exercise Witness 8 disclosed to Witness 33 that the SP had family issues, the specific detail i.e. [redacted] that had been disclosed to Witness 8 was not passed on to Witness 33. However, it did result in Witness 33 offering the SP a sabbatical, which was declined, Witness 8 explained this aspect as follows: Witness 8: And, so, I basically said I think she needs some welfare input … I really do think [they] understood the gravity of, like, me coming to talk to [Witness 33]	[redacted]

I mean, [they] did put [their] foot in it a bit because, like, immediately [they] went to go and see her and I think it was quite obvious because she then says, like, you told [them], oh no I didn't but yes, I did. And [they], like, went straight to her room and I don't think she let [them] in, I think she spoke to [Witness 33] from the door and then basically, because [they] came to my room afterwards to give me, like, a lowdown on what happened and then she talked to me afterwards as well, from what I understood [Witness 33] basically offered her a sabbatical and she was [redacted]	
1.4.307 Witness 33 categorised the SP state "as a crisis of confidence", she discussed transferring to become a soldier on Ex Normandy Scholar. She also discussed with Witness 33 some family matters. They were aware the SP had agreed to abstain from alcohol and reminded her after a night of heavy drinking on Ex Normandy Scholar. Unfortunately, the importance of the SPs abstinence from alcohol was not sufficiently understood by Witness 33. This may be because the degree of importance was not emphasised sufficiently at the handover meeting in August 2018. Of note is that the SP searched the internet on her return from Normandy, on 08 November 2018, on the topic of suicide by [redacted]	[redacted]
CoC handling of the "Crisis of Confidence" matter and actions thereafter **1.4.308** Witness 32 was aware of the previous DSH but not the severity of the situation, (the Learning Account relating to the RE visit was not shared in September 2018) they were aware of Normandy crisis of confidence but did not confirm the details in writing for Witness 36 attention. Subsequently they made the decision to down grade the SP in January 2019 from red to amber on the risk register (see explanation in the next para). Of relevance is the fact that the incident involving Witness 39 on the evening of 01 February 2019 resulted in an upgrade of the SP status on the college risk register from Amber to Red on 04 February 2019. The inconsistency in recording and passing on relevant facts relating to the SP is a constant factor during her time at RMAS. The Panel believe that this poor administration combined with virtually no follow-on actions contributed to the substandard level of care that the SP received whilst she was at RMAS.	[redacted]
1.4.309 The risk register used a colour coding to categorise the OCdts. Red was used to describe an OCdt with "Issues that must be addressed at College and Academy level. Already or imminently affecting the individual's performance and health in an adverse way. Potential for considerable reputational risk. (Welfare team, MRS, College Comd & Ac HQ to be actively engaged)". Amber was used	[redacted]

to describe an OCdt with "Issues that require management at Coy and College level. Expected to impact the individual's performance and health. (Welfare team, MRS, College Comd & Ac HQ to be informed)" and Green was used to describe an OCdt with "Issues that require Coy staff to monitor. Impact on the individual minimal. (Welfare team, MRS & College Comds to have an awareness)".	
1.4.310 Witness 30 provided some of the staff continuity from Jnr term, and was aware of the previous DSH, knew of the crisis of confidence issue and as of 05 February 2019 also knew of the [redacted]	[redacted]
CoC knowledge and actions after the disclosure of [redacted] **1.4.311** For clarity on 05 February 2019, Witness 30 was made aware (and discussed with Witness 33) that the SP disclosed to Witness 8 that she had been [redacted] Witness 36 said they would have expected Witness 30 to "have delivered that information straight up the Chain of Command into the medical service and I would have expected her to be treated as significantly at risk. This is the point at which I would have expected DCMH to go into overdrive." When Witness 30 was asked what they did with that information they said "At that moment I did not act further on this information. I cannot remember exactly what my thought process was. My initial concern was dealing with the discipline investigation at hand, and I probably saw this as a further reason to be careful in my questioning of The SP." Of relevance, at this point in time the SP is graded Red on the risk register and the risk is categorised as suicide. The panel are disappointed to note that no action relating to this new information was undertaken by the CoC during the evening of Tuesday 05 February 2019 nor on the morning of Wednesday 06 February 2019.	[redacted]
Welfare / Medical Actions after the [redacted] in CSM Office Sat 02 February 2019 **1.4.312** Witness 26 was aware of the DSH, but not the severity of the situation. They were unaware of the Normandy incident but were intimately involved in the aftermath of the Falklands Ball, they made no referral to the medical centre after they witnessed [redacted] on the morning of Sat 02 February 2019. They did however follow up with welfare checks over the weekend of 02-03 February 2019 (transcript extracts in TOR2a) and were the only member of the CoC to follow up on the SPs welfare that weekend. The Panel would have expected some form of medical intervention to have occurred on Sat 02 February 2019 it is	[redacted]

noted that the SPs incident was one of many other disciplinary issues occurring that morning and that may explain why this did not occur.	
1.4.313 Witness 23 was in theory, the closest person to the SP in the CoC they were unaware of the DSH, and requirements of the CAP. They were aware of the SPs relationship with Witness 10 and the fact that she hadn't disclosed it to her family. They were not fully aware of the fact that the SP had agreed not to consume alcohol and did not know the details relating to the incident between Witness 39 and the SP which occurred in the bar in Normandy. They disclosed to the Inquiry that they did not think anything would have happened between Witness 39 and the SP after the Ball because they were one of the few people who knew that the SP was in a relationship with Witness 10.	[redacted]
1.4.314 Witness 34, who was not part of the CoC but was there to support OCdts, was aware of the incident in July 2018 DSH and was the only individual who was informed of what the cadets had experienced on the RE visit. The panel noted that Witness [redacted] did offer pastoral support on Sunday 03 February 2019.	[redacted]
1.4.315 Witness [redacted] who was responsible for the intake support in the intermediate term knew of the incident in July 2018 and had sight of the risk registers which recorded the Normandy "crisis of confidence". They did not share that information with the wider Chaplaincy team and did not speak to the SP about the matter.	[redacted]
1.4.316 Witness 38 was aware of DSH and was sent the INCREP at 1220 on 17 July 2018. Witness 38 was granted visibility access rights to the CAP (from 24 July 2018) and should have managed the CAP (from 23 August 2018) once the SP moved to New College. Witness 38 had issues accessing the CAP, in so far as they believe they had limited visibility of the document. However, the Panel has seen no evidence to demonstrate that any attempts were made to rectify the problem. Albeit, Witness 38 made the referral to AWS in July 2018, the Panel believe that the information relating to the SPs Crisis of confidence, in November 2018, were not brought the attention of the CAP lead (Witness 38) as this was not included in the College risk register.	[redacted]

SECTION 2 ANALYSIS OF FACTORS – TOR 2E

Details of the involvement of welfare and other relevant agencies that may have been consulted and any advice or treatment given.

Service Persons involvement with the Chaplaincy Dept

1.4.317 Pastoral confidentiality applies inside the chaplaincy team, as it does outside but Witness 46, was aware of the SPs DSH "her attempt at self-harm was spoken of and it came to my attention" and [they] understood Witness 34 was dealing with it.	[redacted]
1.4.318 Witness 46 attended the Academy level welfare meetings but did not have direct contact with the OCdts and confidentiality within the pastoral team would appear to limit their understanding of the severity of the situation.	
1.4.319 Witness 34 provided the SP with pastoral care following the DSH and met the SP a total of 4 times whilst she was at RMAS, they were aware she was on the risk register with a CAP, however they did not see or have access to the CAP. Witness 29 informed the panel that they were unaware of the seriousness of the DSH incident in the first term. It is now apparent that there was confusion regarding the responsibility for pastoral care in the intermediate term. The panel noted that in February 2019 Witness 29 did not have pastoral responsibility for the SP, having changed colleges and as such would not have had sight of the risk registers or be aware that the SPs status was raised on 04 February 2019. Witness 29 was unaware of the incident which occurred at the Falklands Charity ball on 01 February 2019. The incident during Ex Normandy Scholar in November 2018 was not handed over to Witness 34, which would have enabled them to provide enhanced support to the SP. Following the Falklands charity ball, Witness 34 met with the SP on 03 February 2019. Subsequently Witness 34 arranged to meet with the SP on the afternoon of 04 February 2019, however this meeting did not occur. The SP sent a text message to Witness 34 on 06 February 2019 at 0748hrs, "Are you free to talk this afternoon?" this was replied to at 0919hrs with the message "I am on ex till tom late afternoon, if it can't wait till then [Witness 29] around? Padre. Witness 34 then sent a text message to Witness 29 "…letting [them] know that the SP might be in touch. The Panel asked Witness 29 about this exchange of messages:	[redacted]

WITNESS 29: I can't remember the means by which [Witness 34] conveyed that to me, but [they] absolutely did inform me that [they] had given [the SP] my telephone number and [Witness 34] was setting off to exercise. PRESIDENT: So, you are aware of the incident at the Royal Engineers in the junior term, you have had sight of the Welfare Tracker that mentions a crisis of confidence in November, and when you received that what did you do? WITNESS 29: I didn't do anything in particular. PRESIDENT: Is there any particular reason why you did not do anything? WITNESS 29: The message was not asking me to seek out [the SP] on that day. It was saying that if she wanted to talk to somebody, then I would be available to speak to her. And I took that as read, as given. There was nothing to suggest that there was a need to seek out The SP. This was information from [Witness 34] that, if she wanted to get in touch, then she was assured that there was then pastoral support available to her that day since [Witness 34] would be going away on exercise.	
1.4.320 Having considered all the available evidence, the panel are able to understand why Witness 29 did not act immediately upon receipt of Witness 34s message. Albeit Witness 29 knew of the DSH (as this was recorded on the risk register and discussed at the college HOTO meeting), they were not aware of the events of 01 February 2019. The small team of Witness 29, 34 and 46 shared information and sat in at the various welfare meetings where the SPs case was discussed. Witness 29 would have been aware the SP was on the risk register in November 2018, because they attended the college welfare meetings. The CoC understood that Witness 29 was the SPs focal point for pastoral care in Intermediate term, as such, the incident on Ex Normandy Scholar would have been discussed with Witness 29 at the college meetings. This was not brought to the attention of Witness 34 at any point by Witness 29. Of note is the fact that Witness 29 did not have any meetings with the SP during her time at RMAS, because, as explained to the panel, they believed Witness 34 was providing the pastoral support.	
The CoC understanding of what was meant to be happening **1.4.321** The CoC thought that the Chaplaincy Dept were engaging with the SP as explained to the Panel by Witness 32:	[redacted]

PRESIDENT: What I am trying to determine, Witness 32, is what actions did you ask to take place, or did you direct to take place after reading or becoming aware of that on 19th November? WITNESS 32: There are no specific actions beyond the engagement of the chaplaincy team and CABS. PRESIDENT: And who did you expect to tell [the SP] to engage with those two individuals? WITNESS 32: That would have been through her Company Chain of Command. Sorry, to be clear, Colonel, I wouldn't suggest it was the SP to reach out to them, it would have been for them to go and seek her out and engage with her. The Panel would have expected a padre to have engaged with the SP in the intermediate term, especially after the "crisis of confidence" matter had been recorded on the company risk register.	
1.4.322 Pastoral care at RMAS, during the SPs Intermediate term seemed to the panel to be based on a pull push system in that if OCdts required it then they should have sought it out and arranged the interaction. The Panel have heard that the course was exceptionally busy and as such, the time available for a busy OCdt to pull that support was extremely limited.	
Inter-action with the Welfare Dept **1.4.323** Witness 38 attended the college welfare meetings, sporadically, and was aware of the DSH and VRM account. The CAP was handed over to them in August 2018. No further details were inputted into the CAP following the handover.	[redacted]
1.4.324 The Panel believe that Witness 38 and Witness 21 should have been fully informed of the circumstances of the RE visit and the details of the Learning Account submitted in September 2018; then they should have suggested second line welfare support via the AWS to support the SP and assist her in dealing with the issues that she mentioned to Witness 28 in July 2018 and Witness 33 in November 2018.	[redacted]
Details of the Service Person's Care Action Plan **1.4.325** The CAP was described as "poor" by the policy expert and was only seen by a small number of college HQ staff and Witness 38, nothing further was inputted after 27 July 2018. The CAP is designed as a dialogue between the holder and the supporting elements. There is no evidence to suggest the SP was aware of the CAP or the purpose of it, in addition some of the supporting individuals mentioned in the CAP were not aware they were part of	[redacted]

the CAP or that they were expected to provide additional care. It was noted that the primary tool used at RMAS for tracking OCdts welfare was the Risk Registers, not the CAP. The Panel believe that had the SP been fully engaged with the details of her own bespoke CAP then she would have had a greater understanding of the care and support network that was there to assist her whilst at RMAS.

1.4.326 Witness 17 provided the Panel with an assessment of the SP CAP as follows:

WITNESS 17: I would have expected it to be much more robust, much more detail, much more consideration about the issues that were affecting the individual and what both her Chain of Command and any support services were doing to help address the known reasons for her distress or other underlying issues. They appear to be very much missing from here.

WITNESS 17: So, from the years I have been working in this role, I think this is a poor example of a CAP.

Level of knowledge and understanding of AGAI 110 by the CoC.

1.4.327 The Panel note as previously mentioned in TOR 1 that the RMP SIB should have been another organisation that was involved with the SP, the fact her incident of DSH at the RE visit was not brought to their attention re-enforces the lack of knowledge and understanding of the AGAI 110 policy by the CoC at RMAS.

[redacted]

1.4.328 This aspect identified by the Panel was candidly confirmed by Witness 28 as follows:

PRESIDENT: What I am trying to determine, [Witness 28], is why that policy was not followed. Why was [AGAI] 110 not used as a hand rail to deal with this incident that you were dealing with and the aims of the SVRM are identified in the policy there, assisting them, i.e. guidance to Commanders, assisting them to identify those who may be at risk of suicide and signposting appropriate responses and management tools to mitigate identified risk, in order that they may make a judgment as to how to actively manage support personnel?

WITNESS 28: Sir, I wish I'd known about it. I would have followed it. I was in -- not all over the place, but I could have really done with that -- with more than a handrail. I could have really done with that experience written up as a helpful document, it's not a constraint, that kind of thing, that is borne of experience. That is what I was after, to go, "Flipping heck, have we covered everything? What do we do next? Somebody stopped looking at this, as a unique experience, a very rare experience. Here is experience on paper, this is our handrail. This is what we're to do".

1.4.329 The Panel have identified that Witness 28 had not received specific pre-employment training prior to taking up their role at RMAS and was therefore unaware of AGAI 110, it's requirements and guidance. Irrespective of this omission, Witness 35 had received training on the policy by attending the All Arms Adjutants Course, 2 years previously and there may have been a degree of skill fade. They were in effect responsible for administering the VRM account including the management of the CAP on behalf of Witness 28. The Panel believe that there should have been a much greater degree of collaborative interaction within College HQ.

It is noted that Witness 35 did attempt to seek advice from other departments within RMAS, regarding the management of the SP after the incident. Of relevance, was the fact that Witness 28 and 35 did not have additional support staff within the College HQ, (which could have assisted with the administration). Conversely, these other depts could have and should also have provided advice to Old College HQ this time as they were all aware of the SP position. The impact of not identifying and applying the guidance in this case meant that the ongoing quality of care afforded the SP was not of the correct standard.

[redacted]

Medical Staff's knowledge and understanding of the Service Person after August 2018

1.4.330 The medical agencies being the medical centre at RMAS and DCMH had no direct involvement with the SPs post discharge from DCMH in August 2018 other than for the Boxing medical, and a few minor visits. The medical Chain wasn't consulted after Normandy or the Falklands Ball. Witness 31, a medical expert explained:

[redacted]

[redacted]

[redacted]

PRESIDENT: If you now look at the New College monthly welfare return, it consists of one document, a two-sided document, you will see that there is no reference to either of those events at all. So, I am just asking you to confirm how else would either you or SMO find out what was going on at a company level?

[redacted]

PRESIDENT: Thank you for just clarifying that particular point. But the crux of the issue here is that the information on the Falklands Company weekly welfare return does not make on to the New College monthly welfare return and, as a result, the SMO or yourself would have been unaware of it, which is what you have just told me in the last line, paragraph 19, is it not?

WITNESS 31: Yes.

1.4.331 This evidence taken from Witness 31 identifies one of the key failures during the SP attendance at RMAS and is dealt with in detail in TOR 5. It should be noted that the fundamental omission of the details of Ex Normandy Scholar and the continuing lack of information sharing, concerning the SP behaviour and demeanour at that time effectively meant that the medical staff and the Academy Headquarters staff were unaware of the true position faced by the SP.

Access to Mental Resilience Support and Coaching

1.4.332 Witness 18, from the CABS department, offered 1-2-1 coaching and psychological coaching support to a number of cadets and staff. They were either self-referred or were guided by a member of DS, particularly those who were struggling or wanted to discuss mental resilience, mental health and / or any issues they were struggling with both relevant or external to the CC. Witness 18 allowed and encouraged the individuals to speak openly and attempted to help the individual identify and achieve their personal goals. They worked within the guidelines of confidentiality and, if necessary, informed and referred to the relevant department

[redacted]

(medical team, CoC, etc). Witness 18 was not aware of any referrals for the SP and had no engagement with her. This requirement for support was included on the Coy risk register post Ex Normandy Scholar and was visible to the CoC. Witness 18 remained unaware of any referrals or tasks.	
Ofsted Report **1.4.333** Of particular relevance is the opposing findings the Panel found in relation to the 2017 Ofsted report. The report states there is “An effective and much valued welfare network includes WRVS, welfare Officer, Padres and platoon staff. Very good channels of communication between all welfare agencies ensure the progress and personal development of cadets” and emphasises the “open and free flowing communication between all parties help to ensure the welfare, progress and personal development of cadets”. The Panel have found the communications to be inadequate, (as investigated in TOR 5) particularly with regards to the VRM and CAP. Furthermore, the support that should have been provided to the SP, particularly from the welfare department was not provided, evidenced by the fact that they never met or communicated with the SP.	[redacted]
1.4.334 The Panel are of the opinion that due to obtaining an “outstanding grade” by Ofsted, that this may have led to a level of complacency, as confirmed by Witness 36. The Panel believe that this in turn contributed towards a reduced level of assurance of the welfare support the SP was receiving.	[redacted]

SECTION 2 ANALYSIS OF FACTORS – TOR 2F

Assess, with respect to the Chain of Command, the extent to which the level of support provided to the Service Person by the Chain of Command met the standard set by the extant policy; and express and opinion on, with respect the relevant welfare services, the level of support they provided, in each case considering all the information available at the relevant time.

1.4.335 The policy applicable to the SP during her time at RMAS was laid down in the policy documents listed at TOR 3 a.	[redacted]
Tracking Mechanisms and meetings at RMAS **1.4.336** The Panel are of the opinion that the CoC used various ineffective methods of tracking the SPs welfare and progress on CC182. We have heard that there were numerous meetings to discuss her position and that several individuals were aware of some of the detail concerning the RE visit, the Normandy trip and the incident after the Falklands Coy Charity Ball. **1.4.337** It is apparent to the Panel that albeit the SPs case was discussed at various meetings, what is also abundantly clear is that there was no, or very little positive action taken after such meetings. In addition, there was very little assurance by the CoC of the actions required at such meetings. The SP did not receive any input/support from the Welfare Dept and the CoC was also completely unaware of this omission, of significant relevance is the fact that the Welfare Officer never actually met the SP. After the RE visit the SP was supposed to be monitored as stipulated in her CAP by her Pl Comd and Pl CSgt this monitoring should have included ensuring that the requirements of the Welfare register were enacted, unfortunately this did not occur nor were elements of the SPs CoC aware of the CAP. **1.4.338** The CoC didn't appreciate the importance which the medical Chain placed upon the SP being fully supported by her family. The fact that no one ensured that she spoke to her family in the immediate aftermath of the RE visit is a significant break down in understanding. The CoC didn't fully understand the means by which they could have ensured that this occurred. The Panel are, on the balance of probabilities, of the opinion that had a full and thorough investigation taken place into the RE visit, including the taking of statements from everyone involved, then the CoC would have had comprehensive understanding of the seriousness of the events that evening. These inadequacies and the subsequent lack of information sharing with the medical Chain and DCMH led the assessment of the SP to be based upon an incomplete evidential basis. The SP was also unaware of the specialist support that	

should have been made available to her (by the welfare team) e.g. AWS specialist counselling/ CABS etc. There is no evidence whatsoever to suggest she was involved in her CAP and was aware who she could turn to for support other than the Chaplaincy team.	
Impact of excessive alcohol consumption and CoC actions **1.4.339** The post Normandy welfare register actions were not followed up by the CoC to the extent that the SP had no support from the Chaplaincy Dept, and no interaction with the CABS Dept and/or the coaching on offer by Witness 18 in the intermediate term. The Panel believe that the CoC should have addressed the SPs drinking behaviour immediately and dealt with this relapse in a much more robust manner by referring her to the medical centre for further support. This incident occurred only three and a half months after she had committed self-harm in the form of attempted suicide, the very fact that this was not acted upon demonstrated to the Panel that there was a fundamental misunderstanding by the CoC of the seriousness of the circumstances relating to the RE and Normandy events. A further serious omission after Ex Normandy Scholar was the fact that the incident involving alcohol was not elevated by the College to the Academy level welfare meetings were the Comd and the medical team would have been made aware of this repeated abuse of alcohol.	
1.4.340 At two significant events during the SPs time at RMAS (being Ex Normandy Scholar and the Falklands Coy Charity Ball events), scant regard was given by some members of the CoC to the alcohol policy, the requirement for self- restraint and the application of sound judgement were sorely missing. This was particularly relevant after the Falklands Coy Charity Ball. The actions of the drunk members of staff were, in the Panel's assessment, a significant factor in the events which ensued. The professional integrity of the CoC was effectively undermined.	
The CoC passage of information regarding alcohol consumption **1.4.341** It is clear to the Panel that the internal communications between the elements of the CoC were poor, key information regarding the RE visit and its aftermath were not passed on and the importance with which the SP should have abstained from alcohol was not fully understood by all members of the Falklands Coy CoC. The Panel believe that if the CoC had fully understood the position facing the SP after her AGAI interview in July 18 then they would have been better placed to comprehend the position she was faced with after the Falklands Coy Charity Ball.	

The engagement with the Service Person between 01-06 February 2019 **1.4.342** The final weekend of 02-03 February 2018 was a critical period for the SP. The Panel have seen and heard evidence to prove that she was exceptionally vulnerable at this time, her CAP required her to be monitored but only one member of the CoC showed any regard for her welfare over those two days. It is acknowledged that she sought out pastoral support which resulted in a meeting on 03 February 2019.	
1.4.343 It is evident to the Panel that there was no more detailed monitoring of her on Mon 04 and Tue 05 February after her risk level was raised from Amber to Red on the risk register. The Panel have heard that the SP was able to isolate herself and withdrew from normal social interaction during this time demonstrates to the Panel that during these 2 days the CoC focus appears to have been solely in determining the disciplinary matter rather than appreciating the welfare requirements of the individuals who were subject to the investigation. There were no specific measures in place after the Falklands Coy Ball or after the disciplinary meeting on 05 February to adequately care for the SPs welfare.	
1.4.344 The CoC's lethargic response after being informed of potential criminal activity, being; firstly [redacted] and secondly [redacted] more than adequately demonstrate a fundamentally poor assessment of risk. The Panel are firmly of the opinion that this was a clear omission in the application of safe-guarding policy and basic common sense.	
Summary **1.4.345** As regards to the level of support provided by the welfare services the Panel are of the opinion that both the Welfare Dept did not provide an adequate level of support. The lack of engagement and poor management of the VRM account and CAP by the CoC and the Welfare Dept are way below the standards that the Panel would have expected at a Basic Training establishment.	
1.4.346 The Panel are also of the opinion that the pull push approach to pastoral care adopted by the Chaplaincy Dept in 2018-19 was also below the standards that we expected to find. In summary, the Panel believe that a "reasonable person" would expect that an individual (who had engaged with the Chaplaincy dept), who was registered as Red on the RMAS internal risk register and the risk having been categorised as suicide should expect to have been seen and supported, on an individual basis, by the Padre more than 4 times during her time at RMAS. In addition, of significant relevance is the fact that the SP received no pastoral	

support during the intermediate term as a result of the misunderstanding of the responsibility for the provision of this support.	
1.4.347 Finally, the Panel believe the CoC, Welfare Dept and Chaplaincy Dept did not provide the SP with an adequate, acceptable, and co-ordinated level of support. Their collective in-ability to act decisively upon shared information, and thereafter accurately and honestly report their support and level of engagement with the SP were the primary reasons why the SP received such a substandard level of support. The Panel are firmly of the opinion that the senior elements of the NC CoC (who had a poor understanding and miscalculated the seriousness of the risk they were carrying), did not take reasonable, timely and appropriate action to safeguard the SP during the period 01-06 February 2019, there was an overwhelming pre-occupation with the disciplinary process.	

SECTION 3 – TOR 3 Identify the relevant policies, procedures and other welfare provisions, and how they were applied at RMAS in relation to each case.

To determine RMAS approach to the relevant policies, procedures and welfare and other provisions including, but not limited to

SECTION 3 ANALYSIS OF FACTORS – TOR 3A

Identify what policies, procedures and regulations, both in the wider Army and within the establishment exist for the provision of welfare support in cases such as this, including but not limited to the implementation of AGAI Vol 3 Chapters 81 (Army Welfare policy), 110 (Army Suicide Vulnerability Risk Management (SVRM) Policy) and JSP 893 policy on Safeguarding Vulnerable Groups.

