

THE DEEPCUT REVIEW

A review of the circumstances surrounding the
deaths of four soldiers at Princess Royal Barracks, Deepcut
between 1995 and 2002

Nicholas Blake QC

REPORT

*Return to an Address of the Honourable the House of Commons
dated 29th March 2006
for*

**A REVIEW OF THE CIRCUMSTANCES
SURROUNDING THE
DEATHS OF FOUR SOLDIERS AT
PRINCESS ROYAL BARRACKS, DEEPCUT
BETWEEN 1995 AND 2002**

Nicholas Blake QC

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THE DEEPCUT REVIEW

Rt. Hon. Adam Ingram MP
Minister of State for the Armed Forces
Ministry of Defence
Main Building
Whitehall
London
SW1A 2HB

Dear Minister,

March 2006

On the 15th December 2004, you appointed me to conduct a review, that you had previously announced to the House of Commons, of the circumstances surrounding the deaths of four soldiers at Princess Royal Barracks, Deepcut. The terms of reference were:

"Urgently to review the circumstances surrounding the deaths of four soldiers at Princess Royal Barracks, Deepcut between 1995 and 2002 in light of available material and any representations that might be made in this regard, and to produce a report."

You made plain that the scope of the Review within these terms, and the matters to be examined, were very much a matter for me, when I came to understand the issues prompted by the deaths and the public concern about them. This has, indeed, been a very significant journey of discovery during which I have examined aspects of Army policy on recruitment and training stretching over ten years, as well as matters relating to the Training Regiment at Deepcut over the same period. In addition, I came to the conclusion that, in order to examine the circumstances surrounding the deaths, I should first examine all that was known about the deaths and how they occurred, and seek to address issues that were outstanding and of concern to the particular families and the general public.

As you are aware, for reasons more fully set out in Chapter 1, this approach resulted in some need for discussion with Surrey Police and HM Coroner for Surrey to prevent my Review from impinging on the outstanding inquest into the death of James Collinson, that has only recently been completed. Once it became apparent that the inquest into the death of James Collinson would not take place in the early months of this Review, I concluded that I should proceed without investigating the particular narrative of his death and should not await the outcome of the inquest. Although completion and publication of the Report was, in fact, deferred until after the inquest had concluded, the Report does not, therefore, deal with the particular facts of his death, but is able to note circumstances surrounding it that I have considered relevant.

The protracted nature of Surrey Police's investigations, and the further reviews into aspects of their work that have been generated, added to the complexity of the task, as did the fact that Surrey Police considered that, while they wished to assist my Review, their material should not be made available to employees of the Ministry of Defence, including the civil servant appointed, at my request, to assist me, without the express consent of those who provided it. I am grateful to Surrey Police for the arrangements subsequently made that enabled me to consider all the material they held that I considered relevant to its terms of reference.

I owe an immense debt of gratitude to the members of my team who have worked tirelessly to enable me to produce this Report as speedily as was possible in the light of these and all other surrounding circumstances. Darren Beck, from the Ministry of Defence, has been with the Review for over a year, and, in addition to being the Secretary to the Review, with the wide variety of functions that has involved, has explained how the Army worked in the period under consideration, and where and how I might find relevant information. Julie Albrechtsen has been invaluable in accompanying me on most of my visits and meetings, pointing out lines of enquiry and has had the formidable task of transcribing and editing the transcripts of meetings that have been published in the Appendices to the Report. Kaspar Nazeri joined the Review in July 2005 when it was apparent that I was going to need considerable assistance in obtaining access to material held by Surrey Police and making further enquiries in various parts of the country. Since then he has laboured tirelessly in the provision of advice and assisting me in the drafting of this Report, and has been indispensable in producing it within the timescales subsequently agreed. Kaspar has been on secondment to my Review from Clifford Chance LLP, solicitors. I am grateful to Michael Smyth, senior partner at Clifford Chance LLP for the assistance offered to the Review, and to many others within the firm who have provided support in different ways. All members of my team have made significant contributions to this Report in offering their reflections, identifying supporting material and lines of enquiry and checking drafts for accuracy, for which I am particularly grateful, although the Report, and the responsibility for it, is mine alone.

I am also very grateful to all those who met with me, whether former and serving members of the Army, or others. I am particularly grateful to those who agreed that a transcript of our conversations could be reproduced in the Appendices to the Report along with other representations made to the Review. I would like to thank the staff of the Royal Logistic Corps, the Adjutant General's HQ and the Tribunals and Inquiries Unit at the Ministry of Defence for the assistance they have provided in arranging meetings, supplying documents and answering persistent queries. I am grateful to Mr and Mrs Benton, Mr and Mrs James, Mr and Mrs Gray and Mr and Mrs Collinson for meeting with me and allowing me to use the photographs of their children published at the front of the Report. Mr and Mrs Gray and Mr and Mrs James also met Lieutenant Colonel Laden and Colonel Josling who were, respectively, the Commanding Officers at the time their son and daughter died.