1.4.348 In addition to the 3 specific policies mentioned above, (the application of which is addressed in various sub TORS within this report), the Panel have identified a number of other policies, procedures and regulations that were applicable during the SPs attendance at RMAS. These other areas are listed and commented upon below and where the guidance was not followed this is highlighted accordingly.	
a. JSP 770 Operational and Non-Operational Welfare Policy. Provides welfare policy and guidance to Commanders at all levels as well as welfare specialists on the provision of welfare. Version 12. Dated 01 December 2017 was in date at the time. The Panel have found that aspects of the welfare charter (Annex D to chapter 1 of part 1) were not followed to a level that the Panel would have expected. Namely para 2, the duty of care of the Chain of Command, and Para 6 the reviewing of case conferences. TOR1,2 and 3F look at the result of these lapses.	[redacted]
b. JSP 822 Defence Direction and Guidance for Training and Education Part 1, provides direction and guidance on individual and collective training and education. Version 3, March 2017 was extant at the time. Chapter 2.2 provides guidance and direction for Commanders managing the training environment. The Panel saw evidence of a shortfall in training prior to taking up posts, no continuation or refresher training. Chapter 2.3 gives guidance on supervisory care of trainees. The Panel saw evidence of a lapse in care provided during periods of leave (para 8), a lack of recording of actions on the risk registers (para 9)	[redacted]

	and inadequate application of the expected values and standards from those providing the said care (para 4c). This is investigated further in TOR 1 and 2.	
c.	JSP 835 Alcohol and Substance misuse and testing, provides the guidance on the policy and procedures in relation to alcohol and substance misuse. Version 3.1 January 2018 was extant at the time. Chapter 2 details the hazardous and harmful misuse of alcohol which was evident in this case, it also gives direction that all Officers and Non Commissioned Officers (NCO's) have an expectation to set the example and take a firm stance against alcohol misuse (para 2). The Panel are of the opinion that this was not adhered to by all elements of the Falklands Coy CoC. Annex A includes guidance on Administrative action whilst seeking medical help for alcohol misuse, it explains that a close link is required between the CoC and medical Chain to continually monitor an individual who has harmfully misused alcohol (Annex A Para 3). In addition, personnel should be supported to socialise without drinking alcohol (para 19). Unfortunately, this was not applied in the case of Ex Normandy Scholar nor the Falklands Ball.	[redacted]
d.	The application and direction for Trauma Risk Management (TRiM) is covered by 2 policies 2009DIN01-097 (dated May 2009) and LFSO 3217 (dated August 2011). The application of these policies is examined in TOR 3F.	[redacted]
e.	AGAI Vol 2 Chapter 57 Health Committees (September 2017 (updated April 2020)) was the policy applicable to health committees and confirmed that they were a mandatory policy requirement in order to comply with the Health and Safety at Work Act 1974. During the inquiry it became apparent that numerous aspects of this policy were not adhered to as RMAS did not include OCdts in the UHC meeting. Specific areas of the policy explaining the mandated UHCs and those who should attend are at paras 24, 29, 30, 52, 57, 58 and 72. This is further assessed in TOR 3C.	[redacted]
f.	AGAI 75, Inclusive Behaviours – Diversity, Inclusion and Behaviours, is the Army policy and guidance on the implementation of diversity and inclusion to ensure all personnel are treated fairly. The Panel are of the opinion that the SP was not always treated in accordance with her needs, and particularly was allowed to isolate herself between 03-06 February 2019 unbeknown to the CoC, when she was under significant degree of stress. The application of this policy is assessed in TOR 3E.	[redacted]

	g. AGAI Vol 3 Chapter 81 Army Welfare Policy details the welfare responsibility of Commanders for Army personnel and their families. Para 202 explains that the CO is responsible for ensuring a seamless and coherent welfare service is available. The panel noted that in 2018-19 the College Commanders did not have the Command status normally associated with Commanding Officer appointments.	[redacted]
	h. Army guidance/ digital Army / using social media in the British Army. The impact of the lack of clear guidance relating to the boundaries of social media and messaging has led to recommendation 27 as detailed in TOR 6.	[redacted]
	i. ARITC Supervisory Care Direction (April 2018) explains areas specific to ARITC that should be adhered to (in addition to JSP 822) to create an environment which minimises risk and enhances the training experience. Para 3 details the requirement for supervision and welfare cover over leave and the requirement for systems to be in place to protect trainees who are vulnerable. The Panel have seen inadequacies in both of these areas.	[redacted]
	j. ARITC Relations between PS and Recruits and trainees undertraining, or potential candidates for enlistment. (April 2018) gives guidance on the relationships between staff and soldiers under training. Para 4 explains intimate or sexual relationships between trainees and staff on or off duty are forbidden. The application of this policy is assessed in TOR 2	[redacted]
	k. Sandhurst Group Supervisory Care Directive, welfare and prevent (dated October 2018) is the policy on the care of staff and trainees at RMAS. Para 17d directs the self-control of DS in social environments and that they should consider themselves “on duty” during social events with OCdts. The Panel saw inadequacies of this which are covered in TOR 2. Para 19 also confirms the mandatory status of pre employment training. The Panel saw evidence of DS not attending this training.	[redacted]
	l. RMAS Instructors Pocket Book, is a guide for DS at RMAS and directs in detail the Values and Standards expected of the staff. Para p explains that fraternisation with OCdts is not acceptable behaviour.	[redacted]
	m. RMAS Standing Order Book 2 Part 1 Welfare. The application of this policy is assessed in TOR 2E and F.	[redacted]

n. RMAS standing Order Book 15 Part 2 Standing Orders for Cadets. Provides a comprehensive guide to OCdts. Of note it is recorded that the WO and Sgts mess is an out of bounds area (para 69). The Panel believe that this was ignored twice in this case and is examined further in TOR 2.	[redacted]
o. RMAS Group, Alcohol policy- July 2018. Of specific note in this report, the Panel saw a lack of compliance with the following area of the policy: (i) Alcohol may be consumed privately, in moderation, in SLA, however this must not be permitted to expand into 'Block parties' which are expressly forbidden. The after party that occurred during the early hours of Sat 2 February 2019 was in direct contravention of this policy.	[redacted]
1.4.349 AGAI Vol 3 Chapter 110 is assessed extensively in TOR 3B.	[redacted]
Classification as a vulnerable adult **1.4.350** The Panel considered JSP 893 the policy regarding safeguarding vulnerable groups which was applicable in 2018/19 this policy has been updated and is now titled JSP 834. The policy does not specifically mention OCdts as a vulnerable group, but it categorises a vulnerable adult as one who has reached the age of 18 and "receives any form of healthcare". Of relevance, is that the SP [redacted] The CoC were aware that the SP had received medical attention following the RE visit and as such JSP 893 was applicable in her case. Of note is the fact that neither the Coy nor the College risk registers mentioned that the SP was a classed as a "vulnerable adult". The Panel are of the opinion that the absence of this extra key safety netting descriptor was due to a lack of knowledge, poor staffing procedures, and ultimately a lack of due diligence by the CoC in this case.	[redacted]
1.4.351 The application and understanding of JSP 893 by the CoC is particularly relevant as it also provided the guidance for dealing with [redacted] which were disclosed to the CoC. The Panel find that the CoC did not act in accordance with the policy in this respect as described in detail in TOR 2.	[redacted]

SECTION 3 ANALYSIS OF FACTORS – TOR 3B

Determine the level of understanding and application of AGAI 110 SVRM by the CoC

1.4.352 AGAI 110 was updated in August 2020. At the time of the SPs death, the current AGAI was dated May 2012.	[redacted]
AGAI 110 and the level of training amongst the CoC **1.4.353** Witness 36 understood and had applied VRM Policy in other roles, they had a good working understanding and had practical knowledge of the policy's application in the Field Army. The Panel believe the fact that albeit Witness 36 had a good understanding of the policy those in the CoC below did not and as such this is a key factor. Witness 36 wasn't present at the VRM case conference on 18 July 2019.	[redacted]
1.4.354 The Commanding Officers designates (CO Des) course, is prerequisite training for any CO. This is not mandated for either RMAS College Command posts (as they are not CO posts). The course delivers an overview of VRM training and AGAI 110.	[redacted]
1.4.355 Witness 17, who is involved in delivering VRM training, explained when training is delivered and to whom; including Adjts, OC's, Welfare staff and CO's.	[redacted]
Command Status **1.4.356** The role of New College Commander is not a Command appointment and is titled SO1 Commander New College on the Job specification. The New College Commander at the time had previously served at unit Command and therefore had completed the CO Des Course (2014) but doesn't recall the training. In addition, they did not have visibility of the VRM record for the SP, as it was held by the Welfare dept.	[redacted]
1.4.357 The role of Old College Commander is also not a Command appointment and is titled SO1 Commander Old College on the job specification. The Old College Commander at the time, informed the Panel that the pre-employment trg requirement for the post was to attend one day of the CO Des Course, which covers summary dealings, to provide training for discipline of the OCdts (this is not stipulated on the job specification). There was no requirement to attend the full CO Des Course. The College Commander attended 1 day of the course and therefore did not receive any training on AGAI 110 SVRM. When asked for their opinion of why AGAI 110 was not followed, they explained they were	[redacted]

ignorant of the policy but that they wished they had known about it as they "could have really done with a "handrail.	
1.4.358 Witness 28's lack of understanding of AGAI 110 resulted in them believing that the SP could be removed from the VRM 11 days after the DSH as the VRM offered no additional support. "By 27 August 2018 she had been removed from the VRM". "I wanted to remove her from the VRM on the basis of the medical advice of a 'very low risk of recurrence' of the incident and that being on the VRM did not draw additional support. Witness 17, who has 10 years' experience in mental health policy, explained to the Panel, if they had been asked to remove the SP from the VRM they would "categorically refuse to remove the individual and I would write to the OC accordingly. The policy is very clear; that for the reasons that the individual was placed on the register, that the individual had to stay there for a minimum period of two years". Witness 17 further explains that the VRM is not just procedural but there to ensure that an individual has active care and support to address the underlying issues that are causing them the distress. And that if a Commander felt that placing an OCdt on the VRM would not attract additional support, then they had clearly never read the policy.	[redacted]
1.4.359 The Panel are of the opinion that neither College Commanders applied the policy in a coherent and workable manner, and they relied upon other means, such as the monthly welfare meetings to manage the SP. The Panel find that the College Commanders should have been adequately trained for their specific roles and undertaken refresher training prior to taking up the posts, had this occurred they would have known that AGAI 110 applied.	
1.4.360 Witness 30 had previously completed a posting as an Adjt, but did not recall doing the Adjt course, they also attended the Combined Arms Tactics Course (CATAC), but they did not recall doing any VRM/CAP trg prior to their posting at RMAS.	[redacted]
1.4.361 VRM training is delivered to the Adjt course. The Old College Adjt at the time, completed the Adjt course after taking up post in approx. October 2016 and therefore received the VRM trg. However, they did not have any experience with dealing with VRM and CAP and had no refresher training. The Old College Adjt, also explained Sandhurst didn't routinely use it as they had their own mechanism to track welfare issues, with the focus being on transferring the risk register between colleges. As such they were not familiar with the CAP and VRM process when they were required to use it, nor could they have passed the CAP on to New College as they did not have the means to do so, hence it was passed to Witness 38.	[redacted]

1.4.362 Witness 37 did not attend the prerequisite training for the post prior to the role and once in post the job didn't allow the time, therefore they had not received any training on AGAI 110. In addition, Witness 37 did not have a VRMIS account and therefore did not have access to the CAP.	[redacted]
1.4.363 The Welfare Officer had completed VRM training. They did not attend the case conference. They had visibility of the CAP from 24 July 2018 and subsequently were assigned as the unit lead but took no action to inform the SP or ensure due diligence was undertaken to maintain or monitor the CAP.	[redacted]
1.4.364 No AGAI 110 refresher training was conducted at RMAS, and the Panel are of the opinion that internal risk registers were favoured over the VRM.	[redacted]
1.4.365 As a result of the lack of training, there was a clear lack of understanding at all levels of the CoC on how to use the VRM and its purpose.	
AGAI 110 Understanding and application **1.4.366** The Panel are of the opinion that the perception amongst the staff at RMAS about OCdts being placed on the VRM was negative. Witness 36 explained they understood the SP would not be able to commission if they were on the VRM. Witness 17 explained this was not the case.	[redacted]
1.4.367 AGAI 110 para 26 directs that all personnel on the VRM must be informally assessed and documented at least once a month and a full risk conference must occur every 3 months. Para 22a explains that the individual must remain fully involved in the subsequent reviews "which in itself may be beneficial in helping them to understand their mental state". Para 19 explains "ultimately engagement with the individual is of primary importance, both in acknowledgement that the individual has problems that require resolution, which in itself can be cathartic, and in the development of a care plan to manage this risk". The Panel have seen no evidence or documentation for any risk conferences after 03 August 18.	[redacted]
1.4.368 AGAI 110, para 15 directs units to immediately report an incident of DSH to the RMP SIB. There is no evidence that this occurred.	[redacted]
1.4.369 AGAI 110, para 20 suggests "in some cases, it might also be appropriate for the OC or the UWO to "sound out" colleagues, friends or family to try and determine the individuals state of mind and propensity to self-harm or attempt suicide." there was no evidence to suggest this occurred. A limited investigation took place after the DSH (TOR 1), the SP did not phone home and her CoC did	[redacted]

not ensure she had done so. Witness 30 was advised they "should call in the next 24 hours" but the SPs family were never informed or "sounded out".	
1.4.370 Witness 35 explained that access to VRM and the CAP was not possible for New college hierarchy once the SP started the intermediate term in September 2018 because "I don't even know if they had access rights (to) or they were- on this system". As Witness 35 also managed the rehabilitation platoon (Lucknow) they had access to VRM via the Wounded, Injured, Sick Management Information System (WISMIS). The CoC did not have access to this system and therefore could not read the VRM or CAP.	[redacted]
Summary **1.4.371** AGAI 110 was not adhered to or effectively consulted in managing the SP, Witness 17 testimony was an important factor in assisting the Panel at arriving at this conclusion. Of relevance was the fact that most of the CoC were unaware of the AGAI, untrained in its application and did not take it upon themselves in positions of responsibility to enhance their professional knowledge even after the RE visit in July 2018.	
1.4.372 This resulted in inadequacies at all levels, deficiencies in understanding and ultimately the non-implementation of supporting actions that were required, in addition, the specialist support that would have been available to the SP, was not provided. Those who had been trained and experienced in AGAI 110 offered little guidance or assistance and internal trackers were favoured over the VRM and CAP. AGAI 110 stated the following: "Individuals who have self-harmed are between 60 and 100 times more likely to commit suicide within 12 months of the event than those who have not". This unfortunate statistic and its impact were clearly not understood by all elements of the CoC when dealing with the SP. **1.4.373** The lack of diligence to adhere to the policy and implement the requirements of AGAI 110 ultimately contributed to the SPs care management being of an unacceptable level. The policy was available and straight forward to understand; it was not difficult to interpret or comprehend. The Panel having considered all the evidence believe that it was effectively only given cursory attention and that the over reliance upon the simplistic risk registers contributed to an unacceptable level of care to the SP.	[redacted]

SECTION 3 ANALYSIS OF FACTORS – TOR 3C

Consideration of Unit Health Committee activity and subsequent actions in relation to the Service Person, concentrating on the application and management of her Care Action Plan.

1.4.374 AGAI 57 para 58 and 59 (September 2017 version was in date at the time) explained that Unit Health Committees (UHCs) are mandatory, they are to be ran monthly (part 2), there are no exceptions to this. AGAI 57 Para 068 states, Health Committees at Phase 1 and 2 Training establishments must focus on both the permanent staff and recruit / trainee populations. This was not the case at RMAS. Unit Health committees (UHC) were for permanent staff only. No specific UHCs were convened for OCdts.	[redacted]
Monthly Welfare Meetings **1.4.375** Witness 36 explained that the monthly Academy level meetings to discuss OCdt welfare were their UHC. However, the wider audience required to attend a UHC were not invited to attend the welfare meetings. Witness 40 explained that they weren't asked to attend, and Witness 45 also explained that they weren't invited to give DCMH's perspective on OCdts. Witness 36 explained that they felt that it was the CoC responsibility to ensure that the required action points identified at such meetings were enacted e.g. Padres required to engage, referrals to CABS, follow up with DCMH.	[redacted]
1.4.376 OCdts are not individually discussed at a higher level or outside of RMAS trackers. Witness 32, a member of the CoC, explained that the UHCs didn't include OCdts but they were unsure as to why this was the case.	[redacted]
1.4.377 Witness 17 has considerable experience in AGAI 110 and explained the importance of running the UHC's in order to monitor individuals on the VRM and their CAP. They felt, in comparison to other units and Basic training establishments, RMAS "barely used" the VRM. The Panel are of the opinion that RMAS favoured their own welfare procedures over those specified by policy.	[redacted]
Impact of cancelled Welfare Meeting in July 2018 **1.4.378** In July 2018 the Academy level monthly welfare meeting, that would have considered the SPs case, was cancelled. The panel believe that the consequences of this are as follows; a. The SPs two further appointments at DCMH were not brought into wider circle of knowledge.	[redacted]

b. The investigation into the actual events at the RE visit was allowed to go uncompleted. c. The investigation findings did not feed into the DCMH assessments via the medical Chain. d. The importance with which Witness 45 placed upon the SP abstaining from alcohol in the future did not filter into the monthly meetings for wider distribution and understanding.	
1.4.379 Witness 28 had made clear their concerns about alcohol and its negative impact upon the SP. The missed meeting in July 18 was an opportunity for this specific information regarding the SP and her relationship with alcohol to be briefed to the CoC; ultimately this important knowledge concerning alcohol seems from the Panel's perspective not to have triggered an effective response after the further incident in Normandy in November 2018 and again in February 2019 both of which involved excessive consumption of alcohol. The missed meeting in July 2018 also had the effect of not highlighting to a wider audience that a VRM risk conference had taken place, and that a CAP was in place which had specific requirements for both the PI Staff and the Padres. In addition, the SP was not recorded on the Risk Register until 14 September 2018.	[redacted]
Management of the Service Person's Care Action Plan **1.4.380** The SPs management after the RE visit should have been based upon the requirements of the CAP to "Monitor" her, and the guidance laid out in the welfare register log which stated "[the SP] is being monitored closely by PI staff and is now tee total". These were specific actions required by members of the CoC, when questioned about these such requirements the Panel were informed by Witness 39 "I can't recall any care action plan".	[redacted]
1.4.381 Witness 20 explained that they "didn't fully understand what a care action plan was on the VRM nor who a CAP lead may be".	[redacted]
1.4.382 Witness 23 outlined that they didn't know what the VRM was and that they didn't recall being asked to monitor her and in addition stated, "I don't remember monitoring her".	[redacted]
1.4.383 The only individual who confirmed an understanding of what was required was Witness 33 who stated they were "content it was a closer watching brief on her".	[redacted]
Implementation of the CAP requirements **1.4.384** The Panel are therefore of the opinion that, albeit the middle management of the CoC, may have considered that the actions discussed at the monthly and weekly meetings were being delivered it is now apparent that this was not the case, the	

individuals required to provide this monitoring function were not specifically instructed to do so and not given any metric or timeline to report against. There was no assurance or audit trail to ensure the CAP actions were being adhered to. The weekly and monthly reports appear to be cut and pasted with no updates or meaningful additions, assessments also appear to be based upon performance and progression through the training events rather than a whole person assessment of the SP.	
1.4.385 AGAI 110, para 22 c states "all those who are involved in implementing the plan and providing support are to be directed to read the relevant CAP, take any necessary action arising from risk conferences or other assessments and record the results as appropriate". The CAP names the Pl Comd, Pl CSgt and Padre as personnel required to "monitor" the SP. None of these staff members had training in VRM and none were aware they had been named on the CAP to provide this support. None of them were directed to read or had access to the CAP.	[redacted]
1.4.386 OCdts are considered at weekly Coy risk/welfare meeting. This feeds into the weekly College welfare/risk meeting, which feeds into the monthly Academy level welfare/risk meeting. The number of different meetings and variety may have caused confusion. Meetings appear to have been used as an inform process rather than directing action. The assurance actions after such meetings were not recorded and the Panel have seen no evidence to prove that an action log was used with results being followed up and recorded. The Panel believe that basic accountability measures were not implemented for the SPs case.	
1.4.387 Witness 31 explained that there was no UHC for Cadets other than those in Lucknow (rehabilitation) Platoon and that the Lucknow Platoon UHC was not official. The Panel are of the opinion that the variance in the approach to OCdts management creates confusion. This is worthy of note, as OCdts listed on the risk registers are in theory considered by the College and Academy CoC, whereas those in Lucknow are considered at UHCs which had a much wider remit, with additional parties attending.	[redacted]
Assurance actions by the CoC **1.4.388** There was no assurance of the Adjts to ensure that they were overseeing the CAP in accordance with Policy requirements. The Adjt, who created the CAP, admitted "not really knowing how it was to be used and that the CAP is hardly worth the paper it was written on."	[redacted]
1.4.389 AGAI 110 VRM para 22a. States the individual should sign their CAP (and agree to the details of their CAP being shared where	[redacted]

necessary) and the CAP should be explained to the SP. The Panel have seen no evidence to suggest the SP was aware she had a CAP. She did not sign it. The original owner of the CAP did not think they had shown the SP the CAP.	
1.4.390 Witness 17 explained the importance of an individual signing their CAP in order to consent to other agencies to become involved.	[redacted]
Handover between Colleges and transfer of the CAP **1.4.391** The handover meeting on 03 August 2018, is documented on the CAP as a formal review. This review did not include any medical staff, some staff present at the meeting remained unaware of the CAP and the details enclosed. The evidence indicates to the Panel and Witnesses have confirmed that the SP was discussed at the handover meeting, but the precise details and requirement of the CAP were not adequately shared with staff nominated to provide the additional support and monitoring functions.	[redacted]
1.4.392 Witness 27 was present at the handover meeting on 03 August 2018, they explained they didn't really know what a VRM or CAP was, it wasn't discussed during the handover meeting which led to them being unaware that the VRM or CAP existed.	[redacted]
1.4.393 Following the Handover meeting on 03 August 2018, there are no subsequent entries onto the CAP. The lack of thorough handover along with the lack of understanding of how the CAP should have been used resulted in an ineffective unused document. Witness 17 explained that a CAP should be maintained as a full chronology of events: "So, it becomes a full, chronological version of events throughout the whole time that the individual is on the register. That includes any informal discussions with the individual, formal discussions, formal reviews, any input provided by other parties within the support and care pathways and then any actions and measures they put in place to protect the individual." This perspective is confirmed by the policy which outlined the CAP management requirements (AGAI 110).	[redacted]
1.4.394 The lack of visibility by the New College CoC resulted in the CAP being handed over to the Welfare department on 23 August 2018. No further action was taken with regards to the CAP from this point onwards. The CAP was not updated, no action taken or monitored, no risk conferences occurred, and no due diligence was applied to its management.	[redacted]

1.4.395 Witness 38 explained they had access problems due to account permissions, which resulted in them not being able to read all of the CAP. From July 2018- February 2019 this IT error was not resolved, and the Panel have seen no evidence of the access issue being reported.	[redacted]
1.4.396 In addition to AGAI 110, JSP 822, Defence direction for training and Education (March 2017) Chapter 2.3 Para 9. refers to the requirement for systems to be in place "to identify and protect those recruits or trainees who are particularly vulnerable to harassment, bullying or discrimination; those who have personal, educational or welfare problems that could affect their performance or health; and those potentially at risk of radicalisation, self-harm or suicide. Such individuals must be monitored using an 'At Risk Register' and clear direction on the actions to be taken must be given both to the permanent staff (military and civilian) and to the recruits/trainees within the establishment." The Panel have seen little evidence of any clear direction being communicated to the lower levels of the CoC. (Para 1.4.366-368).	[redacted]
Summary **1.4.397** The omission of policy compliant UHC meetings to consider the SPs case resulted in a lack of oversight of her care and in addition was a missed opportunity to identify the lapsed status of the CAP. There was also a lack of information sharing in a multi-agency forum which ultimately resulted in a CAP that was completed as a paperwork exercise rather than an effective tool to assist and support the SP at RMAS.	
1.4.398 The final key observations the Panel identified were that the majority of personnel named in the CAP were unaware of its' details and that there was a requirement for ongoing input and assurance. The CAP was not maintained in a manner that would have been policy compliant, there was almost no assurance or due diligence paid to its existence.	

SECTION 3 ANALYSIS OF FACTORS – TOR 3D

Determine the extent to which policies and procedures have changed since February 2019 and the extent to which any changes have been implemented within RMAS, at other training establishments and within the wider Army to prevent any reoccurrence of incidents of this type.

AGAI 110 Policy Update 2020

1.4.399 AGAI 110, Army Vulnerable Risk Management Policy, has been comprehensively rewritten as at August 2020. Witness 17 explained the policy in date at the time of the SPs death was the 2012 policy, updated in 2014. The updated Policy gives further detail on completing a CAP, expands on direction from the previous policy and explains the responsibility of the CO within VRM. Witness 17 explained, CO's will be more aware of their responsibilities, from the direction in the new policy.

WITNESS 17: If I am perfectly honest there isn't a measure of assurance for an individual CAP, although what we've tried to do in the new policy, or the updated policy, is make sure that the CO is very much aware that it's [their] responsibility, to ensure that those individuals under their Chain of Command are being managed properly and that the policy is being complied with. In addition, we have the G1 inspections which look at various issues. One of the key factors that if a G1 inspection had been conducted at Sandhurst, from the last time the CAP was entered, which was 23 July [2018], what it would have shown is the screen was red and that would have shown that the CAP was out of date. That should have immediately raised flags for the OC who had access at the time, the Unit VRM Lead and the CAP Lead to ensure that the CAP was up to date.

[redacted]

1.4.400 AGAI 57, Health Committees, was updated in April 2020, (previous version September 17). Witness 17 explained some of the updates

WITNESS 17: Again, I think it links very much with the Commanding Officer and the role that they carry out and the fact that under the new or updated AGAI 57, they must carry out a Commander's review every month of people on VRMIS. I would expect the CO to be fully engaged in that process and should be able, using I think the word is military judgment, to be able to see whether or not the CAPs to which [they are] ultimately responsible for are being completed correctly in accordance with the updated policy. The policy has - basically doubled in size to try to give as much additional guidance as we possibly can. It's very difficult to say what looks good and what doesn't.

[redacted]

RMAS Changes

1.4.401 RMAS have made significant changes to Policy and procedures. Including staff selection, amendments to staff training, running multi-disciplinary welfare meetings and requesting a climate assessment. In addition, there has been a significant investment in creating and staffing an OCdt welfare facility. The excerpts of which are detailed below. [redacted]

1.4.402 RMAS have made amendments to the following policies (evidence L10);

a. **Station Alcohol Action Plan**.

Updated on 24 February 20 (previous policy dated 20 July 2018). The Station Alcohol Policy has been significantly tightened to clearly define where control of events involving alcohol lies. In addition, the policy also specifies the zero-tolerance approach RMAS has towards Permanent Staff drinking with or becoming over familiar with OCdts. Notably, the Charity Dinner night has been removed from the training programme.

b. **Supervisory Care Directive**.

Updated on 06 August 2020 (previous policy dated 30 October 2018). The directive has been expanded to give clear guidance on social functions, risk assessments and the resources available to staff.

c. **Serious Incident Reporting Directive**.

Updated on 14 October 2020 (previous policy dated October 2015). The directive now specifies that incidents involving alcohol or serious welfare considerations were to be reported to RMAS Gp HQ via a formal INCREP.

d. **Site Welfare Policy**.

Updated on 29 June 2020 (previous policy dated 06 September 2019). Clearly stating the welfare provision for OCdts and military staff, with RMAS specific guidance on the management of VRM personnel. Routinely, the Colleges and Sandhurst Support Unit (SSU) run their Part One welfare meeting which then feeds into the Academy level Part Two monthly welfare meeting. At the Part Two (chaired by the Comd, with College Comds, CO SSU, SMO, Consultant Psychiatrist, Padres, Welfare Staff, SO2 G1 and Academy Sergeant Major), policy and general themes are discussed and in addition, College Comds and CO SSU bring their risk registers to the Comd and highlight those staff and OCdts who they deem to be of concern. [redacted]

e. TRiM policy.

Has been highlighted by RMAS as an Area for improvement, RMAS currently has no unit TRiM policy.

f. Handover/Takeover Policy for OCdts.

Currently the handover of OCdts from Old College to New College is not supported by any RMAS policy, nor are there any formal records. From December 20, Records of Decisions are taken as part of every Handover/Takeover meeting to ensure a formal record is captured.

1.4.403 RMAS have also made the following changes to procedures;

a. Revision of Pl Comd Job Specification

In order to drive down risk and raise the quality bar, a new boarding process has been adopted by Army Personnel Centre (APC). This will focus more on Knowledge, Skills, Experience (KSE), behaviours, leadership ability and soft skills. As of October 2020, a revised Job Specification has been agreed and submitted to APC Glasgow to inform the boarding and selection process.

b. Comd Status of College Commanders.

The positions of Old and New College Commanders are currently staff appointments. Comd Home Command (HC) asked No 4 Bd to review this, in October 2020, given Commanders Old and New College's responsibilities are not dissimilar to those of COs at Initial Training Centre (ITC) Catterick and Initial Training Group (ITG) Pirbright. This lack of Command status has resulted in college Commanders not having the appropriate level of authority to deal with administrative and disciplinary action for their respective college staff. No 4 Bd considered this issue on 03 December 2020 and did not support the request for Command earning status for the Old and New College appointments. Comd RMAS Gp will discuss further with the new GOC ARITC re next steps.

[redacted]

c. Selection of Assistant Instructors (AI) (CSgts & SSgts).

From February 2021, when the next Cadre forms-up, AIs will also be formally assessed on both their character and emotional intelligence. This process will include personality assessments, soft skills training and an understanding of the 'Generation Z' perspective and expectations. This is expected to lead to AIs who can empathise more with those OCdts in their charge and cope better with the

demands of instructing young men and women of a different generation to themselves.

d. Sandhurst Staff Context Course (SSCC).

To ensure commonality of knowledge, and an improved focus on training staff, Mental Resilience Training has been included in the content of the SSCC which is run for all new RMAS staff three times a year. An examination of the training regime revealed that there was not a single point of reference for Sandhurst-specific Vulnerability Risk Management Information System (VRMIS) issues; as such, an introduction to VRMIS is now in the SSCC programme. VRMIS refresher training was conducted in the immediate aftermath of the tragic incident in February 2019 and is now refreshed termly at the G1 meetings with the College and SSU Adjts. Additionally, College Adjutants now focus more on the content and actions of Care Action Plans (CAPs) on the handover of OCdts from Old College to New College. The CAPs will remain an Adjutant led responsibility with input from Subject Matter Experts (SMEs); CAPs will not be handed over beyond Adjutants without the authority of SO2 G1 in Ac HQ.

e. Staff Training Half-Day Package.

RMAS Gp has implemented an annual half day training package in addition to the revised content on the AI Cadre, the SSCC and the Day Zero briefings. The aim of the training package is to give cadet-facing staff the tools for dealing with OCdts in vulnerable situations and/or those who have personal issues that affect performance on the commissioning course. This training commenced in October 2020 and consisted of Ethical Leadership, Persons in Positions of Trust (PIPOT) (delivered by the civilian Police), effective Coaching and role-play training.

f. Operation SMART.

(Op SMART is the name given to the Army's Mental Resilience Training Programme) RMAS continues to conduct Op SMART training, with the most recent event in February 2020; this is now an annual event held in the Spring Term.

g. G1 brief to all OF3-5.

To reinforce the focus on welfare matters, all RMAS OF3-5 are briefed on arrival into post to highlight the importance of empathy and welfare.

h. Complaints.

The ability for OCdts to be able to make a complaint, safe in the knowledge that it will be actioned fairly, and, if needs be, anonymously, has been reviewed. Previously, it was briefed very early in the Junior Term; however, it became apparent on validations that OCdts didn't fully understand the brief. It now is repeated at the beginning of each term in the form of a formal lecture. The new SO2 Assurance, who is outside the college Chain of Command, now briefs on complaints and course validation. This has increased OCdts' awareness of the complaints process and reinforces the options they all have to comment on an anonymous validation report completed twice a term. An additional route for making complaints is the anonymous email mailbox which is monitored by RMAS Gp HQ staff.

i. Instructor Validations and Peer Review.

A system has now been implemented to see best practice spread across the training teams, and assistance offered to instructors who may require additional training. A steady feed of information is gathered via instructor observations, internal validations, instructor peer reviews and the Chain of Command. In instances where there are negative issues, the Chain of Command is informed, remedial training offered, and reports conducted. And where there are positive cases, the Coaching and Advisory Team (CAT) will observe the training delivery and best practice reports promulgated. The peer review tool was revised in 2019 and trialled in the May 2019 term, it has been used ever since. It now seeks input not only from the individual OCdt, but from the platoon staff and the OCdt's peers in their 8-person section, leading to a more comprehensive understanding of the individual strengths and areas for improvement from their own, their peer and their staff's perspectives.

j. Multi-Disciplinary Team Meetings (MDTM).

RMAS has a wide array of personnel in G1 roles that form part of the welfare component that supports staff and OCdts. There is often cross-over between stakeholders and formalised meetings, whereby specific issues or topics are discussed. However, it has been identified that this approach can reinforce stovepipes rather than develop a holistic approach whereby stakeholders can add value to each other's work, ultimately for the benefit of OCdts and staff whom we seek to support. In order to address this, RMAS has initiated MDTM to bring G1 SMEs together for the purpose of sharing knowledge, ideas and best practice on a monthly basis. Staffed by those at the coalface, MDTM actions are passed to the Comd as they inform and augment the monthly welfare meetings chaired by Comd RMAS Gp (see next para).

k. Welfare Meetings.

Comd RMAS Gp chairs monthly welfare meetings where those OCdts and staff who are experiencing some form of welfare stress are discussed. College Commanders and CO SSU attend but, importantly so do a variety of SMEs - e.g. welfare staff, medical staff, G1 staff, Padres etc. These meetings are now preceded by the multi-disciplinary team meetings (see previous para).

l. Creation of an OCdt-focused Welfare Facility (known as 'The Huddle') and enhanced OCdt Focused Staffing levels.

In July 2020, following a review of welfare structures, RMAS submitted a business case to enhance the strength of the welfare team. The business case was supported by both HC and ARITC. Three new dedicated members are currently being recruited: 2 x Welfare Warrant Officers and 1 x Civilian Performance Coach, all of whom will be focused solely on OCdts. This will ease the broader welfare burden, provide a dedicated OCdt focus and a dedicated families' focus, with the Welfare Officer retaining overall responsibility of this enhanced team. The OCdt-facing Welfare Warrant Officers and the Performance Coach will be based in the new Welfare hub - known as the Huddle - situated in the centre of the Academy. About £90K is being spent on infrastructure, fixtures and fittings to provide a first-class welfare facility which will be a haven for OCdts; permanent staff will not be permitted to enter. Confidential, soundproofed rooms will offer the welfare staff and OCdts the ability to deal with issues in a private, welcoming and secure environment. The Huddle is expected to be fully staffed by April 2021.

m. OCdt Development Forums.

In October 20, RMAS initiated 2 x OCdt Development Forums (1 x Male and 1 x Female Forum) to provide OCdts with another opportunity to discuss key issues and raise any concerns direct to academy staff. Forums will now take place every term with topics being decided by OCdts voting via a QR code. The forums also provide an opportunity for SO2 Assurance to share directly with OCdts the output of the various surveys and forums to ensure that OCdts receive feedback.

n. Pre-visit letter to hosting units.

It was identified that communication between HQ RMAS Gp and the units being visited was minimal. There were no restrictions imposed on activities undertaken or any expectation of units to look after OCdts in an appropriate manner. As a result, Comd RMAS Gp now

writes to COs each term impressing on them the need to ensure that OCdts are looked after and that behaviour is always appropriate. **o. Approach to Discharging Unsuitable OCdts**. Following the SP death RMAS have altered the approach taken towards dealing with self-harm incidents and now consider such matters at review boards with the inclusion of medical professionals to advise the CoC on the management of OCdts.	
1.4.403 Following these numerous positive changes to policy and procedure at RMAS there is now a requirement by ARITC to ensure the changes are enacted, assured and audited in the future.	
1.4.404 The New College Directive, updated 27 June 2020, includes direction on WhatsApp messaging from staff specifically that "Over, or inappropriate, use can lead to significant problems with information overload and the subsequent detrimental mental health effect. Less for emergencies, WhatsApp is not to be used within the College between the hours of 1900 – 0800 and 1230 – 1330 by permanent staff. Officer Cadets should not communicate with their staff within these hours". The Panel are of the opinion that this direction would reduce the opportunity for over familiarity and allows respite between staff and OCdts.	[redacted]
1.4.405 Noting the passage of time since the panel received the submission (mentioned in paras 402-403), from RMAS Gp HQ, the panel requested a final update in respect of this TOR in May 2022. The full response is included at this point as it provides the evidence to prove that there have been significant improvements at RMAS in the intervening period.	[redacted]
1.4.406 Introduction. In Jan 21 the then 1* Commander Sandhurst Group provided an update on a number of recommendations that APSG had provided relating to policy, training and resourcing following the death of [the SP] at RMAS in Feb 19. Due to the passage of time the SI President has requested a further and final written submission from RMAS to be incorporated into the SI report prior to its further circulation and release. RMAS are grateful for this opportunity to do so.	[redacted]
1.4.407 Context. Since the production of the last update an adjustment to the command and control arrangements at RMAS was directed by ECAB. In order to ensure the required resources, priority and 2* leadership oversight the Academy (and UOTCs) have been realigned back under the 2* Commandant RMAS1 (directly subordinate to CHC who provides 3* oversight). Home Command (HC) and HQ RMAS have now amended the structure of RMAS in order to better empower the key commanders and staff; the Commandant, OF5 leads (COS, Col Trg & Comd OTC) and the	[redacted]

College Commanders/CO SSU. This structure ensures that the chain of command is delegated appropriately from the Commandant to empowered subordinates. From an external assurance perspective RMAS has also received the findings of two Level 3 Climate Assessments (L3CA) undertaken in Nov 20 and Nov 21.	[redacted]
1.4.408 Command Climate and Culture. Since the C2 realignment in the spring of 2021 the Commandant's intent has been to deliver a coherent and shared vision/understanding2 of what RMAS is about, under a unified command. This vision is personally reinforced by the Commandant at the beginning of each term. It champions the requirement for servant leadership at all ranks within the RMAS Group starting at the University Officer Training Corps through to those Senior Officers attending the Army Generalship programme and is underpinned by the requirement for role model exemplars of the Army's values and standards. Significant efforts have also been made in developing a culture of transparency, where staff understand that they operate within a safe to fail environment, where mistakes are resolved rather than hidden and where the focus is upon earning rather than protecting reputation. This change of culture can be evidenced within the most recent L3CA.	[redacted]
1.4.409 Intent. Whilst the majority of the detail provided within the original update in Jan 21 remains extant this update serves to provide further detail on actions that have been completed in order to ensure that the appropriate levels of welfare, duty of care, supervisory care and a safe training environment are being provided to both OCdts and PS, and a summary of ongoing actions focusing both on developing the organisational culture of RMAS and wider reviews on how RMAS operates and delivers its outputs.	[redacted]
1.4.410 Actions Completed. The following additional actions have been completed since Jan 21: a. **Governance and delegation of Discipline responsibilities**. (1) Assurance of all G1 discipline and administrative action cases is led by SO3 G1 Disc on behalf of DCOS. Higher level assurance to ensure that key performance indicators provided by relevant policy are met is also provided on a quarterly basis by HQ HC Pers Branch, although there are occasions where these may be exceeded due to Service/Civ Pol investigations or awaiting decisions by the SPA. (2) Commanding Officer Sandhurst Support Unit (SSU) was previously the only OF4 post in the Academy with command status, which limited the ability of Comd OC and NC to exercise command over	[redacted]

their PS. As a result, Comd OC and NC have been formally delegated the authority to deal with disciplinary and administrative action for their respective College PS and OCdts. This also aligns with their pre-existing MS responsibilities. Under the revised C2 structure the MS and disciplinary chains of command for all Permanent Staff (PS) employed within the Academy now sits with the appropriate CoC. College Commanders for those members of PS employed in OCdt facing training delivery roles, and CO Sandhurst Support Unit for those staff providing a supporting function to training delivery and wider HQ RMAS/Academy HQ outputs.

(3) There is demonstrable evidence of an improved culture that where matters are being raised they are being investigated in an appropriate manner, and where required, are being referred to the relevant authorities (specifically Service Police).

b. **Selection and training of Permanent Staff**. The high standards RMAS expects from its OCdts starts with the example set by the PS, therefore how we select and prepare them has been reviewed.

(1) **Comd Status of College Commanders**. On 2 Dec 21 the No 4 board approved that the role of Commander Old College would become command earning. This will be effective from the Jun 22 command board where the next incumbent will be selected. This change is designed to result in more consistently higher-quality individuals being selected, who will also approach the role with a 'command' rather than 'staff' mentality. The Commander New College post will remain as a post-command appointment, which should also result in an individual of command quality, with the additional experience of having already been a CO. This is reflective of the size, span of responsibility and experience required to deliver against the objectives accorded to that post.

(2) **Assistant Instructors**. The content of the RMAS SNCO Instructor Cadre was revised in Feb 21 to provide a stronger focus on ethos, values and standards and assessment of an individual candidate's character and emotional intelligence. This change in approach is paying dividends, as evidenced within feedback provided from InVAL and both L3CA. The second iteration of the revamped course was delivered successfully in Feb/Mar 22 with those selected due to

arrive from the start of term in Sep 22. By Sep 22 therefore, all the OR7 Assistant Instructors will have been selected through this new approach.

(3) **Pl and Coy Comds**. Prior to autumn 2021, Platoon and Company Commanders were selected by Corps Colonels against a plot that allocated individual slots to specific regiments. As part of this lessons process, it was decided that these roles would be boarded by APC using the process used for other appointments across the Army. It was also agreed that the requirement (as articulated in the job spec) would focus on the appropriate Knowledge, Skills, Experience and Behaviours (KSE(B)), leadership ability and soft skills (emotional intelligence) required to be an instructor of young people; rather than to focus on DCC competence and 'quality'. In the summer of 2021 therefore revised Job Specs for Platoon and Company Commanders were agreed and submitted to APC to inform the separate boarding and selection processes for these appointments. Separate boards were undertaken in Oct and Nov 21 utilising this new grading methodology. Those arriving at RMAS in the spring/summer of 2022 were selected by the No 5 Board using this process. Whilst the requirement to maintain an element of cap badge balance is still a factor, it is no longer the driving factor and to date has not been a decisive factor in any selections.

c. **RMAS Group & Sandhurst Station Alcohol Policy**. The original Station Alcohol Policy was published on 20 Jul 18 and updated in Sep 19, and Jul 21[5]. Most recently it was further revised on 9 May 22 and now more clearly defines, directs and guides the approach to be taken towards the consumption of alcohol across RMAS Group, Sandhurst Station, and at functions/events outside the wire involving OCdts. The previous update provided to APSG in Jan 21 indicated that RMAS had a zero-tolerance approach towards PS drinking with OCdts. Unfortunately the detail provided at the time was neither reflective of the extant (Sep 19) nor the current (May 22) RMAS alcohol policies, but may have been submitted under the understanding that no functions were being delivered as a result of COVID-19 FHP measures. The revised (May 22) alcohol policy directs that RMAS PS are not allowed to consume alcohol with OCdts at any other time outside of the formal events listed within the alcohol policy, unless specific authorisation has been provided by the respective College Comd or CO SSU. It should be noted,

[5] There was reference to a previous update on 24 Feb 20, however it has not be possible to track this version down from an RMAS Information Management perspective.

however, that the list of approved functions is comprehensive and covers most of the directed activities that involve alcohol during the course. The latest edition of the Alcohol Policy also stipulates the following detail:

(1) Zero-tolerance approach RMAS has towards PS being drunk with or becoming over familiar with OCdts. This is to ensure that they are setting a good example of professional behaviour, and to protect them against the risk of poor behaviour when their judgement is impaired.

(2) PS are not allowed to take alcohol into OCdts accommodation.

(3) OCdts are not allowed to have alcohol in their own accommodation (repeated in the OCdt handbook).

(4) All events that include the consumption of alcohol require as a minimum a risk assessment, Main Event List (MEL) and an application to hold a function to be completed by the event organiser.

(5) Authorising Officers must be content that there are sufficient mitigation measures in place to ensure that all attendees, including guests, are fit for work the following day and that there are proactive measures in place (including PS and OCdts as non-drinking SHARKWATCH) to reduce the potential for excessive alcohol consumption.

(6) Commanding Officers and College Commanders are to conduct termly briefings (in the first week of each term) to educate PS and OCdts on the dangers of alcohol abuse and on the content of the policy.

(7) The responsibility for authorising functions in now more logically delegated, with the Coll Comds responsible for their own events, rather than CO SSU, who was not in a position to make informed risk judgements nor to ensure that risk mitigation was enacted.

d. **Charity Dinner Event**. The previous update to APSG also indicated that the Charity Dinner event had been removed from the commissioning course programme. It is assessed that this detail may have been included on the understanding that no external functions had been delivered in the previous 10 months as a result of the COVID-19 FHP restrictions. The Regular Commission Course programme does, however, deliver a Dinner night per term and these

have recommenced post-COVID. Whilst these events are not directly assessed as specific training activity they are linked to a training objective and key learning points surrounding behaviours and leadership. For the Intermediate term the Regimental Dinner has historically been substituted for a Charity Dinner event which has continued to be delivered since the relaxation of COVID-19 FHP restrictions. These events are also an excellent opportunity for OCdts to raise funds for Armed Forces charities and (more recently) a number of Afghan OCdts under the Afghan Relocation Assistance Programme (ARAP).

e. **Effective Welfare Provision**. The improvement in the Welfare provision is one of the most visible changes at RMAS since early 2021.

(1) **UWWOs**. Two new FTRS Welfare Warrant Officers were recruited wef Apr 21; both of whom are focused solely on dedicated welfare provision to OCdts in Old/New College. This has enabled the Academy Welfare Officer to focus their attention directly to the provision of wider welfare support to members of PS and their families.

(2) **WRVS**. The welfare team is also now supported by two dedicated WRVS staff, an uplift of an additional person.

(3) **UWO**. A new C2 Academy Welfare Officer was recruited in Jan 22, filling a gap that had been held since Jul 21. They are now providing a greater level of leadership and coherence of the welfare provision across the Academy.

(4) **Huddle**. The establishment of the 'Huddle' provides the OCdts with the opportunity to engage directly with welfare staff in a safe environment.

(5) **Psychological Support Officer**. In Dec 21 the Army Civilian Workforce Committee provided agreement for the establishment of a C1 Psychological Support Officer post on the RMAS 8005. The incumbent will provide direct support to RMAS Gp PS in enabling their OCdts to fully achieve their potential to meet the standards of the various Commissioning Courses. The post is currently being advertised for external recruitment. It is assessed that it may be difficult to attract significant interest due to the renumeration package being offered for the post when

factored against the high cost of living near Camberley.

f. The increase in access to welfare provision, has naturally been reflected by an increase in the number of cases being presented particularly from within the training audience as they feel more confident in coming forward to seek support. Whilst this increased actively must be seen positively some of the cases being presented are of an extremely complicated nature. Anecdotal evidence suggests that OCdts are reluctant to highlight any ongoing issues throughout the recruitment process to RMAS. If OCdts arrive with ongoing welfare concerns these can play significantly on their mental resilience as they simultaneously try to cope with the demands and scrutiny placed upon them through the rigours of the Commissioning Course (Regular or Reserve). At any one time the College Welfare Warrant Officers can be dealing with as many as twenty cases which in itself is having a direct effect on their own individual resilience in order to deliver their outputs.

g. **Mental Resilience Training (MRT)**. Whilst MRT is not specifically included within the Reg CC or CCS training syllabus at this time, an MRT training package is delivered by the ARITC Staff Leadership School (ASLS) as part of Module B of the Sandhurst Staff Context Course (SSCC) attended to Pl Comds and Assistant Instructors. This course introduces MRT, provides oversight of the psychological skills and practical applications, enables course members to develop tailored action plans in order to deliver MRT and directs them to supporting materials, assurance and further courses for continued development.

h. **Staff Training**.

(1) A recent G1 study day specifically relating to the delivery of discipline has been provided by APSG to the key G1 stakeholders at Gp HQ, Academy, College and UOTC level.

(2) Day Zero and SSCC Pers presentations are now being utilised to cover key topics relating to the provision of effective supervisory/duty of care to both PS and OCdts. The key challenge from an RMAS perspective is to provide continued assurance that the the topics being covered, coupled with a thorough understanding of relevant SOIs (Discipline, VRM, TRiM, Welfare etc) is being applied by PS whilst also providing opportunities throughout the Commissioning Course for OCdts to be provided with a similar level of

understanding. A concerted effort is being made to address this issue, including the intent to undertake regular G1 study periods. Recent presentations to PS have specifically covered:

(a) The requirement to thoroughly investigate every incident of self-harm, including notification to the RMP SIB.

(b) The requirement to inform the RMAS Medical facility, as a matter of urgency, of any identified change in the assessed vulnerability of OCdts.

(c) Recently issued Defence direction on the zero tolerance approach to sexual offences and sexual relationships between instructors and trainees.

(d) Direction on the use of closed messaging applications and social media.

(e) Application of the RMAS Group Alcohol policy.

(f) Direction that the appropriate welfare support is provided to both PS and OCdts who might be subject to an ongoing disciplinary or administrative action proceedings. This also includes the requirement to consider whether individuals ought to be placed on VRM registers.

1.4.411 Ongoing Actions. The following additional actions focusing both on developing the organisational culture of RMAS and wider reviews on how RMAS operates and delivers its outputs are currently being undertaken:

[redacted]

[redacted]

a. **Organisational Culture Strategy**. Whilst it is understood that the L3CA in Nov 20 was undertaken against the backdrop of the enduring COVID-19 pandemic the evidence obtained with regards to the lived experience of the PS and OCdts provided for uncomfortable reading. Significant steps have since been undertaken to improve the organisational culture within RMAS Gp[6]. The Nov 21 L3CA demonstrates improvement and that RMAS remains on an upwards trajectory. However, as a learning establishment

[6] Organisational Culture is about the way things are done (the processes and rules (written and unwritten) that influence individual and group behaviour and attitudes.

there will always be opportunities for further improvement and continual learning in order that RMAS can continue to deliver PS and OCdts to meet the Army's wider overall vision for organisational culture[7]. As such RMAS has produced a draft organisational culture strategy during the first term of 2022. The strategy endeavours to articulate what good will look like, and plots the path of cultural change from where RMAS are now to where we aspire to be in the future, that is an inclusive culture that provides psychological safety for all, underpinned by values and leadership. The strategy moves beyond a basic diversity and inclusion policy. It will be delivered through an incremental approach, resulting in the production of an action plan that will be designed to elicit long term improvement and will be subject to constant scrutiny and review. This action plan will also be used to help bring coherence to the delivery of regularly programmed focus groups (female, BAME, International).

b. **Organisational Culture Outcomes.** The draft strategy defines the key areas that RMAS seek to address derived from evidence obtained from key sources including climate assessments, Independent Advisory Panel report, INVAL/EXVAL, People Survey and the initial Army wide all stop Op TEAMWORK activity. Analysis of the evidence has highlighted five priority outcomes that RMAS must pursue in order to further improve its organisational culture. The first three relate to diversity and inclusion; the remaining two relate to inappropriate behaviours. All are critical to the effective delivery of #*Teamwork* within the RMAS community. An action plan to take forward measures to address the outcomes both from an immediate and enduring basis is now being developed. It is intended that both the strategy and action plan will be release NLT 30 Jun 22. The priority outcomes relate to:

(1) **Removing the barriers to female inclusion**. There are specific challenges with integrating female OCdts and staff into an organisation that is predominately male. The long-term solution is to increase female inflow, but a condition of doing that will be to improve the integration and lived experience of those who are already serving or in training.

(2) **Removing the barriers to the inclusion of those from different ethnicities or nationalities**. There are specific challenges with integrating OCdts and staff from other ethnicities or nationalities into an

[7] *"An inclusive values-based Army where all elements of the Whole Force share and live by a strong moral compass anchored in the Army's Values and Standards and the Civil Service Code so that they do the right things, act as role models, and inspire others to Be the Best to deliver operational capability".*

organisation that is predominately white. This includes international OCdts and minority ethnic UK OCdts. As with female inclusion, part of the long-term solution is to increase the visible diversity of the inflow, but again a condition of doing that will be to improve the integration and lived experience of those who are already serving or in training.

(3) **Removing the barriers to the integration of civilian and military personnel in the RMAS team**. Civilian staff are vital to the successful delivery of RMAS outputs – both civil servants and the contractor staff working within the HESTIA contract. In a military dominated culture inclusion and integration can be a risk.

(4) **Reducing misogynistic behaviour**. One specific challenge at RMAS is misogynistic behaviour towards female staff and OCdts. This is partly a consequence of the gender imbalance but may also reflect wider societal trends. Some of this behaviour may be unintentional, but even that has a negative impact on those on the receiving end.

(5) **Reducing poor behaviour resulting from alcohol misuse**. Alcohol misuse has been a contributing factor in most of the discipline and administrative cases that occur at RMAS. This issues is discussed in para 6.b.

c. **Alcohol Review**. As a Training Establishment, RMAS treads a fine line between reducing the impact of alcohol related behaviours, whilst at the same time acknowledging the benefits that communal alcohol consumption, in moderation, can bring. There must be a balance between the duty of care and the needs to educate sensible drinking behaviours recognising that RMAS reflects society and that when the OCdts become commissioned officers they will be able to affect change within the Field Army. Key to reducing poor behaviours and encouraging responsible drinking is 'leadership by example, education, appropriate duty of care, management oversight, holding to account and by optimising a culture of professionalism'[8]. RMAS has recently initiated a review which focuses on alcohol consumption of both OCdts and Staff, concentrating on their safety throughout the duration of the commissioning course. When considering options this review will take into account that society does not impose restrictions of personal consumption of alcohol and [redacted]

[8] HC Alcohol Directive 22.

balances this with the fact that RMAS is a training organisation, where the organisation is bound to provide a duty of care to its trainees.

d. **Welfare Review**. RMAS had hoped to be able to make use of any potential additional resource that might be made available through the wider Army Welfare Project. However the pilot, which incorporates the use of a contracted professional welfare practitioner will not start before Jan 23. Training establishments are currently out of scope with regard to structural changes, but may be supported as part of the contract.

e. **RMAS Futures Review**. A wider review team has been initiated wef 1 May 22 to look more widely at RMAS. The view is being led by the incoming Comdt (Brig (sel Maj Gen) Stenning), supported by a sprint team from the Army Advanced Development Programme (AADP). Some elements of the review will be undertaken in conjunction with the Basic Training Adaptation Programme (BTAP) lines of effort being led by ARITC. The review is designed to focus upon three specific areas that will have a direct effect on both the PS and OCdts with the Academy:

(1) **RMAS Operating Model Review**. This review will look at the extant span of command, outputs and responsibilities of the RMAS Group, and will generate evidence-based proposals for structural and procedural change. The intent is that it will better balance the breadth of responsibilities with the capacity of key commanders and staff **Timeline: ECAB Jul 22.**

(2) **Young Officer Training Review**. This review (in conjunction with BTAP LOE 1) will turn the revised Role Performance Statement (post Future Soldier) into a revised Regular Commissioning Course and Commissioning Course Short. It will also include a review into the teaching of D&I and UB. **Timeline: IOC Sep 23.**

(3) **Trainer Review**. This review (in conjunction with BTAP LOE 4) will enhance the selection, preparation and training of RMAS DS; both officers and SNCOs. This will be the continuation of the work explained above to improve the Assistant Instructor Cadre and the selection of Officer instructors. **Timeline: TBC.**

f. **Review Choice of Arm process**. The Choice of Arm process places significant stress on PS and OCdts, due to the time commitment and inherent pressure of the procedure. The current process has been subject to review by the Army Advance Development Programme (AADP) to determine whether changes can be made to make it a more efficient, effective and transparent process. This review is currently ongoing and is now subject to further engagement with Hd Army & Services and Corps Colonels. Any adjustments to the current process are not anticipated prior to Sep 22.	
1.4.412 There is a significant amount of work that has been undertaken to improve the command climate, organisational structure, and provision of welfare, duty of care, supervisory care and a safe training environment to both OCdts and PS not just within the Academy but more widely across RMAS Group. It is recognised that the majority of the military staff currently in post have changed over since the sad events that occurred in February 2019, though there are many amongst the civilian workforce who still remain. Whilst this note builds upon the work that has been achieved this is an enduring challenge and has to be driven by strong leadership at all levels. This and the previous update hopefully demonstrates RMAS' desire to continue to learn and adapt as an organisation and we remain grateful for the continued support provided by both APSG and the SI panel in seeking to address the significant number of recommendations that have arisen as part of the SI investigation	
Summary **1.4.413** The Panel acknowledge that a considerable amount of effort has been invested in updating, enacting and developing policies and procedures since February 2019. The revision of AGAI 110 now provides a clearer and more comprehensive handrail for Commanders across the Army to refer to when dealing with vulnerable SP. At RMAS, the "Huddle" along with the additional support staff should provide the welfare capability that the current OCdts at RMAS require and expect. The improvements to selection and greater investment in staff training should create a team of DS that are more readily equipped to deal with welfare situations.	[redacted]
1.4.414 The Panel have identified the fundamental fact that in 2018/19 the policy to effectively manage the SPs case existed. It is an unfortunate finding that the CoC at RMAS did not adhere to the policy or apply it in an effective and diligent manner. The panel believe that the shortfall in knowledge and understanding of the application of the policies was a significant contributory factor in the substandard management and support that the SP received. If the recent changes at RMAS are to be truly successful, then ARITC and RMAS must ensure that they are implemented as intended.	

SECTION 3 ANALYSIS OF FACTORS – TOR 3E.

Express an opinion on the level of support provided to the Service Person by the Chain of Command and welfare services in light of the information available and extant policy.

1.4.415 The level of support provided by the CoC is assessed in detail in TOR 2f.	TOR 2f
1.4.416 Welfare service are inclusive of the welfare team and the welfare aspects of pastoral care are provided by the team of Padres. Many of the aspects of the support provided by the welfare services are covered in TOR 1&2.	[redacted]
Inter-action with the Welfare Dept by the Service Person **1.4.417** The Panel were informed that the Welfare Officer and Welfare WO never met the SP. This evidential fact suggests any support was only in the form of guidance to the CoC. Of the 3 Padres, only one Padre met with the SP and that occurred on 4 occasions. The evidence identified that the support was available but only if the SP sought it out. The support from the welfare team was not forthcoming and she was not actively supported by the welfare services.	[redacted]
Support from the Army Welfare Service **1.4.418** Specific and specialist support from the AWS was not provided as it was understood the SP was receiving support from DCMH, when in reality she was being assessed. This lack of communication within RMAS and between RMAS and AWS to understand that DCMH were providing an assessment and once discharged there was no further support. The Panel are of the opinion that no specialist AWS counselling was offered to the SP despite the fact that the CoC believed that she was dealing with stresses from her family life as reported to Witness 28 in July 2018. The Panel believe having considered the AWS Initial assessment team (IAT) assessment in conjunction with the basic facts known to the CoC that the SP should have been offered specialist second line counselling through the AWS.	[redacted]
1.3.419 The Women's Royal Voluntary Service (WRVS) member of staff (who usually ran the cadet drop in centre and provided support to the Cadets) was directed to act as an escort for a medical appointment. The panel noted that the WRVS member of staff confirmed that the SP did not engage with them after this escort duty.	[redacted]

1.3.420 Details of names and phone numbers of welfare staff were prominent on numerous noticeboards around the academy.

[redacted]

CoC understanding of welfare support for the Service Person

1.4.421 The Panel believe that had the CAP been used, monitored and assured appropriately then this lack of support and engagement from the welfare team would have been apparent to the CoC. Witness 32 gave their perspective of the fact that the SP had not met the welfare team.