Most of the Report had been written some time before 20th February 2006 when the inquest into the death of James Collinson began to hear evidence. As you are aware, I decided that publication of my Report shortly before the inquest began might be unhelpful to the interests of justice, and publication was deferred to the first available date after the inquest had concluded. I, nevertheless, made arrangements to monitor the evidence adduced at that inquest in case it prompted any further reflections. The inquest concluded on 8th March 2006 and I completed the final Chapter a few days later. I have, thus, been able to take account of the Coroner's remarks at the conclusion of the inquest.

It was made plain that my terms of reference included the ability to make recommendations to you addressing issues arising in my Review of the circumstances surrounding the deaths. I have made 34 recommendations in Chapter 12. Some of these reflect changes made after the death of James Collinson in 2002, but which still need to be emphasised as arising from the circumstances of the deaths. Others are new, including the proposed creation of a Commissioner for Military Complaints (or Armed Forces Ombudsman). The question of what are the appropriate procedures for investigating and determining allegations of misconduct by those in the Armed Forces is very much a live issue before Parliament, and, in particular, before the Armed Forces Bill Select Committee of the House of Commons.

I hope the reasoning in this Report and the recommendations made will prove helpful in the formation of future policy. They are based on the principles of fairness, efficacy and the mutual bonds between soldiers, their families and the Army, as acknowledged in the Military Covenant. I have found, in considering these issues and preparing this Report, that human rights principles and related international obligations, far from detracting from the aims of the Army in delivering a fair and effective system, as is sometimes suggested, have been a useful source of guidance to effective delivery of a duty of care towards soldiers and the standards required of an informed inquiry when, tragically, things may have gone wrong.