WITNESS 32: The Welfare Office perhaps has been a source of some frustration for me, and perhaps [a witness] as well, in that they hadn't been as engaged with the Officer Cadets as we might like them to be. And I think that they saw themselves as perhaps offering advice to the Chain of Command rather than engaging as closely as one might wish to provide direct support to the Officer Cadets. So, again, yes, I am disappointed but perhaps in hindsight not enormously surprised that they hadn't engaged with her directly.

LEGAD: And you said this morning, you mentioned [a witness] and you said that [they are] a very busy [person]. You have spent a significant amount of time at Sandhurst, somebody who commits self-harm in the form of an attempted suicide, in my view, that is quite a serious welfare issue. I would suggest that that is welfare business, and I am quite surprised that that is not at the top of their in tray, if you like. Do you disagree with any of those observations that I have made?

WITNESS 32: No, I don't disagree at all. No.

[redacted]

1.4.422 The Panel are of the opinion that during the SP attendance at RMAS the culture did not appear to encourage open discussion of mental health issues. The SP was concerned about being on the VRM. This perspective was outlined to the panel by Witness 28 and 36 in the CoC who explained in their evidence that it was difficult for an OCdt to see it as a positive move. (also see TOR 3b.)

[redacted]

1.4.423 As a result of her CAP not being read by her immediate CoC or those tasked to "monitor" her, the level of support was similar to all those in her Platoon, treating her equally, and not in accordance with her needs. (which contradicts AGAI 75, (Diversity and inclusion policy)).

Assessment of practical support

1.4.424 Witness 31, explained that they now understood that the practical support offered to the SP was insufficient and not of the

[redacted]

standard they would have expected for someone who was recorded on the VRM. They explained that "the picture that's painted on the company tracker is one of building concern that, if it had been discussed at the PHCT or any other meeting I would expect that that would trigger a welfare visit or contact of some sort." They explained that decisions can only be made on the information being provided. "We still are dependent on intelligence, and I think that comes from patients or cadets, but it also comes from welfare and pastoral as well as the Chain of Command." The Panel understand that without this key information they could not adequately understand or assess the risk involved with the SP. Witness 31 explained that had all the information been available their initial assessment of the DSH would have been very different. They stated "Coming back to the initial presentation, did this fit with a suicide attempt, did we think it did, or did it fit more with an acute episode of agitation and self-harm? We thought it was the latter. Now there's other information that suggests that that may have been incorrect".	
Alcohol use and review of Service Person's consumption **1.4.425** JSP 835, The management of the misuse of alcohol, para 3, defines the Hazardous or Harmful alcohol use (alcohol misuse) as "drinking alcohol, either on a single occasion or regularly, in such quantity that there is a risk to an individual, group or the overall operational effectiveness of the Services". And that "When alcohol misuse has been detected, the individual will be given every encouragement to reform their behaviour, but cases will be kept under constant review to ensure that recurrences are dealt with appropriately". The Panel are of the opinion that the SP was not kept under constant review and staff members who were aware she was drinking to excess at social events did not inform their CoC, monitor her or intervene to assist her.	[redacted]
1.4.426 During the last 3 weeks of the term, the SP was still under the care of DCMH which the CoC were unaware of, but they still proceeded with disciplinary action against her, in the form of a formal AGAI interview.	[redacted]
1.4.427 In the SPs circumstance in July 2018, that whilst alcohol may have been an enabler, in that it removed any barriers and inhibitions, which previously prevented her from conducting acts of self-harm. The Panel believe that this incident was a missed opportunity for the CoC, whose focus (once they had safe guarded the individual) on the inappropriate behaviour, would have been best	

re-aligned to have focused upon the welfare support and tackling the underlying issues.	
CoC position on Tue 05 February 2019 Duty to act on information **1.4.428** JSP 834 Safeguarding, (v4 May 2015 extant at the time) Part 2 Chapter 27, Paras 9-10 provides guidance on [redacted] while living away from home in settings provided by Local Authorities, the voluntary sector or independent providers. When such allegations are made, they should be responded to in the same way as contemporary concerns. In those cases, it is also important to find out whether the person accused is still working with children and, if so, to inform the person's current employer or voluntary organisation." The Panel are of the opinion that, the CoC should have responded [redacted] as soon as they became aware of them. Contemplating the validity of the allegations was not the role of the CoC or an excuse to delay reporting the allegations. Sound common sense should have prevailed at this time as evidenced by Witness 36 assessment of the position (TOR 2a, para 1.4.228).	[redacted]
Summary **1.4.429** The level of support provided by the welfare services can be described as passive not proactive. Welfare services at RMAS were family facing not OCdt facing and there was little dedicated support outside of the CoC and the Chaplaincy Dept. Assistance from the Padres had to be arranged within a busy training programme and TOR 1E explored the fact that some OCdts felt the Padres were too close to the Chain of Command. As a result, the SP had 4 pastoral meetings during the period May 2018 – February 2019 with one specific Padre and no other direct support from the welfare team or remainder of the chaplaincy team. There was a significant lack of understanding, specifically concerning the [redacted]. Overall, the Panel determined that the level of support provided to the SP was below the standard they expected at a Basic training establishment.	

SECTION 3 ANALYSIS OF FACTORS – TOR 3F

Express an opinion on the level of support provided by the Chain of Command and welfare services to the permanent staff and OCdts after the deliberate self-harm incident on 16 July 2018 and the immediate period after the Service Persons death on 06 February 2019.

Actions after the RE Visit in July 2018 **1.4.430** Following the DSH incident on 16 July 2018, 5 OCdts were asked to attend a meeting with Witness 34. TRiM had been considered by Witness 35, but instead an informal approach was taken in the form of an informal meeting with Witness 34. (TOR 1A). This resulted in no formal TRiM or monitoring for those OCdts directly involved in the DSH incident. Witness 34 was used as a TRiM filter which is not in line with policy and no concerns were raised or feedback requested.	[redacted]
1.4.431 Due to the fact that a limited investigation was completed following the DSH (see TOR 1), the OCdts who assisted the SP were not able to explain their version of events and as such the CoC was never fully aware of all the details. As a consequence, had a comprehensive investigation taken place, which incorporated the views of the OCdts (who assisted the SP), a more informed decision may have been made and support offered to the first responders.	[redacted]
1.4.432 There is no evidence to suggest any support was given to the RE staff who also assisted the SP on the evening of the 16 July 2018.	
1.4.433 The Panel are of the opinion that the CoC's approach towards dealing with the aftermath of the RE visit is not what the Panel would have expected after a DSH incident at a basic training establishment. The Panel concluded that the lack of information was the primary reason why the CoC misunderstood the seriousness of the events on the nights of 16-17 July 2018.	
Actions after Service Person's death on 06 February 2019 **1.4.434** Following the death of the SP on 06 February 2019, the platoons remained together throughout the evening, the majority of the female OCdts, from the Coy, chose to spend the night together. A member of staff from each Platoon was directed to sleep in the Platoon lines to provide support if required.	[redacted]
1.4.435 The Chaplaincy team organised a memorial service (7 February 2019) and the CoC cancelled the training programme in the days preceding an academy leave weekend. Informal activities	[redacted]

were organised to allow the OCdts time to come to terms with what had happened.

TRiM Planning meeting

1.4.436 A TRiM planning meeting took place on 07 February 2019. Due to inadequacies at this meeting the TRiM process was not conducted as thoroughly as it should have been. The omissions are highlighted below;

a. The lack of a unit TRiM policy resulted in an already busy member of staff, volunteering to act as the TRiM coordinator, without additional support or time to conduct the duties. The team comprised of staff available without a coherent plan. Witness 43 offered their perspective on how difficult it was to manage this task:

WITNESS 43: So, whilst I was, sort of, trying to oversee the TRiM, I was still [an integral part of my Coys CoC] In the senior term, we were preparing for a deployment for their final exercise to Germany and ultimately obviously their commissioning in the weeks following up after that. So, this was in addition to running the Company, organising the training programme and the normal, sort of, duties that I would have to undertake.

[redacted]

b. The First responders, Witness 22 and 26 were not captured in the TRiM process. Neither received any TRiM sessions. In addition, neither were added to the risk register and neither were offered any additional support. Witness 43 told the Panel they understood that TRiM was a process to identify personnel that needed support. Witness 43 understood from the meeting it was decided that if the first responders required support, then as the medical CoC and senior Padre were present at the meeting they would provide that support: This is described by Witness 43 below:

WITNESS 43: As I say, we -- to try and capture 180 people plus in the two Companies and I am aware that these two are at the immediate forefront of the event, but the -- with my understanding of having such high-ranking medical, pastoral support in that meeting, that that should be an indicator for them that we need to provide the support for them immediately from that point onwards with everyone understanding their involvement in the event.

c. The TRiM record keeping was not wholly accurate. The records show the first responders declined TRiM, when in fact they were never offered it.

d. Witness 39, who was removed from post, pending an investigation, was missed off the TRiM list, therefore didn't

receive TRiM and no requirement of TRiM was communicated to their receiving unit.

e. Personnel who missed or declined TRiM initially, were not subsequently offered support. (TRiM DIN, 14.a.i)

f. The TRiM process can result in referrals, for example an individual may be signposted to receive medical assistance. The evidence suggests these referrals were logged on the TRiM records and the New College Adjt informed (H26), but no further action was taken to ensure the individuals received the support required.

g. TRiM practitioners who attended the TRiM planning meeting were not all the practitioners who delivered the TRiM (4 of the 7 practitioners did not attend the planning meeting). (H18)

h. Poor communication between the TRiM practitioners and TRiM coordinator.

i. None of the personnel that received TRiM received a 3 month review as required by policy. Most of the OCdts had moved units at this point and the handover of the TRiM was not completed for all personnel.

j. Witness 25 informed the Panel that they received TRiM from a practitioner, who's training was out of date.

k. The TRiM coordinator was not offered any subsequent support following all the TRiM delivery. Witness 43 explained no one from the CoC checked on them during the TRiM process.

l. Group TRiM sessions conducted by Practitioners did not have a TRiM coordinator present as direct by Policy.

m. LFSO 3217 explains TRiM risk assessments "must not be conducted until 72 hours after the incident". Witness 14 did not receive a TRiM risk assessment for 9 days after the incident. Witness 43 explained that this lapse was due to the pressures of a busy training schedule and available, trained, TRiM personnel.

n. The OCdts selected to receive TRiM were decided at the planning meeting, without consulting the Pl Staff. Therefore, several OCdts felt they couldn't or didn't want to ask for help and were omitted from receiving TRiM. This perspective was explained to the Panel by Witness 5, who explained the SPs best friend in the Pl didn't receive TRiM.

WITNESS 5: “We thought the whole TRIM thing was a joke to be honest. PRESIDENT: And who was [The SP’s] best friend? WITNESS 5: Well, one of [the SPs] best friends was [Witness 12]. No-one came to [them] and said [Witness 12], mate. Actually, I think I went to someone and said I think you need to have a word with [Witness 12]. But, yes, [they were] the rock of the platoon and you could tell [they were] suffering. Well, not that we knew [they were] suffering but there would have been something in that because [the SP] was big pals with them, [they were] the big brother to [the SP] all the time. I think they eventually, a few weeks later, just broke down, I’m pretty sure.”	
Monitoring of the TRiM programme **1.4.437** TRiM updates and progress would ordinarily be covered by a UHC. Multi agency UHC meetings being ran at RMAS only discussed PS (not OCdts). The Panel have seen no evidence, and are therefore of the opinion, that the TRiM progress was not monitored by the CoC, and no assurance took place to ensure the process was conducted effectively.	[redacted]
1.4.438 Policy reference LFSO 3217, para 7.c.3. recommends UWO’s and Padres “undergo TRiM training in order to assist in the provision of second line support”. The College Padres who were in a position to assist with second line support were not trained in TRiM. Witness 34 wasn’t aware they could do this training; “we’re aware of TRiM, but we don’t do the TRiM training because we’re seen as another avenue of support”.	[redacted]
1.4.439 The second line support provided following TRiM, was sporadic. Witness 6 explained a fellow OCdt did not receive the follow up support required (they were recommended to receive counselling, but they did not), and recognised by the TRiM practitioner, so sought support independently elsewhere.	[redacted]
1.4.440 The number of TRiM practitioners normally required for a Batallion sized unit is 20-24 (LFSO 3217). In this case, the TRiM practitioners were trawled on JPA and 21 were found within the academy ranked from LCpl-WO1 and 1 Capt. The Panel have determined from analysing the TRiM records that 7 TRiM practitioners were used to deliver the TRiM programme. Whilst the Panel have been informed as to why the total number of trim practitioners had not been used (due to being on exercise and a busy training programme), we are of the opinion that the requirement to properly TRiM OCdts and staff should have been the CoC primary focus at that moment in time and that the deficit in	[redacted]

trained personnel should have been raised to ARITC and a trawl should have been instigated to assist with this task. **1.4.441** The Panel are of the opinion that had they used more of the trained staff the additional trained TRiM practitioners would have reduced the number of personnel receiving TRiM in group settings (allowing TRiM to be conducted as individuals) and would have extended the opportunity for TRiM amongst members of the SPs platoon.	
Extension of Support to wider family audiences **1.4.442** The Panel are of the opinion that no support was offered to the families of those involved in the incident. In particular, [redacted] Support from the welfare team should have extended to the immediate families of those involved as the first responders.	[redacted]
Internal Communications concerning the Service Person's death **1.4.443** A lack of clear communication following the death of the SP led to some members of staff being unaware of her death. The lack of communication between military and Civilian staff meant civilian staff not all aware of the situation. Witness [redacted] a civilian lecturer, was waiting for their students, following the death of the SP and explained "They weren't turning up and we didn't know why they weren't turning up and nobody knew why they weren't turning up."	[redacted]
1.4.444 The Panel have heard evidence that highlights the poor manner in which the death of the SP was communicated to the staff members outside of the Company, at RMAS. This poor communication strategy had a significant impact upon the OCdts. Witness 2 shared their own perspective of this unfortunate position. Witness 2 explained that after the SPs death, their civilian lecturer asked the class where the SP was once the training programme had recommenced.	[redacted]
1.4.445 The Panel are of the opinion that poor internal communications at RMAS, in the immediate aftermath of the SPs death, may have contributed to the administrative and recruiting staff subsequently using the SPs photograph in an online recruiting project several months after her death. These photographs were seen by her fellow OCdts and caused great distress.	[redacted]
The management of Witness 25 after 06 February 2019 **1.4.446** A relationship between the SP and Witness 25, was disclosed to the CoC after 06 February 2019. It was deemed the relationship was inappropriate and Witness 25 was to be removed	[redacted]

from post and not allowed to instruct OCdts for 4 months whilst waiting for their next posting. Witness 36, had to engage with APC in order to hasten the removal from post procedure. Their posting order took 4 months to be finalised and little employment was provided in the interim. The Panel are of the opinion that if a staff member has been removed from their duties, for disciplinary reasons, the CoC has a duty of care to ensure a new posting is secured in a timely manner. In addition, the disciplinary action was not completed until approx. September 2019.	
Summary **1.4.447** This sub TOR asked the Panel to consider the level of support provided by the CoC and the welfare services. The details recorded and commented upon thus far only relate to the CoC support and actions. In other areas of this report (TORs 1- 5) the Panel has commented upon the involvement of the welfare dept after the RE visit. The reason why the Panel has been silent regarding the welfare dept in this TOR is because Panel have not heard or seen any evidence to prove that the dept provided any support to the OCdts or permanent staff in the immediate aftermath of the SPs death on 06 February 2019. The Panel would have expected a multi-disciplinary approach which harnessed the CoC, Chaplaincy and welfare resources to assist with the impact of the SPs death. The Panel were disappointed to establish this fact and find that this omission was a true reflection of how distant the welfare dept were with the OCdts at RMAS in 2018-19.	
1.4.448 The lack of a thorough understanding of the DSH incident at the RE visit by the CoC led to the neglect of TRiM and wider welfare support for the individuals who witnessed the event. A detailed and resourced unit TRiM policy and UHC's would have captured and ensured a more coherent TRiM programme. The lack of a unit TRiM policy effectively resulted in the detailed planning not being robust enough to ensure everyone was effectively dealt with in accordance with the extant policy. The very fact that the first responders (who dealt with the discovery of the SP and treated her prior to the arrival of the paramedics) were overlooked demonstrated to the Panel the inadequacies of the welfare provision along with the chaotic and haphazard approach adopted by the CoC in the period after the SPs death on 06 February 2019.	

SECTION 4- TOR 4 Establish the relevant policies and procedures which apply to DCMH Aldershot and the extent to which they were implemented in each case, namely 16 July 18 and 6 February 19.

To determine DCMH Aldershot's understanding and application of the relevant SVRM Policy:

SECTION 4 ANALYSIS OF FACTORS – TOR 4A

Identify the SVRM policy applied within DCMH Aldershot and how this is integrated with AGAI 110.

1.4.449 Witness 45 outlined that the policy used in July/August 2018 to assess and manage the SP, was known as the Unified Care Pathway this was used in conjunction with the requirements of AGAI 110. The Unified Care Pathway was a new policy as described by Witness 45: WITNESS 45: The common pathway, the documentation the doctor is referring to, that was implemented in April 2018. It came as an implementation order and people were not implementing it, so there was a further three-line whip coming and the (Defence Consultant Advisor) DCA psychiatry had to make a number of visits to DCMH because this was new. This was new….That is when, in the early days, people were not doing it and then they fell in line and you probably will understand that people always don't do -- especially if it's a paradigm shift. If you say, you know, major change, people don't do it, but it has since been rectified."	[redacted]
Clinical Supervision at DCMH **1.4.450** Witness 45 was involved with the SP throughout her attendance at DCMH; during the first two visits she was assessed by Witness 40 and they discussed their findings with Witness 45. This is an important aspect as it demonstrates that there was clinical supervision of Witness 40 and that the decision to return the SP to training was a joint one and not just based upon Witness 40 findings after the assessments on 17 and 26 July 18.	[redacted]
1.4.451 The SPs case was also discussed at a multi-disciplinary meeting of medical professionals on 18 July 2018 Witness 45 has acknowledged that this was not recorded in the SPs medical records and similar non recording of conversations between Witness 40 and 45 also occurred and that this was an error. The Panel have considered this in the recommendations in TOR 6.	[redacted]

The application of policy at DCMH

1.4.452 Witness 45 continued the explanation of policy matters immediately after this line of inquiry and it is pertinent at this point to record the observations they made as follows:

PRESIDENT: Thanks very much. You have just identified there that obviously procedures and matters have changed as a result of the lessons that have been already learned in dealing with this case. But I just wanted to clarify that that was what the position was in relation to the findings of the (Multi Disciplinary Team) MDT meeting on 18th July.

So, if we just continue talking about information that you were aware of before you saw [the SP] on 09 August. We talked about Witness 40's report that is on DMICP. We talked about the MDT meeting. We talked about the ambulance report information. Then there is a subsequent meeting that Witness 40 has with [the SP] on 26th July. Then the next thing that happens in the [the SPs] journey in relation to DCMH Aldershot is that she comes to see you on 09 August. Just before we talk about the detail of your meeting and the review of the information that you were receiving, can you just explain to the Panel we know that AGAI 110, which is the Army's Suicide Vulnerable Risk Management policy, applies or applied to [the SP] at this moment in time. But is there an overarching policy that you were operating under at this time in July 2018?

[redacted]

WTNESS 45: We did not have -- we had a -- we now have what we call a high interest list policy and I wrote the policy myself. I would not say that it was as a direct result of this tragic event. It was something I had always aspired to do, to highlight the vulnerable patients, have discussions and offer them enhanced monitoring and that was not in place at that time.

So, if there were patients who were deemed to be high risk by the clinician who was seeing them, they would do the clinical information we have or as a result of the clinical assessment that was conducted on the patient and there would have been something akin to the high interest list called Departmental Risk Register, they would be discussed. But there was not a policy underlying how those patients should be managed in terms of clinical contact, supervision, et cetera, et cetera. That was implemented after I took over as clinical lead on 1st October 2018. But there was no existing policy except that the patient was deemed to be high risk. They would be discussed in the multi-disciplinary meeting under the column of "Departmental Risk Register".

PRESIDENT: Yes.

WITNESS 45: And people would share, you know, whatever expertise, information, experience they have about the patient which would contribute to the management of the patient. But there was no set policy at that time and also, in this particular case, coming to the specifics of this particular case, the patient was not deemed to be high risk although she had attempted [redacted] and, you know -- which was a deliberate act of self-harm. The clinical lead was not deemed to be high risk because the context which, you know, I am sure will cover at a point.

That assessment of risk, although it was made by the clinician who saw the patient, Witness 40, it was discussed and we agreed as a team. As I said, there is no documentation. That is regrettable. So, you have to take my word for it, if you will. But at that meeting it was decided, based on the clinical information we have and her evidence, two assessments nine days apart, it was an adequate assessment of the risk that was posed by the SP at that time. The management plan that was suggested, based on that assessment, was adequate. "

Classification of Risk

1.4.453 The Panel understand as explained by Witness 45 that the SP being classified as low risk and free to return to training did not mean that there was no risk it meant that she should be reviewed and monitored and subjected to safety netting procedures. The very fact that she was graded as low risk but discussed at the MDT meeting where high-risk patients were considered demonstrated to the Panel that Witness 45 had considered her case in significant detail even if it had not been recorded on the electronic patient records system.

1.4.454 The Panel heard detailed descriptions from Witness 40 (and 45) about the procedures they used to assess the SP firstly on 17 July 2018 and then again on 26 July 2018. They discussed their findings with Witness 45 before informing the RMAS medical CoC that the SP had been classified as low risk and could return fully to training.

Establishment of trust with a patient

1.4.455 When assessing the SP both Witness 40 and 45 explained that there was a balance to be achieved between establishing the trust of the patient and determining if they were telling the medical professional the truth. Both Witnesses were of the opinion that the SP had told them the truth concerning the RE visit.

1.4.456 Of note is that Witness 42 who conducted the initial assessment of the SP on the morning of 17 July 2018 stated that they [redacted]

manner presented. Both Witnesses 40 and 45 explained to the Panel that they used certain types of questioning to establish the facts of the case. The Panel believe that it was not the medical professional's role to undertake investigative works to verify the facts of the RE visit, this supplementary information could have been provided by the RMAS CoC in the period 17 July – 9 August 2018 or by the RMP SIB had they been informed of the incident there being a requirement under policy AGAI 110 for such incidents to be reported.

[redacted]

The means to acquire further information by medical professionals

1.4.457 One means by which the medical professionals could have sought further information from the RMAS CoC would have been the use of a FMED 1041. This was a reporting form which is commonly used by the CoC to inform the medical professionals as to the performance of a SP. It is typically used when the individual's employment status is being reviewed or they are being considered as temperamentally unsuitable for service it was not used in the SPs case. The report is another mechanism in which the CoC could have communicated the details of the RE visit with the medical staff had it been requested. Unfortunately, there was no detailed investigation to provide the supplementary information which would have been considered by the medical staff in July/August 18. Of note was the fact that Witness 40 and 45 first became aware of the full extent of the self-harm incident when informed by the President at the hearing in the autumn of 2020.

[redacted]

What was known by the medical staff involved with the SP?

1.4.458 The Panel have established that the full details of the events of the RE Visit were not made available to all the medical professionals involved with the SP. This omission is a key factor in the SP Inquiry; similarly, the CoC did not share with the medical staff at the RMAS medical centre that the SP had a "crisis of confidence" issue whilst attending Ex Normandy Scholar and that she had drank alcohol to excess when she was meant to be tee-total. Witness 31 explained this factor when questioned as follows:

[redacted]

PRESIDENT: [redacted]

Witness 31: I suppose there are two elements to that, [redacted]

[redacted]. So I suppose, with the PHCT, the issue that we have is that the list can become quite cumbersome and unwieldy and if we are not getting -- if we've had some sort of assurance that there's no news of concern at the academy welfare meetings and there's no news of concern clinically, then we might remove them. But removing them simply means we don't discuss what's not on the system at the next meeting. Clearly, if someone was flagged up at the welfare meeting the next month or if they presented to a doctor with another episode of concern, they would be coded again and go straight back on. And I would suggest that a second event or a second coding, you would be inclined to keep someone on for the duration of their time at Sandhurst. Whether or not that makes any material difference or not, it simply is an opportunity I think to make the wider medical team aware of any concerns so that we look out for individuals when they do present or can come to a consensus as to the best way to manage them medically	
Summary **1.4.459** This inability of the CoC to share information was repeated for a third time after the Falklands Coy Ball in February 2019 where the SP was clearly suffering from the after-effects of alcohol and in addition self – harmed [redacted] in the CSM's Office. Her actions and behaviour did not elicit an intervention from members of the CoC other than to stop her from [redacted]. The Panel were disappointed to learn that there were in effect 3 incidents involving alcohol and the SP, of relevance is that no-one in the CoC appeared to notice the significance of these events and the continuing demonstration of harming behaviours which should have triggered an interventionist approach by members of the CoC.	[redacted]
1.4.460 The Panel believe that there was a good understanding of the policies and how they should have been implemented by the DCMH staff furthermore the SP case was considered by a wider forum of medical staff at the MDT meeting on 18 July 2018. Based upon the information that had been made available to the medical staff when they assessed the SP, the Panel are able to understand why the SP was graded as low risk and returned to training. The validity, extent of the information and its verification is subject to further comment in TOR 4C below	[redacted]

SECTION 4 ANALYSIS OF FACTORS – TOR 4B

Determine the extent to which policies and procedures have changed within DCMH Aldershot since February 2019 to prevent any recurrence of incidents of this type.

1.4.461 Witness 45 submitted supplementary evidence after appearing at the hearing to further substantiate their responses relating to the changes that have occurred at DCMH since the SPs death.	[redacted]
Medical reports produced after 06 February 2019 **1.4.462** Since February 2019 there have been 4 medical investigations and reports complied into the SPs case, these are as follows: a. Independent Review into the Death of SP by Witness 55. b. Independent Clinical Review on Unexpected Death at RMAS 06 February 2019 by Witness 56 c. Confidential Medical Report produced by Witness 45 for Coroner dated 29 August 2019 d. Internal Clinical Review by Witness 57.	[redacted]
1.4.463 The Panel had sight of these reports prior to taking evidence from Witness 40 and 45 and questioned both Witnesses closely about their interaction and assessment of the SP. Witness 45 acknowledged that there had been an error in recording certain aspects of her medical history on DMICP. They also confirmed that's the manner in which recording is now undertaken had been updated as a result of Witness 55, 56, 57 reports findings.	[redacted]
1.4.464 It is evident to the Panel that there have been a significant number of changes to procedures and working practices that have occurred at the behest of Witness 45.	
Documentation improvements **1.4.465** In order to address the errors identified by the independent medical professionals Witness 45 introduced 5 major changes and these are described in detail by the exert from Witness 45 as follows: a. The most notable improvement has been in the level and standard of clinical documentation or note keeping. What is required by the Unified Care Pathway is now rigorously applied and compliance monitored. The use of prescribed	[redacted]

templates that contain number of useful clinical prompts and checks are now universally used with no scope for derogation. This has to an extent improved the level of information contained leading to better clinical communication.

b. Risk categories have been expanded to explain the meaning of 'Low'. 'Medium' and 'High'. In cases where risk is anything other than low, or there being a score of more than 0 on Q-9 of PHQ-9 (relating to suicide or self-harm), there is requirement to expand of that designation. This would include an exposition of the important positive and significant negatives in the case that informs the designation of risk category as medium or high.

c. As part of improvement in documentation standard, mandatory caseload management is now in place and enforced. It was always a requirement as per the UCP and supporting SOP, but this is now rigorously followed. The caseload management, distinct from clinical supervision (of which more later) asks Y/N answers to questions in the following areas:

Case Load Management;

Professionals Involved – Y/N
Evidence-Based Management Plan in Place – Y/N
Psychometric Questionnaires in Last Four Weeks? - Y/N
On caseload greater than 6 months? - Y/N
Occupational Recommendation in Place - Y/N
Discussed at MDT Meeting - Y/N
Evidence of Risk Assessment (Including Safeguarding) - Y/N
Follow-up Appointment Planned - Y/N
Discharge Plan in Place (If Applicable) - Y/N

d. MDT discussions are no longer recorded in a different WORD Document which had not always been filed in a proper manner (or completed properly to render them useful). MDT discussions are now recorded directly into patient notes and records risk issue, summary of discussions on care pathway besides recording who was present in the meeting.

1.4.466 Supervision:

a. Clinical Supervision is not only expected but is a requirement for safe clinical practice. Although it is up to the clinician to seek (and record) supervision, there is now active logging of supervision in the department. Level of supervision engagement is actively monitored and can form a part of performance management. There is now a requirement to record who the case was discussed with and a short summary of that discussion.

b. Recently and probably unrelated to the index incident (of the tragic death of the SP), there was an additional requirement on DMICP mental health 'Templates' included at the most recent iteration that requires clinicians to indicate that there has been (or not) caseload management (unless exempt) in last 8 weeks. This is not a local initiative, but centrally driven, and a welcome layer of assurance which I feel is appropriate to share with the Panel.

1.4.467 Management of High-Risk Patients:

a. I attach the department's High Interest List (HIL) Protocol at Annex -A. As part of this there is a dedicated slot in the MDT (Multi-Disciplinary Team) to discuss every week a patient on the HIL unless they are (by clinical consensus) removed from the list. High interest includes risk to self, others (including [redacted]), and mission. A paper copy of the list (with identifiable patient information removed) with only Patient ID (or DMICP Number) is held at the reception so any patient on the list calling the department is immediately identified. There is a procedure on how those calls must be handled as well as how to deal with non-attendance or if the patient cannot be contacted.

b. Part of the SOP also requires that, on each case, an extended Risk Assessment is completed and attached. I have appended a copy at Annex B. This document is constantly updated based on emerging clinical information.

c. Any patient on the HIL is readily identified by an alert on the case notes visible to Primary Care. I have over the years advocated the adoption of this protocol across all DCMHs whenever I have been asked to conduct external reviews on 'Sentinel Events[9]'.

[9] Sentinel events are defined by The Joint Commission as any unanticipated event in the healthcare setting resulting in death or serious physical or psychological injury.

1.4.468 Joint Working:

a. The HIL SOP dictates holding a clinical case conference with the Trifecta of Unit CoC, Medical Officer and DCMH within a specified period of the patient being put on the HIL. This meeting invites the patient's participation but is not dependent only on patient's consent. In the rare event the patient withholds consent, justified by the doctrine of clinical necessity, the meeting goes ahead, and only minimum medical information is shared with non-medical personnel. This works to ensure that all three entities contribute in a proportionate manner in managing risk and that relevant risk information flows in a bi-directional manner.

b. Since March 2019, I have been (as Head of Department of DCMH Aldershot) invited to attend RMAS monthly welfare meeting chaired by Comd RMAS HQ Gp on a case by case basis, and as a standing invite since July 2019. There is an opportunity to contribute to the overall management of the Officer Cadets if health/mental health is an issue. I am not limited to speak only on SPs who are under my care but in those instances, my advice is often general. This is a good forum to share information. I do not get sent, nor is it appropriate on privacy grounds, the records of discussion or the action grid. However, if there are any clinical interventions I suggest, I follow the uptake or implementation of such through my PHC Colleagues, usually the SMO or DSMO.

1.4.469 Care plan/Safety plan:

a. Treatment and Care plans are agreed with the patient and documented as such. They are often generic, but every effort is made to individualise the care plan for the patient. Patients are given a copy of their care plan (unless the decline to take it) as a matter of routine which also includes an elaborate safety netting information. Given the youth of our patient cohort and their inevitable reliance on Smartphones, we always encourage them to take a photo of the safety netting information and save it on their phone which would be more available to them to refer to than a piece of paper in times of crisis."

Summary

1.4.470 The Panel are of the opinion that creation of the High Interest List Policy along with the extended Risk Assessment requirements are fine examples of good practise being implemented as a result of the lessons learnt at DCMH following the death of the SP.

1.4.471 The Panel believe that from an RMAS perspective the inclusion of Witness 45 into the monthly welfare meetings is a significant step forward. Witness 45 has been primarily responsible for these changes and has driven their implementation and application. The practical benefit of greater interaction between DCMH, RMAS medical staff and the CoC has had a real impact since February 2019 and this was demonstrated by the way in which RMAS dealt with a vulnerable Cadet in October 2020.	

SECTION 4 ANALYSIS OF FACTORS – TOR 4C

Express an opinion as to whether the policies and procedures are appropriate in ensuring any risk is managed in cases such as these including the impact of the requirement for confidentiality.

1.4.472 TOR 4 primarily asked the Panel to consider matters relating to policies and procedures at DCMH in answering this specific sub question the Panel have included findings and analysis that not only relates to DCMH approach to risk management but also RMAS CoC. The Panel believed that the two organisations approach to risk management and patient confidentiality in July and August 2018, concerning the SP were so tightly interwoven that it would not be sensible to separate them.

Verification of risk assessment

1.4.473 The Panel identified through questioning of Witness 40 and 45 the policies and procedures that were used in assessing the SP and this was dealt with in TOR 4A. The Panel confirmed through questioning the manner in which the SPs risk assessment was derived at and note that even once Witness 40 had conducted an initial assessment that this was subject to scrutiny by Witness 45 and again further scrutinised at the multi-disciplinary meeting on 18 July 2018.

[redacted]

1.4.474 Both Witness 40 and 45 demonstrated a thorough understanding and clear interpretation of risk assessment in this case. Whilst Witness 55's report comments upon the disparity between the test scores and risk stating the following:

[redacted]

[redacted]

1.4.475 Witness 45 commented in response to this observation and explained their position as follows:

Witness 45: [redacted]

[redacted]

[redacted]

Risk assessment and the influence of alcohol

1.4.476 Witness 57's report conversely confirms that the standard DCMH risk assessments were undertaken, the SP was warned about her alcohol intake and that there were timely communications with the Medical centre at RMAS. Witness 45 confirmed this as follows:

[redacted]

[redacted]

1.4.477 The importance with which Witness 45 regarded the risk of alcohol is apparent from this excerpt and demonstrates DCMH's overall concern regarding alcohol and the SP. The Panel believe that this understanding which was conveyed to the medical staff at RMAS may not have been shared with the degree of emphasis or seriousness that Witness 45 expected. This factor concerning the sharing of information is dealt with in greater detail in TOR 5. The Panel make this finding because it is now apparent that no-one in

the CoC acted upon the SPs second and third alcohol related incidents in November 2018 and February 2019.	
Verification of truth and clarification of facts by medical professionals **1.4.478** One factor influencing the assessment of risk in relation to the SP which the Panel have identified as a common theme is the fact that the SP portrayed the image of "loving Sandhurst". It is evident to the Panel that she had expended a significant amount of time and effort to pass the various selection procedures in order to start on CC182 and that it was obviously very important to her to be an OCdt at the Academy. [redacted] The Panel explored the impact of this possible position with a number of Witnesses and Witness 31 explained their perspective in this regard earlier at TOR 4A.	[redacted]
1.4.479 The Panel believe that the SPs outward display of positivity and her boundless enthusiasm and desire to return to training in the immediate aftermath of the RE visit meant that the CoC were not attuned to the level of risk they were carrying by allowing her to continue the CC; which was due to increase in intensity at the start of the intermediate term.	
1.4.480 The determination of risk was ultimately reliant upon one source of information, that being the SPs version of events. Whilst the Panel understand that the ambulance report and Witness 42 referral were all available it was essentially a personal interaction with the SP where the details of the event were explored at length by Witness 40 and 45 when they assessed her. The Panel sought an understanding of this as demonstrated by the excerpt below when questioning Witness 45: [redacted]	[redacted]

[redacted]

The impact of missing information

1.4.481 As mentioned in the earlier TOR there was no further information forth coming to influence the assessment of the SP, the Panel sought to clarify this aspect when questioning Witness 31 and received the following response:

PRESIDENT: “Okay, thank you for that. That explains quite clearly your understanding and I am now quite clear as to how you view that particular time period. So, I identified that there are discrepancies between the company and the college trackers. The fact that your initial PHCT meetings may not be getting the full picture from the Chain of Command as to how [the SP] was getting on, it occurs to me that the Panel may conclude that [the SP] was not tracked, monitored, or managed, properly at all. How do you assess what I have just said to you there please?

[redacted]

Witness 31: I think the purpose or spirit of risk management or providing welfare support is for all the key stakeholders to be communicating effectively and to share information that might be pertinent and to collectively understand it. There is a disconnect here between the company and the academy welfare tracker. We medically would not have been sighted on that unless we had been informed directly. In all honesty, what would I do if I had been told that there had been an escalation of harming behaviour? [redacted] That in itself wouldn’t necessarily be important, but it’s the decision that would be taken collectively by the medical team I think on hearing that information. And I think it would simply be flagging up this is a vulnerable individual and we probably wouldn’t take any unilateral action, pulling someone in for a medical review or sending them to DCMH. [redacted]

[redacted]	
Discussions with the Service Person by OCdts after DCMH appointments in July and August 2018. **1.4.482** Notwithstanding this point of view explained by Witness 31 it is evident to the Panel that all was not well with the SP at this time; two Witnesses described their recollection of discussions with the SP. This is adequately explained by the following two excerpts from the hearings as follows, firstly, Witness 7 recalled a conversation with the SP and the Panel believe that this is pertinent at this point Witness 7 :"I felt very responsible for her after that, so really it was very stressful, and especially because we had, so once she finally got out of the med centre she was back in training, she was happy to talk again we were chatting up there and I said, "you know, you can always talk to me, you know, if you feel like that, let's not let it get to that, you know, let's talk about it," and she said, "You know, Witness 7, when I got back I thought maybe I should just do it because, you know, I've already fucked things up enough as it is," and I was like, "Oh, you don't mean that," and I completely brushed it off, like I seem upset all the time, and she sort of brushed it off as well and we carried on talking and she talked about, like, she had had some issues and things, or so she said, and how she bumped into them, [redacted]	[redacted]
1.4.483 Secondly, in questioning Witness 8, they described conversations with the SP after she had visited DCMH which offers a different perspective to what the medical professionals were being told and reinforces the Panel's understanding that the basis upon which the SPs risk was assessed and managed was not totally accurate. Witness 8 commented as follows: Panel Member 1: Okay, and then I just want to go back a bit to discuss how the incident was treated by the Chain of Command and how you felt [the SP] felt the Chain of Command were dealing with it.	[redacted]

Witness 8: At the time I didn't know it was DCMH because I didn't really know what DCMH was, but I know she went to hospital in Aldershot and I believe she did go to DCMH after. And she just said that, like, basically she just answered all the questions how they wanted answering and she came back. That was a tick. Panel Member 1: Sorry, she answered all the questions how they wanted answering. Did you get the impression from The SP saying that that she had not been fully honest? Witness 8: Yes, she hadn't been honest. Panel Member 1: Did she admit that to you? [redacted]	
1.4.484 These two latter excerpts demonstrate that there was a gulf in understanding between the medical professionals' and the CoC assessment of the SP and the true position in which she found herself in July 2018. The Panel believe that in this case the one way in which this could have been identified and had an influence upon the risk assessment would have been for the precise details of the RE visit to have been shared with the medical professionals.	
1.4.485 The aspect of confidentiality and the requirement for confidentiality in accordance with the Caldicott principles[10] did not in the Panel's opinion have an undue or negative impact upon the SPs case. The sharing of information and the policies and procedures in this respect are dealt with in greater detail in TOR 5d. The CoC understanding of whether they could have contacted the SPs family after the RE visit is dealt with in TOR 2.	[redacted]
Summary **1.4.486** In summary having heard evidence from the medical professionals who dealt with the SP, the Panel believe that the policies and procedures and their recent amendments are sufficient in ensuring that risk is managed appropriately. The Panel believe that the information known to the medical professionals was shared appropriately (with the exception of the FMed 1041 which was not requested), of note is the fact that the full extent of the details of the RE visit were not known at the time of the SPs appointments. The requirement for thorough investigations after DSH incidents is recorded as a recommendation in TOR 6. The Panel are of the	

[10] The Caldicott Principles are guidelines applied widely across the field of health and social care information governance to ensure that peoples data is kept safe and used appropriately.

opinion that the correct sharing of information remains a key supporting factor in enabling the medical professionals to care for service personnel.	

SCTION 5- TOR 5 Investigate the extent to which RMAS and external medical agencies interacted in support of the Service Person.

Examine the effectiveness of the multi-agency interaction, including but not limited to:

SECTION 5 ANALYSIS OF FACTORS – TOR 5A

Determine any similarities in relation to each event and analyse in respect of the post-event care following the self-harm incident on 18 July 18 the action taken by the Chain of Command.

1.4.487 The Panel are of the opinion that the main similarity between the event on 17 July 2018 and that of 6 February 2019 was that the SP conducted acts of self-harm on each occasion. Whilst the event on 16/17 July 2018 was influenced by excess alcohol intake the Panel understand that this was not a factor in the 24 hours before the SPs death on 6 February 2019.	
Mobile Phone data analysis **1.4.488** During the period 1 to 6 February 2019 the analysis material provided by [redacted] shows that the SP undertook internet research into [redacted] The Panel have seen no evidence to prove that she was considering self-harm before the RE visit in July 2018 or that she was suffering from or displaying any form of distress that might have manifested itself in the actions that she undertook. The nature and seriousness of her DSH actions were previously referred to in TOR 1.	[redacted]
Types of Actions **1.4.489** After the RE visit the CoC actions can be differentiated into two categories firstly the practical measures that were implemented to assist the SP and secondly, the management type actions (that she may not have been aware of) such as the Commanders Monthly welfare meeting where her status was discussed.	[redacted]
1.4.490 Once the SP had returned to RMAS on 17 July 2018 she was effectively cared for by the medical Chain of Command which included an initial assessment at DCMH she was released from the medical centre on 18 July 2018, was re-integrated into 33 Pl and resumed the training programme. There were no practical care type interventions by the CoC during the last remaining weeks of the Junior term. The panel acknowledge that the SP did interact twice with Witness 34 on 20 July and 5 August 2018.	[redacted]
1.4.491 The Panel have heard that she was monitored no differently to any other OCdt as there was a fear that this would increase her	[redacted]

stress level and it was acknowledged that she wanted to put the incident behind her. As mentioned in TOR 1 some of the CoC did not know that she attended [redacted] on 9 August 2018.	
Switch in emphasis after 17 July 2018 **1.4.492** The Panel has identified the chronological series of events concerning the SP after the RE visit in TOR 1, the CoC actions in the initial aftermath appear to focus upon her safety and well-being and relied heavily upon the DCMH assessment that she was low risk to recurrence and could return to training. The care aspect being provided through the CAP and the understanding that the welfare and chaplaincy depts were engaging with her. The emphasis switched on 26 July 2018 to a disciplinary focus and the SP received a formal interview with Witness 28 with Witness 35 in attendance. The SP had to sign the AGAI paperwork at that meeting and the Panel believe that she would have been under no illusion as to how seriously the CoC viewed the event at the RE in Weymouth. Thereafter, the panel are of the opinion that the SP understood that a further incident involving excess alcohol may have had severe consequences upon her career. Albeit one of the causation factors alluded to by the SP was [redacted] there was no care intervention in this respect by the CoC. The panel noted that Witness 28 explained to the panel that they had outlined the welfare services, however there was unfortunately no practical engagement with specialist welfare, WRVS or the AWS to assist her with the ongoing issues that she referred to in her disciplinary meeting on 26 July 2018.	[redacted]
Lack of Support over summer leave 2018 **1.4.493** The Pl staff in the junior term did not provide any form of on-going monitoring or check up on the SPs welfare over the summer leave period. The Panel felt that this was remiss of the CoC not to provide any form of care especially as it was only 4 weeks after a serious incident of DSH.	
Purpose of meetings at RMAS **1.4.494** During the SPs attendance at RMAS there were numerous meetings to discuss her progress these were conducted at Company, College, and Academy level. Information concerning her welfare, care and status was discussed some of the information discussed required actions to be undertaken to care for her ongoing welfare. The Panel put this aspect to a member of the CoC and received the following response: LEGAD: There appears to have been a great number of meetings to discuss The SP, she was discussed at the welfare meetings, et	[redacted]

cetera, but the output of these meetings just seems to be shared situational awareness rather than any actual positive actions that assist the individual. What would you say to that observation? WITNESS 32: I wouldn't wholeheartedly disagree with it. No, I think - I mean, it's one of -the - one of the reasons we hold them is to provide that shared situational awareness but the end of that situational awareness is for those that provide a particular service to get on and provide that service and it would appear that that has not occurred in -some - in- some cases here, so I wouldn't dispute it."	
Summary **1.4.495** The continual round of weekly and monthly meetings at which certain aspects of the SPs care or progress was not communicated effectively up and down the CoC do not in the Panel's assessment appear to have had a positive effective or impact. This is particularly the case in relation to the events that occurred on Ex Normandy Scholar. Her care in relation to this event was particularly poor and lacked input from various departments as outlined in detail in TOR 3.	[redacted]
1.4.496 The assurance element of the SPs overall care management was also severely lacking. The Panel believe that there was not a sufficiently robust system in place within Old and New College Headquarters to ensure that the practical support that she should have been receiving was delivered. As a result, Academy Headquarters was also not fully informed of the true position and was consequently unable to influence any outcomes.	
1.4.497 The final observation and finding the Panel have concluded in respect of this sub-TOR is that there was a similarity in terms of approach between the post RE visit events and the period between 1 to 6th February 2019. In both cases, once the SP had been restrained in Weymouth (and handed over to the RMAS medical Chain) and was then physically located on the morning of Sat 2 February 2019 the CoC focus quickly shifted to one of a disciplinary nature rather than one that was outwardly concerned for her welfare. This was particularly the case after the Falklands Coy Ball incident where scant regard by the CoC seems to have been given to the reasons why she was graded Red on the Company, College and Academy welfare tracking systems.	[redacted]

SECTION 5 ANALYSIS OF FACTORS – TOR 5B

Analyse medical procedures and reports to determine the level of care and attention received by the Service Person.

1.4.498 In order to determine and analyse the medical procedures the Panel were granted access to the SPs medical records and in addition had access to the post death medical reviews that were undertaken as listed in TOR 4.	[redacted]
1.4.499 Witnesses 31, 40, 42 and 45 were questioned in detail about their involvement with the SP and the input that they recorded in her medical records. The questioning took the form of following the chronological inputs into the records and asking the Witnesses to explain their findings. Discrepancies between their assessments and those of the individuals who prepared the subsequent reports were put to the Witnesses and they were given the opportunity to counter the report findings both at the oral hearings and in writing if they so wished.	[redacted]
Initial Notification and assessment at RMAS Medical centre **1.4.500** Witness 31 was the first member of medical staff to be informed of the RE incident on the morning of 17 July 2018 they arranged for the SP to be assessed upon return to RMAS. Thereafter, Witness 42 undertook a face to face assessment of the SP at approximately 1115 hrs. The Panel sought to determine what facts Witness 42 knew about the event and were informed of the following: WITNESS 42: I knew that she had, [redacted] PRESIDENT: Yes. WITNESS 42: I understand that the first occasion -- I just need to refer to my notes really. But I think [redacted] were involved and I believe that was the first event. And a [redacted] was involved, and I think that was the [redacted]. I am afraid I can categorically state that I was not aware that she had been [redacted]. PRESIDENT: Or using her [redacted]? WITNESS 42: Or using her [redacted] PRESIDENT: [redacted].	[redacted]

WITNESS 42: That certainly and obviously that's relevant in relation but I would have still taken the same course of action. PRESIDENT: Yes, yes. Okay, what I am just trying to determine is how much information you were told by individuals who were at the Royal Engineers visit or what you were told by the Chain of Command, i.e. the military staff who were either in Old College at that time. I think we have just clarified that you were told some of the information, but you were not aware of the bigger picture as to what actually happened the night before. WITNESS 42: That would be correct, yes; what you have just said, yes.	
1.4.501 Witness 42 was questioned about the detail of the ambulance report, and it was identified that the details of that report may have been received after they had seen the SP not at the time of initial assessment, the relevance of this is outlined in the excerpt below: [redacted] PRESIDENT: Yes, there is certainly a lesson there for us to note and take away	

Significance of the ambulance report details

1.4.502 The specific relevance of this fact is that the SP had told the [redacted]. As time elapsed this fact was oversighted/overshadowed as, when she returned to the medical centre [redacted]

[redacted]

1.4.503 Witness 42 took detailed notes from their first inter-action with the SP and noted her concerns regarding the commissioning course, this was the first time that these had been picked up upon by anyone in a position of authority

[redacted]

Relevance of Witness 42 recorded observations

1.4.504 Whilst no one else at RMAS had identified that the SP was struggling with the stresses of the course and there was no other visible behaviour prior to this incident, it was obviously clearly visible to Witness 42 who's final written opinion was recorded as follows:

[redacted]

The panel note that at the time of recording this, Witness 42, a medical professional, did not know the full extent of the self harm actions which had occurred. Unfortunately, at no time, between 17 July 2018 and 06 February 2019, was Witness 42 informed of the full extent of the self harming behaviour.

Why did the event occur? Was it just an alcohol related incident?

1.4.505 The SP was then referred straight to DCMH, Witness 42 was finally questioned about the influence of alcohol and the SPs actions and they made the following observations:

[redacted]

Transfer to DCMH for urgent assessment

1.4.506 The SP was escorted to DCMH by a WRVS worker for an appointment with Witness 40 which occurred on the afternoon of 17 July 2018.

1.4.507 Witness 40 mentioned at the start of their evidence the following:

WITNESS 40: Yes, in relation to me seeing, yes, Officer Cadets with this type of presentation and given the incident that had happened, this certainly was a rarity for me, yes.

Explanation of pre-appointment questionnaire

1.4.508 Witness 40 explained that prior to physically seeing the SP she had to complete a number of questionnaires, the Panel queried the findings and Witness 40 explained their use of such information as follows:

WITNESS 40: No, no. So, with scorings for us they are a guide. They are not something that you say, "Okay, because a patient has scored this, therefore we should go with this". Often as a clinician, you would seek to explore in terms of really what's their drinking pattern, what's going on and try to marry it with the incident that has happened.

So, scores are normally just a guideline. They are not to be taken as gospel because understandably patients will minimise or sometimes will exaggerate, sometimes for secondary gain, sometimes in order for them not to have any penalties either on a course or in their career. So, they are often just a guide.

[redacted]

Investigation of Service Person's history

1.4.509 The Witness 40 then explained in detail that they discussed the SP previous schooling history and her background and the possible impact the event may have had upon her reputation, as outlined below:

[redacted]

[redacted]

PRESIDENT: Yes. What I am just trying to determine, Witness 40 is how you confirm that what you have been told by the patient is actually the truth. How do you do that?

[redacted]

[redacted]

Knowledge of actual events that occurred at RE visit

1.4.510 Of relevance at this point is that there was no external verification to the Witness of what had happened at the RE Camp and more importantly none was forthcoming during the subsequent appointments. The Panel sought to clarify how much information Witness 40 knew about the event whilst they undertook the SPs assessment and heard the following response:

PRESIDENT: Were you aware of the fact that she had tried to [redacted] and that she had tried to [redacted]

WITNESS 40: No, no. No, I wasn't aware of that.

PRESIDENT: Because that is the key.

WITNESS 40: Yes, that would have made -- I think that would have added on to the risk assessment or to a conversation that would have had with the [redacted]

[redacted]

PRESIDENT: Yes.

WITNESS 40: Yes, yes. And given -- also given the fact that she's in an environment where she wants to do well, where she's keen to pass out as an Officer at Sandhurst. So, yes.

PRESIDENT: Okay. So, just for clarification purposes then, before we move on from the history-gathering phase, effectively you have only been made aware of half of the stories, I would suggest.

WITNESS 40: Yes. Yes, sir.

PRESIDENT: Do you understand why I am saying that to you?

WITNESS 40: Yes, I totally understand.

What did the staff at DCMH know about the RE visit?

1.4.511 The Panel delved deeper into Witness 40's understanding of the whole situation in order to be able to assess the level of care and attention that was applied to the information that they were receiving as well as exploring any interaction with the RMAS CoC as demonstrated by the following excerpt:

LEGAD: The implication of the questioning there, [that the president] is directing to you is that, frankly, Sandhurst did not undertake a sufficiently good investigation to give you all of the background. So, my question to you is did you go back to Sandhurst at any point, either before or after seeing the SP to say, "Right, I've read this very short handover note, this brief that you've got. Is there any more information you can give me?" and is that something that you would normally do?

WITNESS 40: Not, not -- it's not something we would normally do and, no, I didn't go back and confer with them in terms of finding out whether there was any other information.

[redacted]

1.4.512 The final point in this regard was simply summarised by Witness 40 comment as follows:

"So, I think we were all working on the information of that night. So, you would find that if there had been any concerns elsewhere, those would have been highlighted."

[redacted]

Use of FMED 1041 to gather further information

1.4.513 In TOR 4 The Panel investigated and commented upon the use of FMED 1041 reports as a means to communicate with the CoC, Witness 40 explained why one was not used concerning the SP as follows:

PRESIDENT: Can you tell me, please, why an FMed 1041 was not requested? My understanding is that an FMed 1041 is a report on an individual that is written by their Chain of Command so as to inform you as to how that individual is getting on.

[redacted]

WITNESS 40: Okay.

PRESIDENT: Did you request one of those?

WITNESS 40: [redacted]

PRESIDENT: Prior to your meeting on the 26th?

WITNESS 40: [redacted]

[redacted] there was the MDT meeting between the 17th and the 26th, so we would often discuss cases in terms of our assessment, what our thoughts are and this was one that I possibly -- I think I must have brought to the team. Normally, 1041 it's certainly something that's quite good to gain additional information but in this case [redacted] And normally they are associated with a patient who is about to leave the military, for us to just get a bit of a feel on a Unit's perspective on that particular soldier. "	
Internal supervision discussions at DCMH, diagnosis and determination of status **1.4.514** Witness 40 discussed their assessment of the SP with Witness 45 before relaying the assessment that the SP was fit to return to training and was a low risk to recurrence on the afternoon of 17 July 2108. They arranged a follow up appointment for her on 26 July 2018 and an appointment with Witness 45 on 9 August 2018.	[redacted]
1.4.515 The Panel considered whether the option for the SP to have a short break from the course had been considered by Witness 40 and they described the pros and cons of this line of thought: PRESIDENT: What I am just trying to determine is why was the option not taken to give her a break from training, even if that was for a couple of days or send her home to her family to reflect on this? Why did that not happen? Why was that not considered? WITNESS 40: Okay. For me, I had considered that, although it is not necessarily highlighted here because sometimes, as a clinician, you -- especially when things like this happen, you have to consider that given her -- what she was keen to, in terms of continue to engage with the course, because just because giving her a break is what might be considered -- sorry, what I'm trying to say is often with military personnel, going home is great because they're away of the stressful environment, they can spend time with their loved ones. [redacted] [redacted]	[redacted]

[redacted]

Return to RMAS Medical Centre

1.4.516 The SP returned to the RMAS medical centre during the late afternoon on 17 July 2018 [redacted] she was visited by Witness 28 and 35.

[redacted]

Development of coping strategies and understanding alcohol and its impact

1.4.517 Witness 31 met with the SP that day [redacted]

[redacted]

Return to training 18 July 2018

1.4.518 The ward staff recorded on 18 July 2018 that there were [redacted]

1.4.519 Late afternoon there was a further entry which recorded [redacted]

[redacted]

Provision of detailed occupational guidance to the CoC

1.4.520 On the afternoon of 18 July 2018 Witness 31 recorded on DMICP that they had:

[redacted]

1.4.521 The Old College Comd, Coy Comd and Padre are recorded as being present, and of specific relevance is that it was at this meeting that Witness 31 [redacted]

1.4.522 A key factor here is that Witness 31 was providing Occupational guidance at this point. The Panel believe that it was up to the CoC to apply military judgment to determine the SPs next steps and that they should not have regarded this as sacrosanct advice that had to be slavishly adhered to. This understanding or confusion regarding this element of medical advice is dealt with in TOR 1 in greater detail.

1.4.523 Witness 31 recorded their advice to the welfare meeting concerning alcohol as follows:

[redacted]

1.4.524 The Panel assessed that Witness 31 final comments quoted below regarding the meeting are a fundamental part of the SPs care plan, the application and importance of which was obviously not fully understood by the COC. Particularly, that the SP (who had agreed to abstain from alcohol after 16 July 2018) needed to develop an understanding of alcohol and the negative effects that excess consumption had upon her. The detail is as follows:

[redacted]

[redacted]

Importance of family support after DSH incident

1.4.525 [redacted]

1.4.526 Subsequent investigations during the Inquiry have confirmed that the SP did not speak to her family about this incident. The Panel sought to determine the impact of such missing information and the influence this might have had in relation to the SP care and treatment, Witness 31 explained their position as follows:

PRESIDENT: So if we move on, the Panel could conclude that you and your colleagues were naïve and that you just believed [the SP] and did nothing to verify her versions of the events or corroborate what she was saying, her version of the incident. I put that to you and please come back to me and explain to me why it is not the case?