Yours Sincerely
Nigel Stone



Sean Benton

11th October 1974 to 9th June 1995



Cheryl James

22nd October 1977 to 27th November 1995



Geoff Gray

28th January 1984 to 17th September 2001



James Collinson

4th December 1984 to 23rd March 2002

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Part 1

Figure 1.1

Map of Princess Royal Barracks, Deepcut

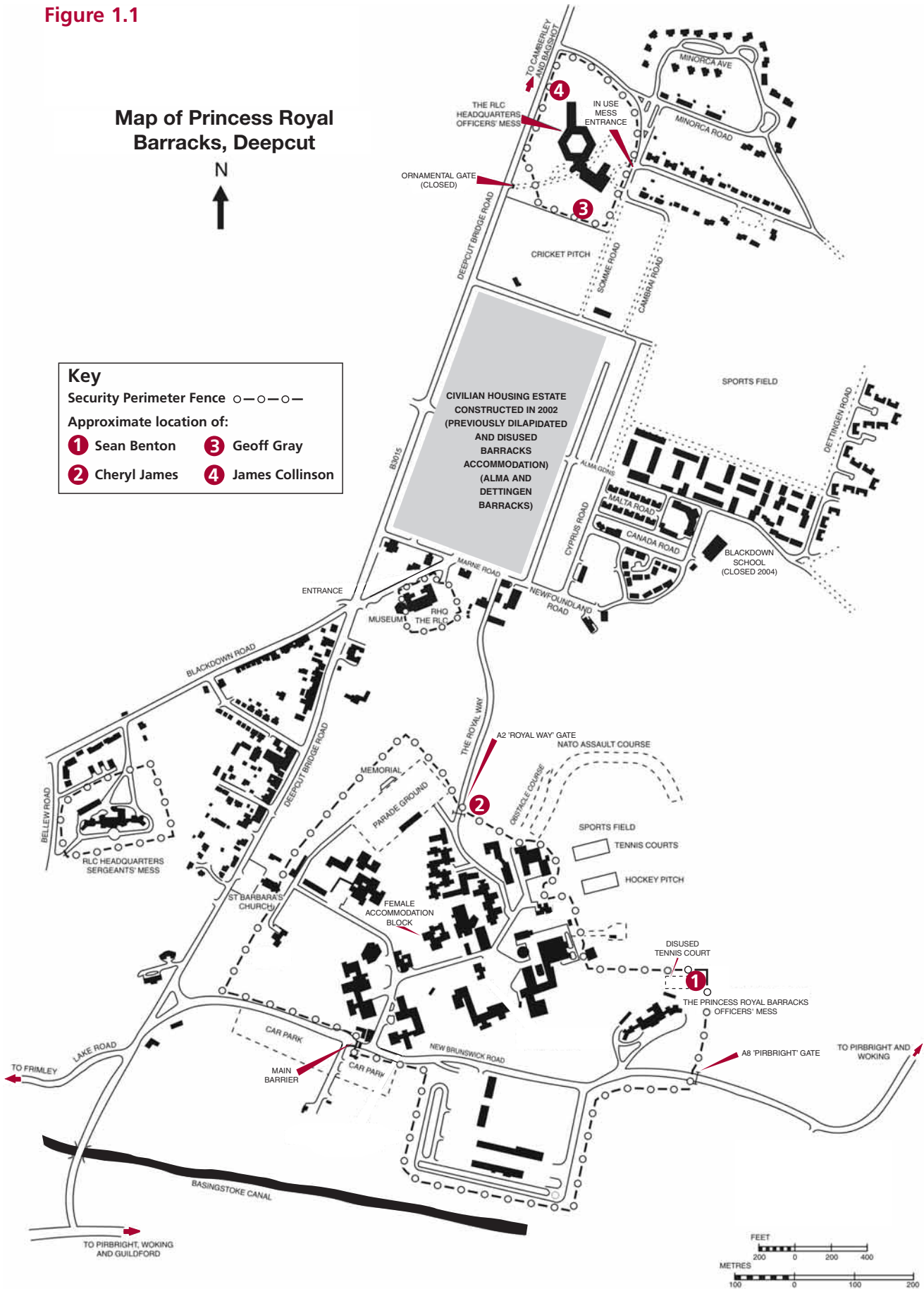


Key

Security Perimeter Fence ○—○—○—

Approximate location of:

1 Sean Benton	3 Geoff Gray
2 Cheryl James	4 James Collinson

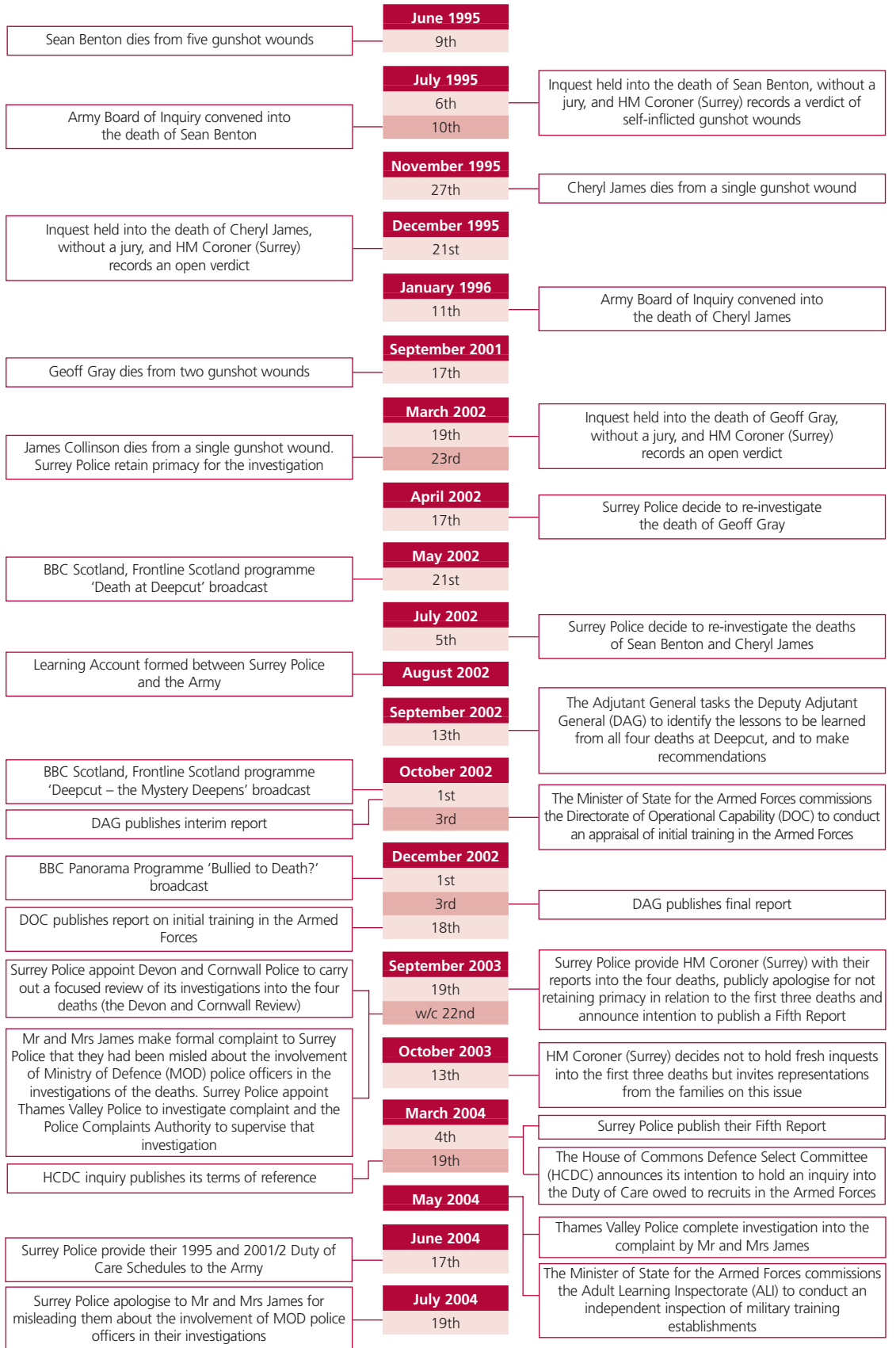


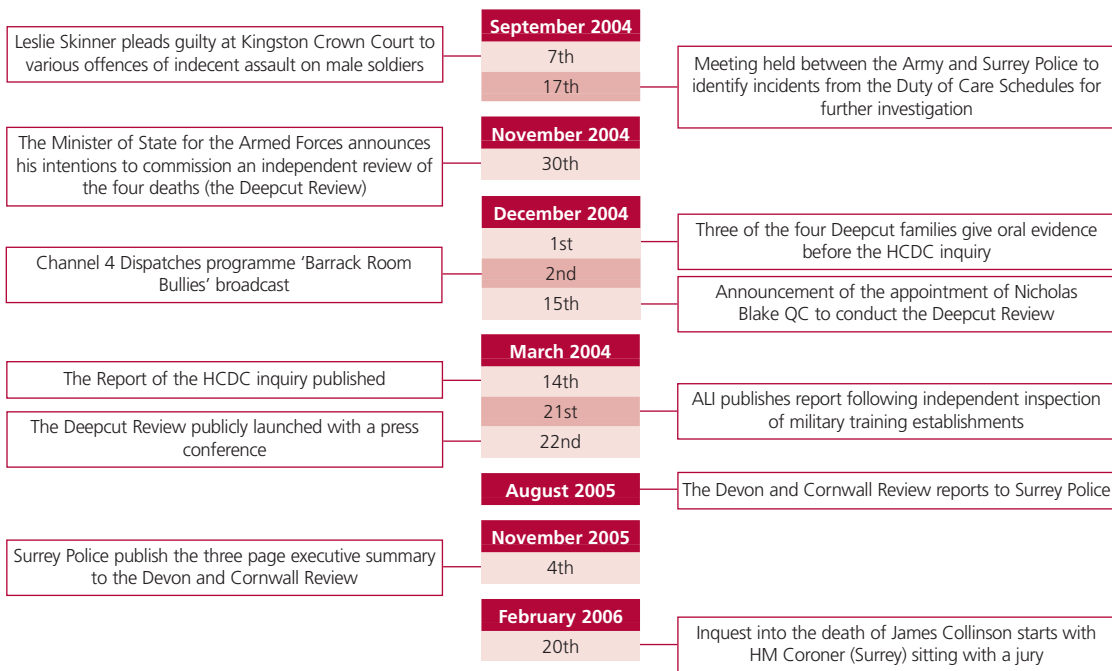
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Figure 1.2 Significant dates leading to the Deepcut Review





The events leading to the establishment of this Review

- 1.1 In the evening of 23rd March 2002, the body of Private James Collinson was found in the grounds of the Officers' Mess at the Princess Royal Barracks, Deepcut, near Camberley in Surrey. He was then aged 17 years and three months and was a soldier of the Royal Logistic Corps (RLC) undergoing Phase 2, or trade, training in the 25 Training Support Regiment (the Training Regiment), Deepcut before taking up his post in the field army. James had been on guard duty when his body was found with a single gunshot wound.
- 1.2 The death of James Collinson set in train a sequence of events that was to lead, in December 2004, to the announcement of this Review. It was James Collinson's death that brought sustained press attention to the events at the Princess Royal Barracks, also known as the Deepcut, or Blackdown, Barracks.
- 1.3 James Collinson was not the first trainee soldier from the Training Regiment to have died of gunshot wounds while performing guard duty at Deepcut. Three other trainees had died there since 1995, all while on guard duty.¹ James's death was striking because it occurred within four days of the inquest into the death of Private Geoff Gray by HM Coroner for Surrey, Mr Michael Burgess. Geoff Gray had died in the early hours of 17th September 2001 from two gunshot wounds and was found in the vicinity of the same Officers' Mess as James Collinson. A plan of Deepcut Barracks showing the location of each death is to be found at Figure 1.1.
- 1.4 Before the death of Geoff Gray, there had been two further deaths of trainees at Deepcut from gunshot wounds. First, there was the death of Private Sean Benton from five gunshot wounds on 9th June 1995 in another part of the Deepcut site. An inquest, without a jury, was held into Sean Benton's death on 6th July 1995 and the verdict of suicide was returned. Secondly, there was the death of Private Cheryl James from a single gunshot wound on 27th November 1995. Cheryl James had been on guard duty at a gate known as the Royal Way Gate at Deepcut. In relation to the deaths of Cheryl James and Geoff Gray, the inquests returned open verdicts on 21st December 1995 and 19th March 2002, respectively, as the evidence was considered insufficient to enable the Coroner, sitting without a jury, to reach a different conclusion.
- 1.5 The three deaths prior to James Collinson's had gone largely unnoticed in the national press. There had not been any public linkage of them. The families were not known to each other. Understandably, they had not raised questions at the inquests about common factors between the three deaths, as no common factors were known. Some of the families had post-inquest correspondence with the Ministry of Defence (MOD) that had petered out over the years. All this was about to change.