WITNESS 31: I think that -- that's a fair -- probably a fair proposition or allegation to make. I think the --

PRESIDENT: It is not an allegation. [redacted]

WITNESS 31: No, not allegation, sorry, allegation, I am using the wrong word. I think proposition is --

PRESIDENT: I know what you mean, though, but just to come back to me on why that is?

[redacted]

[redacted] Now, clearly there's -- already there's new information that is coming out now that -- that I was not aware of so it -- it does suggest that that is flawed.

Getting the right information and its importance in this case

1.4.527 Witness 31 went on to expand upon the issue identified here and also commented as follows:

PREIDENT: So knowing what you now know, what could we do differently if this was to be relived again. What could we change? If there was anything that we could change from your perspective.

WITNESS 31: I think to me the -- the issue is understanding or having to hand the information that is making an individual vulnerable, and I think one of the concerns that I have as more information comes to light here is that -- that I or other people involved in her care did not know that there was a significant amount of information that didn't seem to be to hand that might be important to supporting her.

So, what can we do differently? I think the simple answer is to have a better understanding of what's going in our cadets and our soldiers and our Officers' lives, but the question is how do we do that without breaching their confidentiality and their autonomy? I think my -- my approach has always been to cultivate a trusting environment and relationship where they feel able to disclose perhaps that [redacted]

But, you know, there -- there's information sitting in the background of all of this that -- that I think undermines that perspective. I don't know the answer, I just know that it's -- it's about having -- having the right amount of information without compromising confidentiality and autonomy and where the balance for that sits.

Duty to provide information after a DSH incident

1.4.528 Whilst the perennial problem of gathering facts to support any medical assessment after a distressing incident has been

highlighted in the SPs case, the Panel are of the opinion that the CoC had a duty to provide the medical Chain with as much information as was available in the immediate aftermath and specifically in the period up to 09 August 2018. The panel believe that when the SP attended her final assessment with the [redacted] that the CoC had not provided any further supplementary details of the events that occurred at the RE visit.	
Final appointment at DCMH **1.4.529** On the 9 August 2018 the penultimate day of the Junior term the SP attended an appointment at DCMH with Witness 45. A significant point to note at this stage is that the CoC were unaware of this final appointment and that no further information had been made available to Witness 45.	[redacted]
1.4.530 Witness 45 confirmed that they had discussed the SPs case with Witness 40 on 17 and 26 July and that her case had also been discussed at a multi-disciplinary meeting of health professionals at DCMH on 18 July 2018.	[redacted]
1.4.531 At the start of the hearing Witness 45 confirmed that [redacted] and that this was an administrative oversight which has now been addressed by changes to policies at DCMH.	[redacted]
Sources of information **1.4.532** Witness 45 was questioned about the sources of information that were available to them during the appointment and they also expanded upon the situation faced by DCMH and RMAS at that time explained as follows and is also dealt with in TOR 5D: PRESIDENT: Would you have expected supplementary information to be fed in after an incident? Does that happen? WITNESS 45: It happens now and if you would allow me to elaborate, I will explain why. PRESIDENT: Yes, please. WITNESS 45: Although Sandhurst Military Academy comes under our catchment area, and I have been the [redacted] for Sandhurst for many other reasons, all sorts of issues, there was not a -- I have to choose my words very carefully lest I come across as critical -- there was not a set process of flow of information between what I, being a civilian, could loosely call Chain of Command and the medical Chain.	[redacted]

1.4.533 Witness 45 did confirm that irrespective of the lack of a formal process to allow the flow of information that Witness 31 and 42 could have updated Witness 45 on any additional information had it been forth coming, Witness 45 also outlined that any passage of information should have been through the medical centre and that the CoC should not have communicated this with DCMH directly.	[redacted]
Patient's rights **1.4.534** Witness 45 explained why a FMED 1041 report was not used to enable the CoC to communicate with DCMH and this has been dealt with in TOR 4 in detail. They also explained to the Panel and the panel are in agreement, that it is not DCMH's role to undertake investigations into events and that there has to be a balance in requesting any additional information.	[redacted]
1.4.535 Through questioning it became apparent that Witness 45 was not aware of the full extent of the events that had occurred at the RE visit and this aspect has been dealt with in TOR 4C which investigated risk management. Essentially the degree of self - harming behaviours [redacted] was not disclosed to Witness 45 by the CoC or by the SP [redacted]	[redacted]
1.4.536 At the time of the appointment Witness 45 addressed the issue of information and its assessment and application of clinical judgement as follows: WITNESS 45: [redacted]	[redacted]

Impact of alcohol

1.4.537 The impact and influence of alcohol was explored with Witness 45, and they confirmed this factor a follows :

PRESIDENT: You are saying the fact that alcohol was involved was a significant factor then?

[redacted]

[redacted]

1.4.538 The lack of a previous history of self-harm and an isolated incident with alcohol in during which the [redacted] were all factors that Witness 45 considered in detail prior to making their assessment.

[redacted]

1.4.539 The Panel sought to determine the influence/impact of alcohol and Witness 45 explained in detail their considerations during and after the appointment before preparing their report

LEGAD: [redacted]

[redacted]

Safety netting arrangements and alcohol

1.4.540 Witness 45 outlined how they closed off the discussion with the SP regarding alcohol as follows:

[redacted]

PRESIDENT: Yes.

WITNESS 45: I advised -- I see in my report I wrote, and I did not make it up:

[redacted]

PRESIDENT: Yes.

[redacted]

The abstinence from alcohol and going tee total

1.4.541 The Panel were informed that the CoC understood that the SP was to be tee- total after this incident [redacted]

[redacted]

The influence of alcohol and the incidents in Normandy and at the Falklands Ball

1.4.542 The Panel shared with Witness 45 the two further incidents involving alcohol namely Ex Normandy Scholar and the Falklands Ball and questioned them about the importance of alcohol involvement at those times:

[redacted]

[redacted]

PRESIDENT: Yes, yes.

[redacted] The panel noted at this time the SP was still meant to be teetotal, was categorised as a vulnerable adult by the medical staff and that the CoC were aware of her drinking and they did not inform the medical Chain or refer her.	
Alcohol and the focus of attention **1.4.543** The importance with which the SPs ability to develop a relationship with alcohol [redacted] was obviously not fully understood by all elements of the CoC. Witness 45 was explicit in their determination as to what should have happened as is described below: [redacted]	[redacted]
1.4.544 Witness 45 explained in detail their engagement with the SP and [redacted] [redacted]	[redacted]
1.4.545 Having discussed the history to the SPs presentation Witness 45 moved onto the latter part of their assessment and explained in detail to the Panel how they undertook a full evaluation which is best described as "[redacted]	[redacted]

[redacted]

Assessment of Service Person's mental state

1.4.546 Witness 45 described in detail how they used various factors to determine the SPs mental state, their findings were as follows:

[redacted]

1.4.547 The interpretation of this paragraph is best described below by Witness 45 who explained in lay-man's terms what their findings were:

[redacted]

Determination of [redacted]

1.4.548 The final element to part 1 of the report concerned [redacted] and Witness 45 explained how they made the determination that there was no increase in any domain as follows:

[redacted]

[redacted]

1.4.549 Witness 45 recommended that [redacted]

Further Review after discharge

1.4.550 The Panel inquired as to why Witness 45 [redacted]

Observation regarding the alcohol related incident in Normandy in November 2018

1.4.551 One of Witness 45 final comments to the Panel related to the Ex Normandy Scholar incident and their observations are relevant when considering the level of care and attention received by the SP.

WITNESS 45 :" I'm sad to see the November incident that you mentioned in Normandy, that was not brought to the attention of the medical faculty because if medical faculty knew -- I'm not saying what they would have done but they could have been reasonably expected to say, "Okay, well in the context of alcohol, something

happened in the past. It's happening again. Maybe we should look at it". The panel believe that in November 2018, the second incident involving alcohol should have been referred to the medical staff. This would have then been considered by the PHCT review team and can reasonably be expected to have triggered a formal medical intervention. This event in Normandy should also have been recorded on the SPs CAP and should have reasonably led to an intervention by the CoC.	
Care assessments and medical reports on the Service Person **1.4.552** [redacted]	[redacted]
1.4.553 [redacted]	
1.4.554 [redacted]	[redacted]
1.4.555 [redacted]	[redacted]

[redacted]	
1.4.556 The Panel agreed with both the lessons and the recommendations suggested by Witness 56 and have incorporated them into our recommendations in TOR 6.	[redacted]
1.4.557 Witness 57's report titled "Initial Internal Review Following Suspected Suicide of [the SP]" Dated 22 February 2019. This report was undertaken following a self-referral by Witness 45.	[redacted]
1.4.558 [redacted]	[redacted]

1.4.559 [redacted]	[redacted]
1.4.560 [redacted]	[redacted]
1.4.561 The report concludes with an initial lessons learnt paragraph and Witness 57's observations are recorded below: [redacted]	[redacted]
Requirement for improved recording **1.4.562** The Panel are in agreement [redacted]	
1.4.563 These observations were taken forward and are referred to in TOR 6 as part of the Inquiry's recommendations.	[redacted]
1.4.564 The Confidential Medical Report produced by Witness 45 for Coroner dated 29 August 19 was considered by the Panel but did not generate any specific observations.	[redacted]
Differences between medical specialities and possible implications thereof **1.4.565** The final report considered by the Panel was the "Independent Review into the Death of [the SP]" produced by Witness 55 dated 23 April 2019.	[redacted]

1.5.566 [redacted]	
Confirmation that policy was adhered to in the Service Person's case **1.4.567** [redacted]	

1.4.568 [redacted]	[redacted]
1.4.569 The Panel note that the recording did not occur but the discussions concerning the SP did and it did not unduly affect her care or treatment.	
[redacted] **1.4.570** [redacted]	
1.4.571 [redacted]	[redacted]
1.4.572 The Panel are aware from Witness 31 [redacted]	[redacted]
1.4.573 [redacted]	[redacted]

[redacted]

Process

1.4.574 [redacted]

[redacted]

1.4.575 [redacted]

[redacted]

The formulation and understanding of the extent of the DSH incident

1.4.576 [redacted]

1.4.577 [redacted]

Lessons

[redacted]

Recommendations

[redacted]

1.4.578 [redacted]

[redacted]	
Summary **1.4.579** In summary, having examined in detail the procedures that were used to assess and then care for the SP and also having had the benefit of 3 reports prepared by individuals who were not involved in the care and management of the SP, the Panel were in the fortuitous position of being able to widely consider the evidence relating to this matter.	
1.4.580 The Panel are of the opinion that the assessment and medical care of the SP was of an acceptable level, [redacted] but do not think that this materially affected the care that the SP received from those involved in the medical Chain.	

SECTION 5 ANALYSIS OF FACTORS – TOR 5C

Determine the procedures in place at DCMH Aldershot for sharing of information and concerns with Units.

1.4.581 The process and procedures which RMAS and DCMH used to shared information in relation to the SP has been referred to in other TORS, The Panel have attempted to identify and explain the various means in this following TOR.	
How does information pass to and from DCMH **1.4.582** Information flows into DCMH in the form of referrals from medical centres using FMED 7 documentation and telephone referrals. [redacted]	[redacted]
1.4.583 [redacted]	[redacted]
1.4.584 [redacted]	[redacted]
1.4.585 [redacted]	[redacted]
1.4.586 On 18 July 2018 a meeting occurred at RMAS to discuss the future management of the SP, this included Witness 28,31,34, and 35. Witness 40 was not invited to attend. RMAS recorded this meeting as a VRM meeting under the auspices of the policy document AGAI 110. Witness 40 described to the Panel how they were invited to other units' meetings to provide updates on patients, this would have been another means by which DCMH could have shared information relating to the SP. This attendance in person at meetings at RMAS in 2018 was not normal practice, Witness 45 has described to the Panel that they would not normally communicate directly to the CoC and therefore the attendance in person at such meetings was the only means by which DCMH could have communicated with members of the CoC in a forum without having to pass all information through the medical CoC.	[redacted]

1.4.587 [redacted]	[redacted]
1.4.588 [redacted]	[redacted]
1.4.589 [redacted]	[redacted]
1.4.590 [redacted]	[redacted]
Summary **1.4.591** The Panel believe that information relating to the SP followed the established routes that were normally used in cases of deliberate self-harm in 2018 at DCMH. [redacted]	

SECTION 5 ANALYSIS OF FACTORS – TOR 5D

Identify whether sensitive and confidential information was appropriately shared between and within RMAS and DCMH Aldershot.

1.4.592 There were effectively 4 major interested parties which held information relating to the SP whilst she was at RMAS, namely the CoC, the Welfare team, the Chaplaincy department, and the Medical Centre (including DCMH). The Panel believe that knowledge of the RE visit can be considered by a lay person as being of a sensitive nature and for this reason the Panel have considered the CoC as an integral part of this circle of knowledge. Whilst limited information was passed to the CoC by Witness 31 at the meeting on 18 July 2018 the Panel believe that no confidential medical information was disclosed.	[redacted]
The Chain of Command **1.4.593** The Panel have learnt that the OCdts who attended the RE and the staff who assisted with her care during the visit knew of the precise details of what occurred, but this information was not adequately collated and shared with the medical staff who assessed the SP.	[redacted]
1.4.594 After the RE visit the CoC recorded the SPs status on the weekly and monthly welfare registers, the CoC did not share updates to these registers with the medical staff, namely after the battlefield study trip to Normandy in November 2018 and again after the Falklands Coy Charity Ball on 1 February 2019.	[redacted]
1.4.595 Sensitive Information relating to the SP was known to the CoC as it was recorded on her CAP and details were discussed at the VRM meeting which occurred on 18 July 2018. The Panel believe that the information recorded in the SPs CAP was not shared with her nor were the monitoring actions adequately explained to the Pl Staff who were meant to undertake that task. Information regarding the SPs disciplinary position was also known to the CoC but this was not shared with the medical Chain.	[redacted]
1.4.596 On the afternoon of 5 February 2019 the CoC was made aware of allegations of a sensitive nature concerning [redacted] by the SP. The panel would have expected the CoC to have acted immediately, as soon as they were informed of the allegations, unfortunately they did not raise them with Academy Headquarters or seek advice from the medical staff, the welfare staff or the military or civilian Police.	[redacted]

1.4.597 The quality and extent of the information known by the CoC was poor, several Witnesses have explained to the Panel that they did not have a full understanding of what had happened at the RE visit and as such were not alive to the vulnerable position that the SP was in, this is apparent to the Panel as no one actually did anything after the SP continued excessive drinking and specifically after [redacted] incident on the morning of 2 February 2019.	[redacted]
Welfare **1.4.598** The Welfare team at RMAS were informed of the DSH incident through the INCREP which was sent on 17 July 2018, Witness 38 explained that they were further informed after the meeting on 18 July 2018. The SPs case was referred to the AWS by Witness 38 the details of the case were discussed and recorded. The panel believe that the level of risk that was recorded by the AWS Initial Assessment Team worker was not shared with or by the Welfare Dept. As a result the significance of the level of risk associated with the SPs immediate return to training was not clearly and precisely communicated to the CoC, medical staff or the Chaplaincy dept.	[redacted]
1.4.599 The Panel noted that Witness 38 was an attendee at the PHCT meetings held at RMAS but there are no notes regarding their inputs to the said meetings.	
1.4.600 Witness 34 conducted a meeting with the OCdts who had assisted the SP and met with her twice after the incident to provide pastoral care. The CoC requested Witness 34 assistance with dealing with the said Cadets and it was noted by the Panel that TRiM was not offered to the OCdts, in the immediate aftermath of the visit. The panel believe that the OCdts concerns should have been brought to the attention of the CoC at this time.	[redacted]
1.4.601 During the Intermediate term the Panel noted that there was no information forth coming from the Chaplaincy Dept to assist with the care and management of the SP.	
1.4.602 Witness 34 confirmed that they met with the SP on 3 February 2019 for a pastoral meeting, and that she seemed visibly re-assured thereafter. Due to exercise commitments Witness 34 was unable to meet with the SP again they did however refer her to Witness 29 in their absence. This electronic referral occurred on 6 February 2019, Witness 29 confirmed that they did not follow up this matter with the SP.	[redacted]
Medical Centre Staff and DCMH. **1.4.603** TOR 5C dealt with the means by which information passed between DCMH and RMAS in summary this occurred by the use of	[redacted]

DMICP and telephone in the case of the SP. [redacted]	
1.4.604 [redacted]	[redacted]
1.4.605 Whilst Witness 45 and Witness 31 had discussed the impact of alcohol and its negative effects with the SP (and the CoC had engaged with her [redacted]	[redacted]
1.4.606 [redacted]	
1.4.607 The limited sharing of information by the CoC with the medical centre staff had the unintended consequence of restricting the [redacted] understanding of the SPs position as mentioned in TOR5b above.	
Summary **1.4.608** The Panel find that in totality, sensitive and confidential information was shared appropriately between DCMH and the RMAS medical staff. However, the Panel believe that there was insufficient sharing of information by the welfare dept, the chaplaincy team, and the CoC.	
1.4.609 The level of information sharing was nowhere near the standard that the Panel had anticipated in finding within a Basic training establishment. In addition, the Panel also believe that as a direct consequence of this deficiency, the CoC had a sub-optimal level of knowledge and situational awareness concerning the SP. The combination of these factors ultimately led the Panel to determine that the CoC did not discharge their duty of care towards the SP at the required standard.	

SECTION 5 ANALYSIS OF FACTORS – TOR 5E.

Express an opinion on whether the interaction between DCMH Aldershot, RMAS, medical agencies and welfare organisations was appropriate and sufficient in the circumstances known, or which could reasonably expected to be known, to those agencies and organisations at the time.

1.4.610 The Panel believe that in this sub-TOR the word "interaction" is key to understanding our position and subsequent assessment of the various organisations who were involved with the SP whilst she was at RMAS.	
The impact of the missing investigation. **1.4.611** The vital factor now apparent to the Panel is that the lack of a thorough and detailed investigation to determine the facts and inform the medical professionals was a serious omission. This lack of diligence effectively led to a misunderstanding of the seriousness of the events which occurred on the evening of 16/17 July 2018. The building blocks of understanding the SPs situation were not put in place, as a result everything decided upon thereafter was based upon incomplete knowledge. The medical staff were essentially basing their assessments upon half of the facts, it is understandable why the SP sought to minimise the seriousness of the situation, she had worked incredibly hard to start Officer training and clearly did not want to be removed from the course after a [redacted] Irrespective of this desire to continue, the facts relating to the event were readily available from the OCdts on the morning of 17 July 2018. Unfortunately, this information was overlooked and not brought to the attention of any of the medical Witnesses or the CoC. Witness 36, a senior member of the Chain of Command, was candid about their assessment of this assertion as follows: "If the right people were not spoken to in terms of that investigation, then the right procedure wasn't followed. I mean, it is self-explanatory, isn't it? If we didn't get the right evidence into that folder and, therefore, the narrative that was then read back into me and the Chain of Command and to the DCMH was wrong, then something didn't go right."	[redacted]
Limited sharing of information particularly from November 2018 to February 2019 **1.4.612** The lack of interaction between the welfare, chaplaincy and CoC elements in the intermediate term to support the SP was extremely poor, the inability to comprehend the position faced by the SP at that time was an example of the poor judgement shown by all	

members of the NC CoC. The continued omission by the NC CoC from November 2018 to February 2019 to not alert Witness 36 and the medical Chain to the specific details of the Normandy incident cannot be regarded as an administrative oversight. The panel can find no plausible reason why this information was not shared with the Ac HQ and the RMAS medical centre.	
1.4.613 The Panel believe that the welfare department did not interact at an acceptable and appropriate standard with the SP, the medical staff, AWS or the CoC. The continuing CAP access problems and lack of active VRM account management were below any acceptable standard. The problems with the IT system should have been raised so that the problems could be overcome at the earliest opportunity.	[redacted]
Ineffective meetings and limited assurance activity **1.4.614** The Panel have mentioned previously in TOR 3c, the fact that there were lots of meetings to discuss the SP, meetings offer the opportunity and forum in which to interact, share information and agree courses of action in order to support an individual, unfortunately this does not seem to have happened in this case; what was of note was the lack of drive to grasp the initiative and do something positive to assist the SP. The Panel have deduced that the assurance element of these said meetings was flawed and sub optimal as there is no evidence to prove that individuals were ever held to account for their actions in support of the SP, this is specifically applicable to the welfare and chaplaincy teams. The very fact that the CoC recorded that the SP should seek help from Witness 18, but nobody sought to confirm that this had happened highlights our findings and supports our assertions.	
Collective inability to act decisively and engage the medical professionals **1.4.615** As previously, mentioned the interaction between the RMAS CoC and the medical centre staff appears to be limited and this phenomenon repeated itself again after the Falklands Ball incident. The SPs status was raised on 4 February 2019 from an Amber to a Red risk rating, but the medical centre was not alerted, nor were they informed that this was because she had been involved in a third serious alcohol related incident that was being investigated as a potential major AGAI action.	
Summary **1.4.616** In summary, the Panel are of the opinion that the interaction between the medical professionals was appropriate and sufficient but that the interaction between the CoC, welfare	

department and the Chaplaincy team was not of the expected standard.	
1.4.617 The Panel acknowledge that a number of concerns identified by the Inquiry have been addressed in the intervening period and that certain policies and procedures have been updated.	

SECTION 6 ANALYSIS OF FACTORS – TOR 6

Based on the evidence, make such findings and express opinions as are appropriate to support recommendations in order to prevent recurrence.

TOR 1 Recommendations

In light of the facts identified whilst investigating TOR 1 the Panel make the following recommendations.

Policy Matters **1.4.618 AGAI 110**. The Panel are of the opinion that the lack of understanding and compliance with AGAI 110 (Army vulnerable risk management policy) had a significant effect on the management of the SP following the incident of DSH in the form of attempted suicide. Commanders at all levels need a greater understanding of AGAI 110- (Army wide). The majority of the staff involved in the management of the SP were untrained or uninformed of AGAI 110, the process to follow and the direction that should have been adhered to.	
1.4.619 Training on AGAI 110, VRM, is currently provided for personnel taking up posts as Adjt, OC's, UWO's and CO's appointments. The Panel heard evidence of personnel not attending the prerequisite training for their roles. RMAS did not offer any inhouse training on AGAI 110 or any refresher training.	
1.4.620 If RMAS staff had a sound understanding of AGAI 110 their unit policy would align with extant Army policy.	
1.4.621 AGAI 110, Annex D identifies risk factors that have been associated with suicidal behaviour amongst soldiers and Officers as a result of detailed analysis of all Army Boards of Inquiry (14 listed in total). If CoC had been fully informed (by investigation into DSH and completed CAP with input from all agencies) they may have recognised some of the 10 listed below which could be associated with the SP and therefore taken immediate action. a. History of Previous Suicide Attempts. b. History of Deliberate Self Harm (DSH). c. Mental Health Referral or Diagnosis. d. Relationship Problems. e. Loneliness and Isolation	

f. Sense of Hopelessness Powerlessness, or Helplessness. g. Current or Pending Disciplinary or Legal Action. h. [redacted] i. Substance Abuse. j. Work Related Problems	
1.4.622 AGAI 110 explains that evidence shows that an episode of DSH is one of the strongest predictors of suicide; a previous history of DSH will be found in between 40-60% of suicides deaths. Whilst a 'cry for help' episode does not necessarily mean that an individual has any intent to die, that intent may become manifest if action is not taken to resolve those difficulties, perceived or real. The Panel believe that this fundamental fact was never understood by the CoC as they were unaware of the guidance.	
Recommendation 1: ARITC are to ensure that all training establishment staff receive training on AGAI 110 VRM with specific reference to the management of Care Action Plans. Training and refresher training, as identified, should be undertaken prior to return postings to training establishments for appropriate Permanent Staff.	
1.4.623 Engagement of Family support. The Panel found that the CoC made an assumption of not being able to contact the SPs family, following the DSH incident. An assumption made due to a misunderstanding of AGAI 110. The SPs medical guidance allowed her to return to training due to factors including a "supportive family network". The CoC believed that the SP had informed her mother of the incident, unfortunately this was not the case and there was no assurance undertaken by the CoC to confirm that the SP actually had a supportive family network. The Panel believe that the SP had to come to terms with the after-effects of a serious incident of DSH alone with no effective support mechanism to aid her.	
1.4.624 AGAI 110 explains that in many suicide cases, the potentially benevolent influence of the family has been underestimated. This is not always the case, however, and so it is always important to clearly establish the soldiers' domestic situation and relationship with their family. Whenever possible, soldiers should be encouraged and persuaded to voluntarily tell their families about their problems and difficulties. If they will not, then if possible, they should be persuaded to allow the Chain of Command to speak to their families – even if it is only to tell them that the soldier is not happy. In exceptional circumstances, the Chain of Command may approach a family without the soldier's permission but in such a situation no personal information may be disclosed other than to say that there is concern about the individual's welfare and it would be helpful if the family made contact.	

Recommendation 2: ARITC are to establish guidelines for Permanent Staff defining how and when the Next of Kin of trainees are contacted if training establishment Permanent Staff have significant welfare or medical concerns relating to trainees (detailing guidelines for U18 Soldiers Under Training in particular).	
Recommendation 3: HQ RMAS are to establish guidelines for Permanent Staff defining how and when the Next of Kin of trainees are contacted if training establishment Permanent Staff have significant welfare or medical concerns relating to trainees.	
1.4.625 Investigation. Any incident of DSH should involve a full and thorough investigation. The lack of investigation resulted in missing information and a lack of understanding of the situation.	
1.4.626 The Panel are of the opinion that statements should have been taken from all personnel, listed as "involved personnel" on the LA. (It is noted that the SP was not listed as an involved person). Furthermore, limiting the statements taken to staff members resulted in evidence not being obtained from first responders at the DSH incident.	
1.4.627 As a thorough investigation was not completed, the Panel concluded that the CoC had a limited understanding of the incident, its seriousness and the intent of the actions undertaken by the SP.	
Recommendation 4: HQ RMAS are to ensure that after every incident of SH a thorough investigation is undertaken, including notification to the RMP SIB that an incident has occurred as required by AGAI 110.	
Recommendation 5: HQ HC are to remind Units that after every incident of SH a thorough investigation is undertaken, including notification to the RMP SIB that an incident has occurred as required by AGAI 110.	
Recommendation 6: HQ Fd Army are to remind Units that after every incident of SH a thorough investigation is undertaken, including notification to the RMP SIB that an incident has occurred as required by AGAI 110.	
Recommendation 7: JSP 751 Working Group are requested to review whether a serial be added to NOTICAS and INCREP	

formats, that in the event of an incident of self-harm the respective Service Police Force is notified.	
1.4.628 Managing Risk. The SPs DSH incident occurred on 16 July 2018. Due to the monthly Commanders meeting being cancelled and summer leave, the Panel have found that the SP was not recorded on a risk register until 14 September 18 (A4). At which point the SP had been discharged from DCMH without any information from the CoC being input to the medical Chain.	
1.4.629 The Panel believe that the details of the risk register should be accessible to all those individuals in the CoC especially when Pl Comds and CSgts are expected to perform actions to support OCdts.	
Recommendation 8: RMAS College monthly risk register meetings must be held as a priority, in line with AGAI 57. In addition, the details of the risk register must be accessible to those individuals who are expected to perform actions to support the OCdts.	
1.4.630 Alcohol Policy. The Panel are of the opinion that a robust unit alcohol policy should be briefed to staff and Cadets prior to social functions, unit visits, battlefield tours, and dinner nights to reinforce the acceptable standards.	
1.4.631 Greater supervision should be taken to ensure staff and OCdts adhere to the alcohol policy and that those who continue to misuse alcohol should be supported through the welfare and medical Chains.	
1.4.632 Clearer direction on the roles and responsibilities expected of a receiving unit, for RMAS familiarisation visits is required. Specific guidance concerning alcohol should be briefed to hosting units	
1.4.633 The Panel have heard evidence of the SPs misuse of alcohol on 3 occasions. Elements of the CoC were aware of the drinking incidents but did not act upon them or report these to the medical Chain or even their own CoC.	
Recommendation 9: RMAS Unit Alcohol policy be reviewed – to include its application and enforcement during events away from RMAS that Cadets may attend, such as Unit familiarisation events. OCdts and Permanent Staff are to read and acknowledge that they have understood the policy. The policy is to be robustly enforced at events where alcohol is allowed.	