Surrey Police begin their investigations

- 1.6 The civil police (that is to say Surrey Police), the Royal Military Police (RMP) and the Coroner's officer were called to the scene of James Collinson's death on 23rd March 2002. Surrey Police took charge of the investigation. A Detective Inspector was appointed as the Senior Investigating Officer (SIO) to conduct an investigation, known as Operation Model, into James's death. Such an investigation would have the dual functions of examining whether there was evidence of homicide and, if not, whether there was any other cause of death that could be identified that would assist the Coroner in the performance of his functions. No such civilian police SIO had been appointed in respect of the previous three

¹ Sean Benton was part of the 'reserve' guard.

deaths, where such investigation as had been undertaken was conducted by the investigatory arm, the Special Investigations Branch (SIB), of the RMP. One issue for this Review is why this had been the case. With four deaths by gunshot wounds at the same Barracks, there was mounting media interest in these events and what might have linked them.

- 1.7 By 17th April 2002, a decision had been taken by Surrey Police that the investigation into the death of Geoff Gray should be re-opened and a re-investigation by Surrey Police detectives should be undertaken. That re-investigation was to be merged into the ongoing investigation into the death of James Collinson. A Detective Chief Inspector was appointed as SIO to head the combined investigation (now known as Operation Nickel, rather than Operation Model) and the Detective Inspector, the previous SIO of Operation Model, was appointed as his deputy. On 29th April 2002, Mr and Mrs Gray were briefed by Surrey Police as to the nature of the re-investigation into their son's death. There was also some contact with the Army by Surrey Police to explain the nature and purpose of the re-investigation.
- 1.8 Thereafter events progressed. On 5th July 2002, following a paper review, a decision was taken by an Assistant Chief Constable of Surrey Police to re-open the investigations into the deaths of Sean Benton and Cheryl James. A second Detective Chief Inspector was appointed to take charge of the re-investigations (known as Operation Nodule) into these two earlier deaths. There were, thus, two separate teams of officers making enquiries into two deaths per team: Operation Nodule for the re-investigations of the deaths of Sean Benton and Cheryl James; and Operation Nickel for the re-investigation of the death of Geoff Gray and the investigation of the death James Collinson.² Detective Chief Superintendent Denholm was appointed with overall responsibility for Operations Nodule and Nickel. It is clear that very senior officers in Surrey Police had an interest in these investigations. The issue had now become a prominent feature in the national media in which a number of allegations were being ventilated, from the perfunctory nature of previous investigations into the first three deaths to indications of harassment and bullying of trainees at Deepcut. Surrey Police, perhaps conscious that they had shown little interest in the previous three deaths, were now anxious to assure the families and the general public that their investigations would be broad and comprehensive, and explaining their activities to the media was a significant aspect of the policies developed at a senior level.

The four Surrey Police reports

- 1.9 By September 2003, the investigations into each of the individual deaths had been completed and four reports, one for each death, were written summarising the conclusions and outcome. During their investigations, Surrey Police had seen 900 witnesses, taken over 1,500 evidential statements and commissioned independent forensic and ballistic examinations.³ No evidence of third party involvement in any of the deaths had been uncovered and, therefore, no criminal prosecutions could be brought.⁴ The four reports were provided to HM Coroner for Surrey, Mr Burgess, on 19th September 2003. While the report into the death of James Collinson would assist the Coroner in the

²For ease of reference, where Surrey Police's 'investigations' are referred to in this Report, they are taken to refer to, collectively, the *re-investigations* into the deaths of Sean Benton, Cheryl James and Geoff Gray and the *investigation* into the death of James Collinson.

³Surrey Police's reports note that Operation Nodule consisted of 1,257 investigative actions, 617 statements and 3,153 documents; Operation Nickel consisted of 1,815 investigative actions, 873 statements and 4,375 documents.

⁴Surrey Police's press release of 19th September 2003 stated: "In order for the police to send papers to the CPS [Crown Prosecution Service] it would be necessary for us to establish credible evidence that an offence had been committed and that named individuals were responsible. Despite the scale of the investigation, no evidence has come to light so far to indicate any prospect of a prosecution directly related to these deaths. Accordingly, we will be handing over all the evidence we have gathered to the Surrey Coroner, Michael Burgess."

inquest he was to hold into that death, he had to make a decision in relation to the first three deaths as to whether their re-investigations had revealed new information that might lead to a change to the verdicts previously recorded at the inquests. The reports have also been made available to this Review. They have not, at the time of writing, been made available to the families of the first three young soldiers who died, or their legal representatives, although there has been extensive briefing of the content of the reports to the families by Surrey Police since 2002. On 13th October 2003, the Coroner wrote to the legal representatives of the families notifying them that, in his opinion, the reports did not reveal sufficient new information to suggest that different verdicts would necessarily result if fresh inquests were held, but invited representations from the families on this issue.⁵ The law relating to inquests and the re-opening of inquests will be examined in Chapter 2.

- 1.10 The fact that the investigations into the individual deaths were essentially concluded but no criminal proceedings were to be instituted, and, in relation to the three earlier deaths, no fresh inquests were to be convened, presented a problem for Surrey Police about disclosure of the statements they had gathered in the course of their investigations. Whilst statements gathered for the purpose of potential judicial proceedings are not inherently confidential, and might well need to be disclosed to interested parties in the interests of fairness, where no such proceedings were contemplated it could amount to a misuse of power by Surrey Police for such material to be released to others without a clear purpose, and unless subjected to appropriate safeguards. It was in this context that Surrey Police, on legal advice, devised their disclosure policy towards the statements they had gathered that has had a significant impact on both the Army's and the families' ability to access material. Subsequently, the policy has also affected the way this Review itself has been able to operate and make use of the available material. The reasons for this strategy and its consequences for the Review will be considered further in this Chapter.⁶
- 1.11 Three other developments took place in September 2003. First, in the press release explaining that they had passed their four reports to the Coroner, Surrey Police acknowledged that the re-investigations into the first three deaths were necessary because Surrey Police had not retained primacy for the original investigations:

*"The families have, quite rightly, refused to accept the deaths of their children without question. Surrey Police apologised to the four families last year for not properly challenging early assumptions that these young soldiers had taken their own lives and for our failure to overturn the custom and practice of the day, which allowed for the investigation to be delegated to the Army. We have recognised that we should have maintained primacy for these investigations over the Army. We have also acknowledged that in order to ensure confidence that the truth is available, the civil police must assume primacy immediately when an untimely and non-combatant death occurs in the military and conduct an independent investigation that treats each case as having the potential to be a homicide, unless, and until, compelling evidence to the contrary is available. These lessons are now being taken forward through the Association of Chief Police Officers (ACPO) with a view to establishing national best practice for the investigation of deaths at military establishments."*⁷

The issue of primacy for the investigation of deaths will be considered in Chapter 3.

⁵The Coroner also stated that he had no objection to the statements obtained by Surrey Police during their re-investigations being made available to the families and their legal representatives for the purpose of making such representations to him. However, he stressed that such disclosure should be only for that purpose and not further copied or used by the families, or their legal representatives, without consent. See also paragraph 2.38 ff below.

⁶See paragraphs 1.43-44 and 1.70-73 below.

⁷Surrey Police press release dated 19th September 2003.

- 1.12 Secondly, Surrey Police announced that they intended to commission Devon and Cornwall Police to report on certain aspects of Surrey Police's investigations (the Devon and Cornwall Review). The terms of reference of the Devon and Cornwall Review, and the impact it has had on this Review – the Deepcut Review – will be examined further in this Chapter at paragraph 1.53 below. Thirdly, Surrey Police announced their intention to produce a final or fifth report (the Fifth Report) detailing their "*concerns about the current approach to the care and supervision of trainee soldiers*",⁸ at Deepcut and more generally in the Army, arising from their investigations. It was the publication of this Fifth Report, in March 2004, that was, ultimately, to provide a direct stimulus to the setting up of this Review, although what it has been tasked to do may not be the same as what Surrey Police considered needed further public scrutiny.⁹

The formation of a 'Learning Account'

- 1.13 However, returning to Surrey Police's investigations, by the end of July 2002, while enquiries were still underway, it was apparent that Surrey Police were concerned with a number of factors beyond the hypothesis of homicide. In light of the information they were receiving from their investigations, they, therefore, also considered issues beyond the traditional ambit of a Coroner's inquest.¹⁰ They accordingly raised their concerns with the senior officer of the Army responsible for personnel matters, the Adjutant General (AG). In August 2002, these concerns had led to a joint decision to open a 'Learning Account'. The idea of this Account was that the Army could review risk factors emerging from the police investigations and address them as the investigations proceeded, rather than wait until they had been completed.
- 1.14 From the Army's side, the process of learning and reporting on conclusions to be drawn from the deaths was headed by the Deputy Adjutant General (DAG), who was tasked on 13th September 2002 by the AG:

*"...to assist the Surrey Police by conducting a supporting military investigation in order to identify the lessons to be learned from all 4 cases, and to make recommendations."*¹¹

The DAG produced his final report (reproduced as Appendix 15 to this Report) on 3rd December 2002,¹² after an intense period of consultation, reflection and review. Although the Army's primary response to the deaths at Deepcut was made in that final report, on 3rd October 2002 the Minister of State for the Armed Forces also commissioned the Directorate of Operational Capability to conduct an appraisal of the initial training of non-officer recruits across the Armed Forces. The resulting report was published on 18th December 2002. The process of reflection and refinement has continued since, indeed a number of the lessons learned from the deaths at Deepcut are reflected in the Armed Forces Bill published on 30th November 2005, while this Review's Report was in preparation. Other issues may need to be addressed by the Army following the completion of the outstanding inquest into the death of James Collinson that started on 20th February 2006.