Recommendation 10: People-Sec-DCL Discipline Pol (the policy holder) is requested to review JSP 835 Alcohol and Substance Misuse and Testing policy to consider occasions where alcohol misuse occurs and results in SH, first time incidents should trigger an automatic welfare support intervention.	
Recommendation 11: Senior Health Advisor Army (SHA (A)) is requested to review AGAI 110 (Vulnerability Risk Management) to ensure that on all occasions involving SH, an individual is placed on the VRM and is actively supported by the CoC and Welfare, pastoral, and medical services as applicable.	
Command and Control **1.4.634 Handover Procedures**. The poor handover of the SP, the VRM and her CAP between Colleges (at the end of Junior term), allowed for a fundamental misunderstanding of the SPs situation. (J37 pg 4). Some of the CoC were unaware of the DSH or that the SP was on the VRM and had a CAP which required positive actions to be undertaken by them.	
1.4.635 If there is a requirement for a change of staff (as there was in this case) a full and thorough HOTO should be completed, and sufficient time be allocated to enable this to occur.	
Recommendation 12: HQ RMAS are to ensure that the handover of OCdts between RMAS Colleges is completed in an open and comprehensive manner, ensuring that all members of the CoC and welfare team are aware of any ongoing OCdt welfare concerns (subject to the normal confidentiality rules, where applicable). The Chain of Command are to inform Permanent Staff of what their precise future role is in supporting any at risk trainees.	
1.4.636 Command PIDs. The College Commanders role is titled SO1 G7 and is not a Command appointment, this results in no requirement to attend the CO Des course (where VRM trg takes place) or the Defence Commanding Officers of Training Establishments course. Neither were attended, in full, by either College Commander. As a result, no training has been provided in the welfare and care of basic training trainees. And the lack of Command authority leaves a deficit in the Commanders ability to deal with G1 (in some cases falling to CO SSU to deal with).	
1.4.637 There are significant discrepancies in the Job specification between Old and New College Commanders, most notable that the Commanding Officers Designated Course is not recommended in	

the Old College pre employment training, additionally, SO1 Comd Old College does not have the requirement for prior Command experience; it is classed as essential for the Comd of New College but desirable for Old College and recent operational experience is essential for Old College and desirable for New College. The discrepancies require amendment.	
Recommendation 13: MS (APC) is requested to review the 2 RMAS College Commander Job specifications to determine whether the posts should become Command earning appointments. This will result in appointees attending the CO Designate Course and the Defence Commanding Officers of Training Establishments Course as part of their pre-employment training.	
Recommendation 14: HQ RMAS are requested to ensure that College Commander appointments contain Command responsibilities and that all incumbents are fully aware of their role with regards to risk and their responsibilities within the duty holder framework.	
1.4.638 Staff selection. The Panel saw evidence of instructors, who were new to instructing potential Officers, taking up roles in the Junior Term. As such, they are arguably not as well prepared and therefore the Panel are of the opinion that Pl Comds on arrival, wherever possible, should not be placed in the junior Term.	
1.4.639 Whilst the selection of Pl Comds now takes place at APC which is a recent change this was not the case for the SPs cohort of Pl Comd. Of note is the fact that CSgt instructors must undergo a selection cadre whereas Pl Comds are selected by a paper board at APC.	
1.4.640 Pl CSgts should have experience in an instructor role at a Basic Training or Initial Trade Training establishment prior to taking up the role as Pl SNCO.	
Recommendation 15: MS (APC) is requested to review the selection of RMAS Permanent Staff, both Officers and SNCOs in order to ensure that the appointees have the correct balance of KSE and interpersonal skills, including a high level of applied emotional intelligence.	
Recommendation 16: HQ RMAS is requested to review the training of RMAS Permanent Staff, both Officers and SNCOs in order to ensure that the appointees have the correct balance of	

KSE and interpersonal skills, including a high level of applied emotional intelligence.	
1.4.641 Pre-employment trg. During the Inquiry, the Panel heard from several members of staff who had not had the time/opportunity to complete the prerequisite training required for the role, before starting the post.	
1.4.642 Refresher trg and arrival training should take place, irrespective of rank, in order to ensure all staff are up to date with latest policies and procedures.	
Recommendation 17: ARITC are to direct that by default all pre-employment training requirements for Training Establishment Staff are to be completed prior to commencing appointments at Basic training establishments. In the event that pre-employment has not been completed Permanent Staff do not undertake any unsupervised instruction until qualified.	
1.4.643 Welfare support during Leave. There is a duty of care for RMAS to provide welfare support during periods of leave or stand down. The Panel were informed that the DS also require a period of rest so should not be contacted during leave. This resulted in the SP having limited identifiable formal welfare support within the remaining weeks of the Junior term and none whatsoever during the summer leave period.	
1.4.644 Whilst the Panel are of the opinion that the rigors of working at a Basic training establishment should allow for DS to take leave. There is a requirement for a robust welfare network to be available and proactive at all times.	
Recommendation 18: ARITC are to implement a robust and informed welfare support system to be available to basic trg trainees currently on a CAP, identified as vulnerable or are classified as an at-risk individual, during periods of leave and when moving within establishment and between units; in line with AGAI 110.	
Recommendation 19: HQ RMAS are to implement a robust and informed welfare support system to be available to basic trg trainees currently on a CAP, identified as vulnerable or are classified as an at-risk individual, during periods of leave and when moving within establishment and between units; in line with AGAI 110.	

1.4.645 Welfare team. The Panel have seen evidence that the welfare department at RMAS is family facing and not Cadet facing. The Panel are of the opinion that the welfare team should be more integrated with the OCdts. They focus on the wider Sandhurst community, which is just as important, but to the detriment of the Cadets.	
1.4.646 The welfare team never met or communicated with the SP during her time at RMAS. The Panel are of the opinion that a Cadet who is recorded as "red" on the risk register or has a VRM entry, should by actively (as opposed to passively) supported by a robust welfare team.	
Recommendation 20: HQ RMAS are to implement a larger cadet facing welfare team in order to ensure Cadets have designated and trained personnel available to offer welfare support.	
1.4.647 Chaplaincy. The welfare requirements expected of the chaplaincy department were not inputted into the CAP. The Panel saw evidence that the CoC relied heavily on the pastoral support that they believed was being provided by the chaplaincy department. The panel noted that there is no evidence to prove that the chaplaincy department met with the SP between August 2018 and 02 February 2019. The panel have identified that the SP only met a member of the Chaplaincy team a total of 4 times during their time at RMAS. A more formalised record of pastoral meetings with OCdts, (and where confidentiality allows, concerns being raised to the CoC) would allow assured interaction between the CoC and chaplaincy department.	
1.4.648 The Chaplaincy Dept are relied upon extensively by the CoC for wide ranging support for the OCdts, as the welfare team are predominantly focused on the DS and families. A welfare department that was significantly more OCdt focused would allow the Chaplaincy department to focus specifically on pastoral and spiritual care.	
1.4.649 The sub-standard provision of pastoral care for the SP at RMAS leads the Panel to believe that a wider ranging review of the Chaplaincy department is required now.	
Recommendation 21: HQ RMAS and the Chaplain General are requested to conduct comprehensive joint review of the role and responsibilities of the Chaplaincy Department, its integration and purpose at RMAS.	

TOR 2 Recommendations

In light of the facts identified whilst investigating TOR 2 the Panel make the following recommendations.

Values and Standards **1.4.650 Relationships**. The Panel of the opinion in 2018-19 there was a culture at RMAS that enabled relationships to occur between OCdts and Staff. The CoC are aware of the "God complex" which can develop in intense training environments. This complex is essentially a situation where trainees are in complete awe of their instructors who are held up on a virtual pedestal and are untouchable.	
1.4.651 The Panel are of the opinion that a more robust and inquisitorial type of junior leadership, from Pl Commanders is required. Pl Comds must have the time to be more influential and involved in the welfare of their cadets. They must possess the desire to understand their Pl dynamics, if this was achieved, they would not need to rely so heavily on their SNCO's. Stronger junior leadership may also assist in ensuring that the Army's values and standards of behaviour are instilled in trainees right at the start of their military careers.	
Recommendation 22: HQ RMAS are to deliver refresher training during the Commissioning Course, of what constitutes unacceptable behaviour and inappropriate relationships within a basic training establishment.	
Recommendation 23: ARITC are to direct refresher training, where required, during the delivery of courses at Training Establishments, of what constitutes unacceptable behaviour and inappropriate relationships within a basic training establishment.	
1.4.652 Standards of conduct. The Panel heard evidence of several examples of instructors using inappropriate language. Staff need to better understand the impact of the use of unsuitable language when dealing with trainees. Instructors at RMAS would benefit from coaching and mentoring in order to enhance their ability to inculcate a positive learning environment.	[redacted]
1.4.653 In an intense training environment OCdts should expect to be treated fairly, the CoC expectations of the instructor need to be clearly communicated prior to taking up the post.	
Recommendation 24: ARITC are to educate recruit facing Staff in training establishments to better understand the importance	

and impact of inter-personal skills and the appropriate use of language when dealing with trainees.	
Recommendation 25: HQ RMAS are to educate recruit facing Staff in training establishments to better understand the importance and impact of inter-personal skills and the appropriate use of language when dealing with trainees.	
1.4.654 Witness 25 was disciplined whilst at RMAS for an [redacted] The CoC should reconsider the position of instructors who have previously been subject to disciplinary action for inappropriate behaviour/relationships.	
1.4.655 The OJAR and SJAR "suitability for instructor recommendations" needs to be accurately declared by reporting Officers in annual reports. Any concerns regarding an individual's suitability to work within a training establishment can be recorded here. This will then be visible at future appointment boards.	
Recommendation 26: ARITC should confirm annually the suitability of its training establishment Instructor's to continue working with Basic training trainees. If an instructor is subject to administrative or disciplinary action, then an assessment of their suitability should be conducted, and they should be removed from post if deemed appropriate.	
1.4.656 Communications. The Panel have seen evidence of OCdts and Staff communicating in an inappropriate manner. Resulting in over familiarity which could potentially lead to further inappropriate behaviour. There appears to be an over reliance upon messaging apps for the passage of basic day to day information concerning the CC.	
Recommendation 27: HQ RMAS are to robustly enforce, clear, distinct boundaries for Permanent Staff and OCdts in the use of social media and messaging apps.	
1.4.657 Mental resilience. The Panel saw evidence of personnel within the CABS department being heavily relied upon to provide psychological support to OCdts. This support was positively received by some Witnesses and encouraged by some of the CoC and the medical staff. However, this was an informal secondary duty (of Witness 18) without a formal referral system or feedback loop to ensure that all referrals had been received, engaged with and completed.	
1.4.658 The Panel have identified a requirement for improved mental resilience trg at RMAS for OCdt and DS.	

Recommendation 28: HQ RMAS is requested to review the requirement to establish a psychologist / mental resilience lead as a primary job role, not secondary, to support OCdts and Permanent Staff at RMAS, to be added to the RMAS 8005 if endorsed.	
Recommendation 29: HQ RMAS to review the requirement for, and if approved implement a comprehensive mental health resilience training programme.	
1.4.659 Information sharing within RMAS. Following the SPs crisis of confidence issue, raised during Ex NORMANDY SCHOLAR, there was inadequate engagement and no active support. The incident was reported on the Company risk register but not raised to College level. As a result, the medical Chain was unaware of the incident and were unable to identify patterns of behaviour or increased risk.	
1.4.660 As well as the crisis of confidence matter, a member of the Company DS who was aware of the SPs previous alcohol misuse and the DSH incident and were aware she had agreed to stop drinking alcohol, did not act when she was behaving in an intoxicated manner. They then didn't report this to their CoC or take any action. The Panel are of the opinion that this resulted in the details of the incident not being fully understood by the Coy CoC. This was not explained fully on the Company risk register and may have explained why the incident was not raised at the College welfare meeting. As a direct result the incident was not brought to the attention of the medical Chain. [redacted]	
1.4.661 The Panel have seen little evidence of audit and assurance actions with regards to communication between the CoC and the medical Chain. The Panel believe that there was limited analysis of the SPs risk and vulnerability particularly between August 2018 and 6 February 2019.	
Recommendation 30: HQ RMAS are to review the manner in which information is collated and subsequently shared between the CoC, the medical chain and the welfare department. This specifically applies to OCdts who are recorded on the risk register. A robust medical referral process must be implemented for any suspected alcohol misuse and self-harm incidents in addition to adhering to Army Policy.	
1.4.662 Welfare support. There is a requirement for proactive welfare support for individuals listed on welfare register. The Panel	

are of the opinion that OCdts listed on the risk register should be supported by the chaplaincy as another arm of the welfare element.	
1.4.663 The co-ordination of welfare support, assurance and holding individuals to account would be significantly improved if this function was directed by the Academy HQ.	
1.4.664 The lack of any interaction from the welfare department and chaplaincy throughout the whole of the Intermediate term, highlights a significant inadequacy in the welfare system.	
1.4.665 Disciplinary action. The management of personnel undergoing disciplinary investigation needs to ensure clear communication channels and timely action, whilst also providing the support required in accordance with individual circumstances and need. The Panel have seen evidence to suggest the SP felt she was going to be discharged before the investigation had started. The Panel are of the opinion that, given her lack of military experience, she would have had very little understanding of the disciplinary process that was about to take place which would have cause significant pressure.	
1.4.666 The Panel are of the opinion that the SPs misunderstanding of the possible outcomes of the disciplinary process, through a lack of guidance and support immediately following the incident on 1 February 2019; may have resulted in a such a degree of pressure building upon her that it led to a feeling of helplessness resulting in the SP researching the subject of [redacted] the days leading up to her death.	
1.4.667 The Panel are firmly of the opinion that the focus of the CoC shifted from welfare to a disciplinary manner once the investigation started.	
Recommendation 31: HQ RMAS must establish and adopt an immediate, bespoke welfare support system for OCdts subjected to the disciplinary process.	
1.4.668 The Panel have seen evidence of poor management of staff members during their own disciplinary investigations. One staff member waited 4 months before being removed from post, during this time they were not properly employed. Another was removed from post without any welfare support or TRiM following a traumatic incident.	
Recommendation 32: HQ RMAS are to ensure that disciplinary action is dealt with promptly and efficiently across all ranks in accordance with policy timeframes.	

1.4.669 Collective responsibility to act upon information. [redacted]	
1.4.670 An OCdt raised concerns to members of staff, but these were not recorded and there is no evidence to prove that the concerns were acted upon in a prompt manner.	
Recommendation 33: HQ RMAS are to provide instruction to all military and civilian instructors and trainees to inform them of signs or concerns of abuse or Discrimination, Bullying and Harassment (DBH), and that it is their duty to report it through the chain of command immediately, or to the military / civilian police where appropriate.	
Recommendation 34: ARITC are to provide instruction to all military and civilian instructors and trainees to inform them of signs or concerns of abuse or Discrimination, Bullying and Harassment (DBH), and that it is their duty to report it through the chain of command immediately, or to the military / civilian police where appropriate.	
1.4.671 [redacted]	
Recommendation 35: Welfare Team, Armed Forces People Support are requested to review if there is a requirement for Units to identify (and inform via INCREP / NOTICAS) if the Service Person involved in an incident is in a relationship or is estranged from a former partner that is not listed as either their Emergency Contact or next of Kin.	
Recommendation 36: AFPSp are requested to review policy to further explain the phrase "next of kin" and to inform all SP about the implications when completing their online records. The required outcome is to enable SP to provide clear instructions on who they wish notifying in the event of an	

incident, including any complex personal circumstances. The addition of a JPA text box is a suggested solution.	

TOR 3 Recommendations

In light of the facts identified whilst investigating TOR 3 the Panel make the following recommendations.

Policy **1.4.672 Pre employment trg**. The Panel have seen evidence of policies not being adhered to (AGAI 110 examined further above) due to lack of understanding or lack of application.	
1.4.673 Care Action Plan. Poor application of the CAP resulted in mismanagement and no assurance of the welfare support of the SP. The Panel are of the opinion there is a requirement to improve staff training for those with G1 responsibilities at trg establishments and to specifically ensure they are current and competent in the delivery and management of the CAP process. Capturing all welfare involvement on the CAP would have prevented assumptions that support was being provided which as the Panel have identified it was not.	[redacted]
1.4.674 The CAP must follow the trainee (if posted, or internally between colleges), be discussed at UHCs, were necessary and then be reviewed in accordance with policy. Ensuring CAP plans are followed ruthlessly and handed over correctly is a key finding.	[redacted]
1.4.675 Junior members of the CoC didn't receive training or exposure to VRM or CAP, yet they were named on the CAP, to provide support and policy directs that they must read and understand their involvement in the CAP (when named on the CAP). There is a requirement for training of Junior Officers and SNCO's if they are going to be required to administer the actions of a CAP.	
1.4.676 Confidentiality. AGAI 110-110.022 (in place in July 2018) states the rules surrounding information sharing and confidentiality are strict. Once individuals have been assessed as being at risk, they must be offered an explanation of the SVRM process and asked to agree the resulting summary information about their management and care. The summary information can be shared with those who can implement the plan and provide support for them. They should be asked to sign the information sharing agreement in the relevant section of the CAP. Any decision not to allow information sharing must be documented.	
1.4.677 The Panel are of the opinion that due to incomplete knowledge and a misunderstanding of the CAP management requirements; the SPs CAP was not handled in accordance with policy. The panel draw this conclusion because we have seen no	

evidence to prove that the SP was aware that a CAP had been established for her.	
Recommendation 37: ARITC are requested to review all instructor pre-employment training and work-based induction programmes to ensure that training staff fully understand all of their G1 responsibilities regarding their trainees.	
Recommendation 38: HQ RMAS are requested to review work induction programmes to identify if there is a specific requirement for their training staff to have a greater understanding of all their G1 responsibilities.	
1.4.678 UHC. UHC's at RMAS did not consider OCdts. The Panel are of the opinion that, according with policy, RMAS should have been conducting UHC's which covered OCdts and permanent staff. UHC's should be conducted at College level. This requirement will require oversight from a CO. If the College Commander is not in a Comd appointment and hence does not have Comd authority (see recommendations 13 and 14) then this risk would have to be elevated to the next level of Command.	
1.4.679 UHC's would provide the opportunity for oversight of CAPs, VRM, TRiM medical and welfare matters and ensure staff and OCdts are properly supported.	
Recommendation 39: HQ RMAS are in accordance with AGAI Vol 2 Ch 57, Health Committees, to ensure the Unit Health Committees for all staff and OCdts are conducted in line with policy.	
1.4.680 Assurance. Following the numerous positive changes to policy and procedure at RMAS there is now a requirement by ARITC to ensure the changes are enacted, assured and audited in the future.	
Recommendation 40: ARITC must ensure that any policy and procedure amendments that are introduced within training establishments are enacted – establishing and directing a continuous assurance process.	
TRiM **1.4.681 Policy**. Defence information note 2009DIN01-097, pg 4 specifically mentions field army units requiring sufficient numbers of trained TRiM personnel to deal with a traumatic event. The Panel have heard evidence from experienced soldiers, to support the opinion that incidents at a training unit can be equally as traumatising.	

1.4.682 [redacted]	
Recommendation 41: Senior Health Advisor Army (SHA(A)) is requested to review the requirement for TRiM Policy to be updated to ensure direction on the provision of sufficiently trained TRiM trained / aware personnel applies to both Field Army and training establishments / units.	
1.4.683 Unit TRiM Policy. LFSO 3217, TRiM, states Commanders must issue a policy statement giving clear direction on how TRiM should be implemented within their formation/unit. The Panel found there was no unit TRiM policy at RMAS.	
1.4.684 Policy specific to the unit would give the direction for a coherent TRiM plan, which is likely to result in less errors being made in the event of an incident.	
1.4.685 A unit TRiM policy must confirm the number of TRiM trained personnel required within the establishment. The obvious advantage of having the correct number of trained personnel is that a more bespoke TRiM service can be offered, and it would enable smaller grouped sessions to be offered to individuals who have been affected by distressing incidents. The Panel heard evidence from the TRiM coordinator that they required more in date TRiM trained personnel.	
1.4.686 A unit TRiM policy in consultation with 2009DIN01-097 would ensure that individuals who decline TRiM at the first sessions are recorded as having declined. This would also serve as a prompt for the TRiM co-ordinator to follow up with those said individuals at a later date. The importance of correct recording of TRiM and subsequence assurance actions was identified during the Inquiry. The panel believe that had there been a greater degree of assurance then the first responders who dealt with the SP may have received TRiM in the aftermath of the incident.	
1.4.687 The outcome of many of the TRiM sessions following the death of the SP resulted in signposting or monitoring by welfare or medical Chains. A unit TRiM policy would capture the plan for communicating this activity in order to ensure the second line support was completed.	
Recommendation 42: HQ RMAS are to issue a policy statement with clear direction on how TRiM should be implemented and delivered within the unit.	

1.4.688 Continued support. Trainees who receive TRiM, especially first responders should be placed on the Risk Register and considered at a VRM risk conference, to ensure that monitoring and welfare support is maintained after the event. This would ensure that there is continuity of care once trainees transfer into the field Army. Of note, from a chronological perspective, is that, in this inquiry 30 OCdts were offered TRiM after the SPs death; 9 weeks later they Commissioned and transferred into the Field Army. A number of the OCdts receiving units were unaware of the incident.	
Recommendation 43: All ARITC training establishments are to direct that Basic Training trainees who receive TRiM are recorded on the Risk Register and considered at UHCs.	
1.4.689 Training. The Panel are of the opinion that the TRiM co-ordination role is key to successful delivery of TRiM. Training personnel in key roles with the capacity to manage a TRiM incident would ensure an effective and efficient TRiM plan was delivered after traumatic events. The TriM co-ordinator should not be a CSM in Old or New Colleges.	
Recommendation 44: ARITC are requested to direct that all RSMs assigned to training units must complete the TRiM co-ordinators training course. This must be included in their Job Specification and form part of their pre-employment training.	
Recommendation 45: HQ RMAS are requested to direct that all RSMs assigned are to complete the TRiM co-ordinators training course. This must be included in their Job Specification and form part of their pre-employment training.	
1.4.690 TRiM trg is recommended for UWO's and Padres in 2009DIN01-097, pg 4. At a Basic training establishment where the CoC are extremely busy and absorbed in the trg programme, having extra TRiM trained personnel in the supporting welfare branches would provide a useful asset to the CoC. The Panel saw evidence of 2 Padres not trained and not aware they could be, as a result they didn't fully understand the TRiM process and were unable to fully support the CoC in this aspect.	
Recommendation 46: Army Chaplaincy Dept are requested to review the requirement for Chaplaincy staff at Basic training establishments to be TRiM trained. This will ensure that they better understand TRiM, its application and thereafter be able to provide enhanced support to the Chain of Command.	
Female focus **1.4.691** JSP 822 states there should be a Female focus, within the unit. The Panel heard evidence from OCdts, reinforced by staff	

members (J26D, 33) that the female focus wasn't accessible, that the OCdts wouldn't know who she was or where to find her. The appointment of a female focus Officer must be considered, where relevant, to provide a specific point of contact for female recruits, trainees and staff.	
Recommendation 47: ARITC are to produce unit level guidance regarding female focus leads including for example (roles and responsibilities, key outputs and engagement targets).	
Recommendation 48: HQ RMAS are to produce Establishment level guidance regarding female focus leads including for example (roles and responsibilities, key outputs and engagement targets).	
1.4.692 Welfare Staffing. In 2018 the welfare team consisted of the UWO, UWWO and a WRVS member of staff. There were approximately 2000 people at RMAS who could expect to rely on welfare support from those individuals. The Panel believe that there is a requirement to increase the size of the welfare department with properly trained and proactive staff. (J28E, 35)	
1.4.693 [redacted]	
Recommendation 49: HQ RMAS are to ensure that the welfare team is staffed with sufficiently trained proactive personnel committed to supporting the OCdts, staff and their families and that their output is assured.	

TOR 4 Recommendations

In light of the facts identified whilst investigating TOR 4 the Panel make the following recommendations.

1.4.694 [redacted]	
Recommendation 50: [redacted]	
Recommendation 51: [redacted]	
Recommendation 52: [redacted]	
Recommendation 53: [redacted]	
Recommendation 54: [redacted]	
Recommendation 55: [redacted]	

TOR 5 Recommendations

In light of the facts identified whilst investigating TOR 5 the Panel make the following recommendations.

1.4.695 A common theme in the Panel's investigations has been the fact that there was limited follow up action after the various meetings to discuss the SPs position. An established standard operating procedure to monitor post meeting actions would have enabled the CoC to monitor the level of care that the SP received and offered an opportunity to rectify this by simple intervention.	
Recommendation 56: ARITC are requested to review the requirement for an assurance procedure to be adopted at training establishments to ensure that advice from medical and welfare professionals is acted upon in a timely manner.	
1.4.696 [redacted]	
Recommendation 57: [redacted]	

TOR 6 Recommendations

In light of the facts identified whilst investigating TOR 6 the Panel make the following recommendations

1.4.697 The Panel heard evidence from 46 Witnesses in total, of which 16 were former OCdts and 14 were individuals who were in the CoC at RMAS. As a direct result of all the evidence heard the Panel has decided to make 1 final recommendation which does not logically sit within the remit of any of the 5 previous TORS.	
1.4.698 Course Intensity – Whilst the Panel can appreciate the challenge facing RMAS of turning civilians into effective Army Officers in a 44-week time frame the very fact that many of the Witnesses complained about the pace of life at RMAS raised concern with the Panel. One staff Witness stated, “that it was worse than being on operations” and another commented with the telling analogy “if you are pushing your people and expecting them to perform a match every day, then you are going to break them”.	[redacted]
1.4.699 The Panel found that the short notice changes to the programme combined with the constant staff churn had a disproportionately negative effect upon the staff and OCdts alike. The Panel believe that the changes to the Command-and-control relationship governing RMAS along with the hollowing out of the Academy Headquarters staff has also had a detrimental effect upon the “Sandhurst experience “. A telling fact was that only one OCdt commented in a positive manner when asked to look back on their Commissioning Course.	
1.4.700 A number of the Senior elements of the CoC expressed their concerns to the panel about the inadequate staffing at RMAS. Witness 36 raised this concern in October 2017 with Home Command and ARITC and endeavoured to transfer this risk to the higher headquarters. The pressures of competing demands on limited staff resources resulted in no additional staff being allocated to the RMAS establishment, which continued to hold these risks.	[redacted]
1.4.701 It appears to the Panel that the attempts to integrate the female OCdts have met with limited success however the issue of female isolation was apparent, especially in 33 Pl after the SPs death on 6 February 2019. The professional interaction between predominantly male infantry cap badged Colour Sergeants and female OCdts in some cases was exceptionally poor and has had a significant impact upon some of the Witnesses as they started their military career**.**	
1.4.702 The panel were unable to ascertain if the concerns identified; namely, course intensity, varying training experience ,	

OCdt/Staff relationships and a deficit in welfare support, were considered by ARITC as the last External Validation was completed on 18 April 2012. JSP 822 (Part 1 Annex B) notes the requirement to review the Role performance statement (including the consideration of assurance reports (An External validation report being one of those reports)) at least every 5 years). In addition, there were no records available to confirm when a climate assessment had last been undertaken at RMAS prior to death of the SP.	
1.4.703 In 2018/19 some members of the CoC were prepared to break the rules that were designed to safeguard OCdts and staff. Considering all the evidence, this very fact when combined with poor administrative procedures, weak leadership within the Colleges and poor decision making at key moments lead the Panel to make the following recommendation:	
Recommendation 58: Pers Pol are requested to review the content, duration, and delivery methods of the Commissioning Course by conducting the following: to review the course requirement to ensure that over-training is not taking place; to review external assurance processes to ensure they are fit for purpose; and to ensure the course is subject to periodic external review and continuous improvement.	
Recommendation 59: HQ RMAS are requested to review the culture within RMAS Gp with regards of the Commissioning Course; with particular focus on trainee experience and female integration.	
Recommendation 60: HQ RMAS are requested to review the content, duration, staffing, staffing capacity (particularly ability to deliver all required G1 outputs) and delivery methods of the Commissioning Course. Ensuring there is a robust internal assurance mechanism in place.	
Recommendation 61: HQ RMAS are requested to review internal assurance processes are fit for purpose, and to ensure that the commissioning course is subject to periodic internal review and continuous improvement.	

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PART 1.5

RECOMMENDATIONS

PART 1.5 – RECOMMENDATIONS

1.5.1 The Panel recommends the following:

1.5.2 TOR 1 Recommendations Summary

Recommendation 1. ARITC are to ensure that all training establishment staff receive training on AGAI 110 VRM with specific reference to the management of Care Action Plans. Training and refresher training, as identified, should be undertaken prior to return postings to training establishments for appropriate Permanent Staff.	
Recommendation 2. ARITC are to establish guidelines for Permanent Staff defining how and when the Next of Kin of trainees are contacted if training establishment Permanent Staff have significant welfare or medical concerns relating to trainees (detailing guidelines for U18 Soldiers Under Training in particular).	
Recommendation 3. HQ RMAS are to establish guidelines for Permanent Staff defining how and when the Next of Kin (NoK) of trainees are contacted if training establishment Permanent Staff have significant welfare or medical concerns relating to trainees	
Recommendation 4. HQ RMAS are to ensure that after every incident of SH a thorough investigation is undertaken, including notification to the RMP SIB that an incident has occurred as required by AGAI 110.	
Recommendation 5. HQ HC are to remind Units that after every incident of SH a thorough investigation is undertaken, including notification to the RMP SIB that an incident has occurred as required by AGAI 110.	
Recommendation 6. HQ Fd Army are to remind Units that after every incident of SH a thorough investigation is undertaken, including notification to the RMP SIB that an incident has occurred as required by AGAI 110.	
Recommendation 7. JSP 751 Working Group are requested to review whether a serial be added to NOTICAS and INCREP formats, that in the event of an incident of self-harm the respective Service Police Force is notified.	
Recommendation 8. RMAS College monthly risk register meetings must be held as a priority, in line with AGAI 57. In addition, the details of the risk register must be accessible to those individuals who are expected to perform actions to support the OCdts.	

Recommendation 9. RMAS Unit Alcohol policy be reviewed – to include its application and enforcement during events away from RMAS that Cadets may attend, such as Unit familiarisation events. OCdts and Permanent Staff are to read and acknowledge that they have understood the policy. The policy is to be robustly enforced at events where alcohol is allowed.	
Recommendation 10. People-Sec-DCL Discipline Pol (the policy holder) is requested to review JSP 835 Alcohol and Substance Misuse and Testing policy to consider occasions where alcohol misuse occurs and results in SH, first time incidents should trigger an automatic welfare support intervention.	
Recommendation 11. Senior Health Advisor Army (SHA (A)) is requested to review AGAI 110 (Vulnerability Risk Management) to ensure that on all occasions involving SH, an individual is placed on the VRM and is actively supported by the CoC and Welfare, pastoral and medical services as applicable.	
Recommendation 12. HQ RMAS are to ensure that the handover of OCdts between RMAS Colleges is completed in an open and comprehensive manner, ensuring that all members of the CoC and welfare team are aware of any ongoing OCdt welfare concerns (subject to the normal confidentiality rules, where applicable). The chain of command are to inform Permanent Staff of what their precise future role is in supporting any at risk trainees.	
Recommendation 13. MS (APC) is requested to review the 2 RMAS College Commander Job specifications to determine whether the posts should become Command earning appointments. This will result in appointees attending the CO Designate Course and the Defence Commanding Officers of Training Establishments Course as part of their pre-employment training.	
Recommendation 14. HQ RMAS are requested to ensure that College Commander appointments contain Command responsibilities and that all incumbents are fully aware of their role with regards to risk and their responsibilities within the duty holder framework.	
Recommendation 15. MS (APC) is requested to review the selection of RMAS Permanent Staff, both Officers and SNCOs in order to ensure that the appointees have the correct balance of KSE and interpersonal skills, including a high level of applied emotional intelligence**.**	
Recommendation 16. HQ RMAS is requested to review the training of RMAS Permanent Staff, both Officers and SNCOs in order to ensure that the appointees have the correct balance of KSE and	

interpersonal skills, including a high level of applied emotional intelligence**.**	
Recommendation 17. ARITC are to direct that by default all pre-employment training requirements for Training Establishment Staff are to be completed prior to commencing appointments at Basic training establishments. In the event that pre-employment has not been completed Permanent Staff do not undertake any unsupervised instruction until qualified.	
Recommendation 18. ARITC are to implement a robust and informed welfare support system to be available to basic trg trainees currently on a CAP, identified as vulnerable or are classified as an at-risk individual, during periods of leave and when moving within establishment and between units; in line with AGAI 110.	
Recommendation 19. HQ RMAS are to implement a robust and informed welfare support system to be available to basic trg trainees currently on a CAP, identified as vulnerable or are classified as an at-risk individual, during periods of leave and when moving within establishment and between units; in line with AGAI 110.	
Recommendation 20. HQ RMAS are to implement a larger cadet facing welfare team in order to ensure Cadets have designated and trained personnel available to offer welfare support.	
Recommendation 21. HQ RMAS and the Chaplain General are requested to conduct comprehensive joint review of the role and responsibilities of the Chaplaincy Department, its integration and purpose at RMAS.	

1.5.3 TOR 2 Recommendations Summary

Recommendation 22. HQ RMAS are to deliver refresher training during the Commissioning Course, of what constitutes unacceptable behaviour and inappropriate relationships within a Basic training establishment.	
Recommendation 23. ARITC are to direct refresher training, where required, during the delivery of courses at Training Establishments, of what constitutes unacceptable behaviour and inappropriate relationships within a basic training establishment.	
Recommendation 24. ARITC are to educate recruit facing Staff in training establishments to better understand the importance and impact of inter-personal skills and the appropriate use of language when dealing with trainees.	

Recommendation 25. HQ RMAS are to educate recruit facing Staff in training establishments to better understand the importance and impact of inter-personal skills and the appropriate use of language when dealing with trainees.	
Recommendation 26. ARITC should confirm annually the suitability of its training establishment Instructor's to continue working with Basic training trainees. If an instructor is subject to administrative or disciplinary action, then an assessment of their suitability should be conducted, and they should be removed from post if deemed appropriate.	
Recommendation 27. HQ RMAS are to robustly enforce, clear, distinct boundaries for Permanent Staff and OCdts in the use of social media and messaging apps.	
Recommendation 28. HQ RMAS is requested to review the requirement to establish a psychologist / mental resilience lead as a primary job role, not secondary, to support OCdts and Permanent Staff at RMAS, to be added to the RMAS 8005 if endorsed.	
Recommendation 29. HQ RMAS to review the requirement for, and if approved implement a comprehensive mental health resilience training programme.	
Recommendation 30. HQ RMAS are to review the manner in which information is collated and subsequently shared between the CoC, the medical chain and the welfare department. This specifically applies to OCdts who are recorded on the risk register. A robust medical referral process must be implemented for any suspected alcohol misuse and self-harm incidents in addition to adhering to Army Policy.	
Recommendation 31. HQ RMAS must establish and adopt an immediate, bespoke welfare support system for OCdts subjected to the disciplinary process.	
Recommendation 32. HQ RMAS are to ensure that disciplinary action is dealt with promptly and efficiently across all ranks in accordance with policy timeframes.	
Recommendation 33. HQ RMAS are to provide instruction to all military and civilian instructors and trainees to inform them of signs or concerns of abuse or Discrimination, Bullying and Harassment, and that it is their duty to report it through the chain of command immediately, or to the military / civilian police where appropriate.	
Recommendation 34. ARITC are to provide instruction to all military and civilian instructors and trainees to inform them of signs	

or concerns of abuse or Discrimination, Bullying and Harassment, and that it is their duty to report it through the chain of command immediately, or to the military / civilian police where appropriate.	
Recommendation 35. Welfare Team, Armed Forces People Support are requested to review if there is a requirement for Units to identify (and inform via INCREP / NOTICAS) if the Service Person involved in an incident is in a relationship or is estranged from a former partner that is not listed as either their Emergency Contact or next of Kin.	
Recommendation 36. AFPSp are requested to review policy to further explain the phrase “next of kin” and to inform all SP about the implications when completing their online records. The required outcome is to enable SP to provide clear instructions on who they wish notifying in the event of an incident, including any complex personal circumstances. The addition of a JPA text box is a suggested solution.	

1.5.4 TOR 3 Recommendations Summary

Recommendation 37. ARITC are requested to review all instructor pre-employment training and work-based induction programmes to ensure that training staff fully understand all of their G1 responsibilities regarding their trainees.	
Recommendation 38. HQ RMAS are requested to review work induction programmes to identify if there is a specific requirement for their training staff to have a greater understanding of all their G1 responsibilities.	
Recommendation 39. HQ RMAS are in accordance with AGAI Vol 2 Ch 57, Health Committees, to ensure the Unit Health Committees for all staff and OCdts are conducted in line with policy.	
Recommendation 40. ARITC must ensure that any policy and procedure amendments that are introduced within training establishments are enacted – establishing and directing a continuous assurance process.	
Recommendation 41. Senior Health Advisor Army (SHA(A)) is requested to review the requirement for TRiM Policy to be updated to ensure direction on the provision of sufficiently trained TRiM trained / aware personnel applies to both Field Army and training establishments / units.	

Recommendation 42. HQ RMAS are to issue a policy statement with clear direction on how TRiM should be implemented and delivered within the unit.	
Recommendation 43. All ARITC training establishments are to direct that Basic Training trainees who receive TRiM are recorded on the Risk Register and considered at UHCs.	
Recommendation 44. ARITC are requested to direct that all RSMs assigned to training units must complete the TRiM co-ordinators training course. This must be included in their Job Specification and form part of their pre-employment training.	
Recommendation 45. HQ RMAS are requested to direct that all RSMs assigned are to complete the TRiM co-ordinators training course. This must be included in their Job Specification and form part of their pre-employment training.	
Recommendation 46. Army Chaplaincy Dept are requested to review the requirement for Chaplaincy staff at Basic training establishments to be TRiM trained. This will ensure that they better understand TRiM, its application and thereafter be able to provide enhanced support to the Chain of Command.	
Recommendation 47. ARITC are to produce unit level guidance regarding female focus leads including for example (roles and responsibilities, key outputs, and engagement targets).	
Recommendation 48. HQ RMAS are to produce Establishment level guidance regarding female focus leads including for example (roles and responsibilities, key outputs and engagement targets).	
Recommendation 49. HQ RMAS are to ensure that the welfare team is staffed with sufficiently trained proactive personnel committed to supporting the OCdts, staff and their families and that their output is assured.	

1.5.5 TOR 4 Recommendations Summary

Recommendation 50. [redacted]	
Recommendation 51 [redacted]	

[redacted]	
Recommendation 52. [redacted]	
Recommendation 53. [redacted]	
Recommendation 54. [redacted]	
Recommendation 55. [redacted]	

1.5.6 TOR 5 Recommendations Summary

Recommendation 56. ARITC are requested to review the requirement for an assurance procedure to be adopted at training establishments to ensure that advice from medical and welfare professionals is acted upon in a timely manner.	
Recommendation 57. [redacted]	

1.5.7 TOR 6 Recommendations Summary

Recommendation 58. Pers Pol are requested to review the content, duration, and delivery methods of the Commissioning Course by conducting the following: to review the course requirement to ensure that over-training is not taking place; to review external assurance processes to ensure they are fit for purpose; and to ensure the course is subject to periodic external review and continuous improvement.	

Recommendation 59. HQ RMAS are requested to review the culture within RMAS Gp with regards of the Commissioning Course; with particular focus on trainee experience and female integration.	
Recommendation 60. HQ RMAS are requested to review the content, duration, staffing, staffing capacity (particularly ability to deliver all required G1 outputs) and delivery methods of the Commissioning Course. Ensuring there is a robust internal assurance mechanism in place.	
Recommendation 61. HQ RMAS are requested to review internal assurance processes are fit for purpose, and to ensure that the commissioning course is subject to periodic internal review and continuous improvement.	

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PART 1.6

CONVENING AUTHORITY COMMENTS

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CONVENING AUTHORITY COMMENTS

1.6.1 As the Convening Authority for this Service Inquiry (SI), I am grateful to the President and the panel for the thoroughness of their Report in meeting their Terms of Reference (TOR).

1.6.2 I have reviewed fully the Service Inquiry Report reference APSG/SI/19 and I am content with the outcome of the findings along with the recommendations made in relation to TORs at Annex A to the Convening Order dated 5 Feb 20

Timeline.

1.6.3 The investigation has taken some time to reach a conclusion. This is partly due to the nature and complexity of the case, exacerbated by the various COVID lockdowns which hampered the investigation throughout. The investigation was also paused for a significant period following a referral to the RMP SIB who, after investigation, deemed that there was sufficient evidence for a charging decision to be considered by a bespoke CO. A Brigadier was subsequently appointed and assessed that due to the complexities of the case the matter should be considered by the Service Prosecuting Authority.

Conduct of the Panel.

1.6.4 The investigation has been a complex undertaking, involving interviews and submissions of evidence from 57 witnesses over a prolonged period. The President and panel have delved deeply into the workings of the RMAS systems and processes, the thoughts and decisions made by the chain of command, directing staff, medical experts and officer cadets under training, with specific regard to the tragic events of 6 Feb 19, and with regard to wider cultural and behavioural issues at RMAS at the time. The panel have also reported on the subsequent changes made by RMAS and other relevant stakeholders as a result of their findings.

Findings of the Inquiry.

1.6.5 The findings of the inquiry present a picture of an Officer Cadet described as performing well; enthusiastic, engaging, polite and humble and a strong member of the platoon. Throughout the course, however, [redacted] surfaced with excess alcohol use, which appear to have been aggravated by [redacted] whilst on leave, academic pressure, inappropriate relationships with staff, the potential for disciplinary action and the anticipation of removal from RMAS.

1.6.6 Although these pressures manifested in several indicators, no single individual or body appears to have had sufficient understanding to recognise the need for more in-depth investigation and greater medical, welfare and pastoral support. The lack of regular multidisciplinary meetings to assess the SP's situation, with appropriate medical, welfare, pastoral and chain of command representation, and a shared understanding of events, meant that appropriate action and support was not put into

place and there was insufficient monitoring during times of vulnerability, or enforcement of an agreed alcohol abstention that followed her initial attempt at deliberate self-harm. [redacted]

1.6.7 On three specific occasions spanning all three terms, alcohol-related incidents occurred that pointed to an underlying welfare issue of significance:

a. The initial investigation into the first incident, which involved attempted deliberate self-harm, was fundamentally flawed. This led to an incomplete picture of the seriousness of the incident presented to the RMAS staff and the medical chain. Medical and welfare decisions were taken based on this incomplete understanding of the incident and the RMP were not informed. An Army Welfare Service assessment of the incident recognising the potential for unresolved issues was not passed to the chain of command or medical fraternity; indeed, the RMAS Welfare team did not engage with the SP throughout her time on the course, and a recommendation for support from the RMAS Communications and Applied Behavioural Science team was not actioned. A letter of apology to the chain of command indicating that the cause of the incident involved a combination of alcohol and [redacted] was not investigated or referred to a specialist. A Care Action Plan was put in place, but little action was taken as a result.

b. The second event, during the second term, again involved alcohol despite an agreement to abstain. This was registered as a crisis of confidence over academic stresses. Allegations [redacted] were raised with fellow Officer Cadets during the incident, but not passed to the chain of command. Aside from a chaplain, no-one outside the college chain of command was aware of the second incident, including the medical fraternity; indeed [redacted] Subsequent to this event, the SP was involved in a prolonged inappropriate relationship with a member of the Academy PT staff.

c. The third incident, in the third term, involved missing a parade as a result of significant alcohol consumption at a party and an inappropriate relationship with a member of the directing staff. The member of staff was suspended as a result. During subsequent interviews with the chain of command the SP engaged in self-harming activity in front of staff. The SP appears to have blamed herself for the incident and the member of staff's suspension and believed that she would be removed from RMAS. Following this incident, an Officer Cadet revealed [redacted] to a member of the chain of command. No immediate action was taken, following this revelation or following the second attempt at deliberate self-harm,

despite the SP being assessed on the college risk register as a red risk, categorised as suicide. Following this incident, the SP indicated to the chain of command that she wished to leave RMAS and enlist as a soldier, despite having accepted a commission with the Royal Artillery.

1.6.8 The findings of the inquiry therefore indicate several contributory factors leading up to the tragic situation on 6 Feb 2019, that appear to have stemmed from an [redacted]
Various opportunities to recognise and deal with the issue were either missed or misinterpreted and no coherent picture of the situation was developed or assessed by appropriate authorities as the incidents mounted.

1.6.9 The situation was exacerbated by: an incoherent and disjointed support and welfare mechanism for cadets under training as they progressed through the course; poor coordination and communication between the various welfare-related organisations; inadequate information flow between the chain of command and medical fraternity; a lack of company staff continuity following the move from Old College to New College; limited enforcement of the Academy alcohol policy; a lack of understanding of the extant policy and processes for dealing with vulnerable adults; incidents treated through a disciplinary rather than welfare lens; and a local culture of staff fraternisation and inappropriate relationships with officer cadets under their care.

Recommendations of the Inquiry.

1.6.10 The report provides 61 recommendations based on comprehensive analysis of the findings. These focus on:

a. Ensuring adherence to and understanding of the policies surrounding alcohol, discipline, vulnerable adults, Care Action Plans and the TRiM process as well as the provision of robust risk management processes, health committees and welfare support systems that ensure that all appropriate subject matter experts are included and that actions directed by risk management boards or medical and welfare professionals are audited and held to account.

b. Staff selection and job description improvements to ensure that staff engaged in vulnerable risk management have the appropriate KSE and training prior to assuming appointment, and that handovers between the chain of command include robust welfare handovers and include the welfare team.

c. Regular refresher training covering unacceptable behaviours and inappropriate relationships, with additional education on the importance and impact of inter-personal relationships.

d. Improving the coordination between Primary Healthcare, Secondary Healthcare (DCMH) and the chain of command, as well as the provision of complete, comprehensive risk assessments including safety netting and care plans upon discharge from DCMH.

e. Assessing and refining the culture, content, staffing, delivery and assurance of the RMAS Commissioning Course.

1.6.11 I note that at the time of writing 25 of the 61 recommendations have already been actioned by the appropriate stakeholders.

Summary.

1.6.12 I endorse the SI's findings and the recommendations made therein and submit it to Hd APSG as the final report.

1.6.13 On behalf of the Army, I wish to offer my sincere condolences to [redacted] family, friends and loved ones.

D J Eastman MBE 24 Jun 2022
Major General
General Officer Commanding Regional Command

PART 1.7

REVIEWING AUTHORITY COMMENTS

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INTRODUCTION

1.7.1 I have reviewed the Service Inquiry report into the untimely and tragic death of [redacted] on 6 February 2019. My observations are below.

Context

1.7.2 [redacted] started Commissioning Course 182 at RMAS in May 2018, joining 33 Platoon within Falklands Company. Prior to this she had completed the pre-RMAS development course at the Army School of Education, completing it as the top student.

1.7.3 Despite instances of Self Harm and the abuse of alcohol during the Junior and Intermediate terms of the Commissioning Course, her overall performance at RMAS was good and her potential considered to be above average. In November 2018, at the Regimental Selection Boards, she successfully secured offers of places to commission into either the Royal Artillery or Royal Logistic Corps. She chose the Royal Artillery.

1.7.4 On 7 January 2019 [redacted] commenced the final, Senior, term of Commissioning Course 182. 6 February 2019, Falklands Company were scheduled to conduct skill at arms training on the onsite training area, training which [redacted] was due to undertake after first conducting administration tasks set for her by the Chain of Command. These tasks related to a disciplinary investigation following events at a Falklands Company Charity Ball on 1 February 2019 and her relationship with a member of the RMAS Permanent Staff which had commence in November 2018.

1.7.5 At 0805hrs [redacted] messaged the training staff that she was en route to the training area. However, when it was noted by staff that she had not arrived a search for her was initiated. At 1403hrs she was located, unresponsive, in her room and shortly afterwards declared deceased by the RMAS Senior Medical Officer.

Service Inquiry

1.7.6 On 30 July 2019 my predecessor as the Army's Single Service Inquiries Coordinator directed that a Service Inquiry be convened to investigate the circumstances of [redacted] death. The purpose was for the Army to identify any lessons that would help prevent a recurrence and to enable appropriate changes to policy, processes, and procedures.

1.7.7 The General Officer Commanding Regional Command convened the Service Inquiry on 7 October 2019 and approved the completed report on 24 June 2022.

1.7.8 It has been an unusually complex Inquiry which consequently took longer than normal to investigate. The impact of the global Covid pandemic compounded these given restrictions on the movement of the significant number of witnesses. However, the principal cause of delay was the requirement to stay the Inquiry to

enable a police investigation. In March 2021, the Service Inquiry was stayed by the referral of the case to Provost Marshall (Army) for investigation of possible Service offences. Following investigation by the Special Investigation Branch of the Military Police, the case was referred to the independent Service Prosecuting Authority for consideration of charges against seven individuals. In February 2022, the Service Prosecuting Authority decided not to bring charges and, after application of the Victim's Right to Review process, the Service Prosecuting Authority decision was upheld in late March 2022 and The Inquiry reinstated on 5 April 2022.

1.7.9 The Service Inquiry panel afforded Regulation 18[11] status to 22 witnesses. I am satisfied that this was appropriate and that these individuals were treated in accordance with the requirements of Joint Service Publication 832.

1.7.10 I am grateful to the President and their panel for their thoroughness, and I am satisfied that the Terms of Reference were appropriately pursued and answered.

RECOMMENDATIONS OF THE SERVICE INQUIRY

1.7.11 **Findings of the Inquiry.** I endorse the Convening Authority's analysis of the findings of the Inquiry. I concur that it presented a picture of a young woman who outwardly was thriving at RMAS [redacted] the extent of which only became clear after her death.

1.7.12 **Shortcomings**. The Inquiry identified shortcomings across the following areas:

a. The application of extant policy, processes, and procedures.

b. Failures to communicate critical information pertaining to the management of vulnerable people.

c. Failures to monitor and support vulnerable SP during periods of leave and when transferring roles internally.

d. Inconsistent and ineffective delivery of welfare and pastoral support.

e. Training competency of staff in supervisory roles.

f. Failures to adhere to the acceptable behaviour standards expected of British Army personnel.

g. Culture.

1.7.13 **Recommendations.** The Service Inquiry has made 61 recommendations to address these shortcomings. All are specific to individual establishments or activities. However, where appropriate, they are being or have been applied across the wider Army and shared with the Royal Navy and Royal Air Force. They are grouped as follows:

[11] The Armed Forces (Service Inquiries) Regulations 2008.

g. **Policy updates**. Amendments have been recommended as follows:

(1) **Defence / Joint policy**: Joint Services Publications (JSP):
(a) JSP 751 - Joint Casualty and Compassionate Policy and Procedures.
(b) JSP 835 - Alcohol and Substance Misuse and Testing.
(2) **Army policy**: Army General Administrative Instructions (AGAI):
(a) AGAI 57 - Health Committees.
(b) AGAI 110 - Vulnerability Risk Management.
(3) **Formation Instructions**: Standard Operating Instructions at RMAS, Army Recruiting and Initial Training Command and higher Headquarters levels.

h. **Selection, Training, and behaviour of staff**. The Inquiry identified multiple failures in the selection and scrutiny of potential instructors and personnel in trainee-facing roles. It identified general and specific change requirements, including to:

(1) Pre-employment training and induction programmes.
(2) Assurance of competency and currency during assignment (including refresher training and supervision of unqualified staff).
(3) Increase emphasis on reinforcing what constitutes unacceptable behaviour.

i. **Management and support of trainees**. Shortcomings in the oversight and management of trainees generated recommendations to improve:

(1) Identification, gathering, use of and communication of detailed management information about trainees' welfare.
(2) The monitoring of trainees during transitional periods.
(3) Guidance for female focus leaders.
(4) The conduct of health and welfare meetings and ensuring the application of policy.
(5) Unit and higher Headquarters Alcohol policies.
(6) Trauma Risk Management activity.
(7) Next of Kin informing processes.

j. **Welfare and Pastoral support**. Welfare support was found to have been inadequate, having been under resourced and poorly targeted. Pastoral support from the Chaplains was identified as particularly lacking. The Inquiry recommended:

(1) A comprehensive review of Chaplaincy support.
(2) Targeted and focussed interventions, including the delivery of Trauma Risk Management activity.
(3) A significant uplift in staff and adjustment to protocols to ensure support is more widely and readily available.

Management of the recommendations

1.7.14 **Ownership**. Each recommendation has been allocated an accountable sponsor with the authority to effect the required changes. They are allocated as follows:

a. RMAS – 29.
b. Army Recruiting and Initial Training Command - 14.
c. Defence Primary Health Care and Department of Community Mental Health – 6.
d. The remaining 12 are divided between: MoD - Chief Defence People; Army Headquarters - Army Personnel Health and Personnel Policy and the Chaplain General's Directorate; Headquarters Home Command; and Headquarters Field Army.

1.7.15 **Progress to closure**. All recommendations have been endorsed and accepted allowing them to be addressed and implemented. 54 will be completed by 5 September 2022 with a further five being completed by December 2022. The remaining two recommendations have closure dates of June 2023 and September 2023 as they are linked to structural reviews of the Commissioning Course and RMAS. At the time of writing, 19 have been implemented.

1.7.16 **Record keeping**. These recommendations, their associated progress to completion and supporting evidence is recorded on the Defence Lessons Identified Management System (DLIMS). Progress is monitored and assured by the APSG Lessons Team.

ASSURANCE - CLIMATE ASSESSMENTS

Initial Climate Assessment

1.7.17 A Climate Assessment was undertaken at RMAS in Autumn 2020. It provided a confirmation baseline understanding of the lived experience following implementation of changes recommended in the [redacted] immediate Learning Account and led to further refinement of structure and policy at the Academy.

Subsequent Climate Assessment

1.7.18 A follow-up Climate Assessment took place in Autumn 2021 to assess the perceived effect of these changes on staff and cadet experiences. They reported improvements, especially in the areas with the most direct bearing on the circumstances of [redacted] case, but also perceptions of continued vulnerability in some areas of welfare. These are being addressed.

Assessment

1.7.19 The Climate Assessment team assess that RMAS staff and cadets recognise the significant efforts to address factors noted in the Learning Account and which have been identified during the Service Inquiry.

WIDER ORGANISATIONAL INITIATIVES

1.7.20 In addition to the changes recommended by this Service Inquiry, regular single Service initiatives and policy updates driven by a wide body of evidence and reporting across Defence have resulted is routine organisational review. Notwithstanding the delays to this Service Inquiry timely change has been implemented because of this and in direct response to the findings of the case's immediate Learning Account. Changes that have or will improve the Army's support to vulnerable Service People include:

a. **Defence Policy improvements and initiatives**. In response to the Defence Safety Authority's *Focused Review of Suicides among Armed Forces Personnel*[12] (November 2018), in 2019 the MoD established a Defence-wide Service Personnel Suicide Prevention Working Group. Under the Armed Forces Suicide Prevention Strategy this enables the identification, resourcing and prioritisation of requirements and improved coherence.

b. **RMAS Futures Review**. On 1 May 22, a review was established to consider:

(1) **RMAS Operating Model Review**. The review will evaluate the existing breadth of command responsibilities and outputs of the RMAS Group and generate evidence-based proposals for structural and procedural change. It reports to the Executive Committee of the Army Board in July 2022.

(2) **Young Officer Training Review**. This review will translate our most recent thinking about how we operate under the "Future Soldier" initiative into revised training objectives for the Regular Commissioning Course and Commissioning Course Short. It will also include a review into the teaching of Diversity & Inclusion and Unacceptable Behaviour. This review will deliver the first stages of revised behaviours in September 2023.

(3) **Trainer Review**. This review will deliver a detailed examination of how we select and train the best Instructors to train Officers and Soldiers.

c. **Command and Control**. RMAS has been re-instated as a 2* Command, with a permanent resident Commandant, has improved resourcing and oversight.

SUMMARY

1.7.21 I am satisfied that the death of [redacted] has been comprehensively investigated, the findings appropriately analysed and reported on thoroughly. The Inquiry recommendations have been endorsed and are already tasked for implementation.

[12] Published 9th November 2018: https://www.gov.uk/government/publications/dsa-focused-review-of-suicides-among-armed-forces-personnel.

1.7.22 I acknowledge the Convening Authority's remarks that the level of support afforded to [redacted] as a trainee, specifically from the CoC, welfare department and Chaplaincy Dept, fell below the standard that should have been expected.

1.7.23 [redacted] Next of Kin will now be offered a copy of the Service Inquiry report and a briefing by the President to explain the findings and answer any questions that they may have.

1.7.24 On behalf of the Army, I offer my sincere condolences to the family, friends, and colleagues of [redacted]. I hope that the Inquiry has provided information which will enable them to reach some peace and closure.

E J R Chamberlain 28 June 2022
Brigadier
Head Army Personnel Service Group and
Single Service Inquiry Coordinator (Army)