⁸ *Ibid.*

⁹ The press release later continued: "...we consider that a broader inquiry may make a further contribution to avoiding tragedies like those we have investigated at Deepcut. Our fifth report is intended to be available should any such inquiry occur."

¹⁰ See paragraph 2.24 below.

¹¹ See Appendix A15.001, paragraph 1.

¹² An interim report was produced on 1st October 2002.

Surrey Police's Fifth Report and the Duty of Care Schedules

- 1.15 From Surrey Police's perspective, the formation of the Learning Account was to lead to the publication of their Fifth Report ('Deepcut Investigation Final Report') on 4th March 2004. As noted, while Surrey Police were primarily investigating four deaths at Deepcut, their investigations had raised concerns about the care and supervision of trainee soldiers generally and the Army's ability to implement changes to address these issues. The Fifth Report accordingly had a wider perspective than the four deaths at Deepcut:

*"Our principal focus has been to conduct a thorough criminal investigation relating to deaths within a confined geographical area. It has not been within the remit of the Surrey Police to conduct an in-depth investigation of the level of bullying at Deepcut or throughout the Army Training and Recruiting Agency. However evidence of such behaviour has been uncovered in sufficient quantity to raise concerns."*¹³

- 1.16 The Fifth Report called for a broader investigation or 'enquiry' into issues it had raised concerning the training of young soldiers and the disciplinary environment in which they found themselves.¹⁴ Paragraph 1.24 of the Fifth Report included three brief summary examples of harassment and bullying in 1995, 1999 and 2000, and the next paragraph went on to indicate that "other examples and further details" were available if required and that "some of these allegations may be subject to further investigation in due course."
- 1.17 This brief reference to allegations of harassment and bullying led to further developments. The Army were concerned to know of specific allegations of bullying that had not been investigated by them or the civilian police. They asked Surrey Police for further details and, in response, two schedules of summary information were provided, with the complainants and those complained against remaining anonymous. These schedules were derived from material gathered during the Nodule and Nickel Operations. They are, therefore, principally concerned with events around 1995 and 2001/2, respectively, but some of the material relates to events before and between these dates. These two schedules were to become known as the 'Duty of Care Schedules' (reproduced as Appendices 5 and 6 to this Report). They were provided to the Army on 17th June 2004, with a covering letter explaining that if the Army required additional information Surrey Police would consider what other details could be provided, but that if the Army wanted to make contact with any of the complainants Surrey Police would have to seek the permission of the anonymised complainant to pass on their details.

The House of Commons Defence Select Committee Inquiry in 2004/5

- 1.18 The Army were not the only ones interested in the Duty of Care Schedules. During their investigations, Surrey Police had kept the House of Commons Defence Select Committee (HCDC)¹⁵ briefed of developments, and the HCDC took a keen interest in the Fifth Report. Indeed, on the same day as Surrey Police published their Fifth Report, the HCDC, under the Chairmanship of Bruce George MP, decided to conduct a major inquiry of its own looking into the duty of care regimes in initial training establishments in all three Services of the Armed Forces. The terms of the inquiry were published in a press release on 19th March 2004. Although the HCDC had a long-standing interest in the personnel of the Armed Forces, and both it and individual members of the House of Commons had

¹³ Paragraph 1.24 of the Fifth Report.

¹⁴ *Ibid*, paragraphs 1.31-32 and 4.21.

¹⁵ Surrey Police refer to the House of Commons Defence Select Committee as DSC or HCDCS.

expressed concern over allegations of bullying and the tragic deaths at Deepcut, the HCDC inquiry was not a specific inquiry into those four deaths. Bruce George MP had said at the press conference launching the inquiry:

*"Although our inquiry was prompted by the deaths of young soldiers at Deepcut barracks and elsewhere, we are not a substitute for the police, or for the judicial process. We will not be questioning the findings of the police or the Coroner about how specific deaths occurred."*¹⁶

- 1.19 The Report of the HCDC inquiry was published on 14th March 2005, shortly after the announcement of the establishment of this Review, and shortly before this Review announced its own programme and approach to its task. The HCDC inquiry received a vast mass of informative written evidence and heard from a number of significant witnesses between May 2004 and December 2004. Amongst those it heard from were Dennis O'Connor, who had been the Chief Constable of Surrey Police until some ten days before his hearing, and Craig Denholm, the Detective Chief Superintendent at Surrey Police whose role in the investigations has been noted above.¹⁷
- 1.20 During its inquiry, the HCDC became aware of Surrey Police's Duty of Care Schedules, that were prepared in response to the Army's request for further details of allegations, and asked to see them. They were supplied as an annex to Surrey Police's written evidence and appear in the documents submitted to the HCDC in Volume II of their Report.¹⁸ One of the questions of concern to the members of the HCDC was whether either the civil police or the Army were investigating the allegations in the Duty of Care Schedules and whether any form of conclusion could be reached as to whether bullying had or had not taken place. Detective Chief Superintendent Denholm explained: *"as we spoke to people, the allegations were made to us. An awful lot of those allegations were uncorroborated."*¹⁹
- 1.21 Following requests for further information, Surrey Police have explained to this Review:

*"The focus of Surrey Police's investigation has always been on the deaths of the four soldiers. Much of the information appearing in the schedules is, in effect, a by-product of an investigation which is why when the copies were provided to the Army and the DSC [Defence Select Committee] they were accompanied by clear warnings that the majority of the issues cited were untested and uncorroborated."*²⁰

*"The duty of care schedules were compiled to support comments in para 1.24 of the final report that bullying had been uncovered in sufficient quantities to raise concerns. The report went on to recommend that such behaviour should form part of any subsequent broader inquiry. The Surrey Police investigation concentrated on the four deaths and other issues, such as these, were not lines of enquiry."*²¹

¹⁶ House of Commons Defence Select Committee, News Release 17, 19th March 2004.

¹⁷ House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Questions 658-759. The oral hearing took place on 13th October 2004. For Detective Chief Superintendent Denholm's role see paragraph 1.8 above.

¹⁸ They are referred to in questions posed by Mike Hancock MP and Rachel Squires MP (*Ibid*, Ev 128, Questions 735 to 742). Surrey Police had in fact written to the HCDC when supplying them with the Duty of Care Schedules in June 2004 adding: *"It is important to point out that to a great extent, the witness recollection is uncorroborated and untested and thus any examples cited should be treated with necessary and appropriate caution. Many of the examples have not been formally investigated at this time as the details were given more as background information as opposed to specific allegations."*

¹⁹ *Supra*, footnote 17, Question 735.

²⁰ Response received by this Review, 18th March 2005.

²¹ Response received by this Review, 14th July 2005.

The Army and the Duty of Care Schedules

- 1.22 As noted above, the Army were provided with the Duty of Care Schedules in June 2004. Following a meeting on 17th September 2004 between Surrey Police and the Army, 16 individuals from the Duty of Care Schedules were selected, on agreed criteria, for further investigation by the RMP into the alleged offences. As noted, the Army were aware, when they received the Duty of Care Schedules, that Surrey Police's disclosure policy required the express permission of the informants before their details could be passed on. The 16 individuals that had been identified as falling within the agreed criteria were first contacted by phone to confirm contact details and then written to by Surrey Police in November 2004. Only two agreed for their statements to be handed to the Army.²²
- 1.23 This Review understands that this frustrated the Army's ability to investigate the Duty of Care Schedule material. Some allegations of serious assaults and sexual assaults have been referred to the civil authorities for consideration, but in each case a decision has been reached that there is insufficient evidence to bring criminal proceedings. The position remains that most of the allegations have not been formally investigated and those that have, have not enabled anyone to reach any conclusions on the substance of the allegations. This poses considerable problems for the Review insofar as its remit is to consider this material as part of the circumstances surrounding the deaths. These difficulties are explained below at paragraph 1.44.

The trial of Leslie Skinner

- 1.24 In the meantime, media interest in the events at Deepcut was revitalised by the guilty plea by one Leslie Skinner entered at Kingston Crown Court on 7th September 2004 for various offences of indecent assault on male soldiers. It emerged that Skinner was a former Warrant Officer in the RLC who, following a Court Martial conviction for indecent exposure in 1996, had been reduced in the ranks and posted to Deepcut. The Skinner case was mentioned in the evidence before the HCDC on 13th October 2004 and will be considered in detail in Chapter 7 of this Report. The Review has been considerably assisted by the Surrey Police material gathered in the investigation into Leslie Skinner.

The calls for a public inquiry

- 1.25 In November 2004, the contents of the Duty of Care Schedules were revealed and reported on in the media, although rarely with attention drawn to the health warning that the allegations were "*untested and uncorroborated.*" Since the death of James Collinson in March 2002, the media have been increasingly concerned with the Deepcut story. There has been extensive media reporting on other allegations by former trainees at Deepcut. The first televised journalistic product was a programme from the BBC Scotland series Frontline Scotland titled 'Death at Deepcut', broadcast on 21st May 2002. A follow up programme, 'Deepcut – the Mystery Deepens' was broadcast on 1st October 2002.

²² The Review has been informed by Surrey Police that initially 18 individuals were identified but that, after further research of the incidents, it was agreed to contact 16. Six individuals (one deceased) did not reply to the letters sent in November 2004. Of the ten that responded, eight were unwilling to have their details passed to the Army and two consented.

- 1.26 Two further television programmes of prominence followed: a Panorama Programme, 'Bullied to Death?' broadcast on 1st December 2002; and a Channel 4 Dispatches programme, 'Barrack Room Bullies', broadcast on 2nd December 2004. All these matters led the families of the Deepcut soldiers and others to call for, or renew their call for, a public inquiry into events at Deepcut and the deaths of their children. On 1st December 2004, three of the four Deepcut families gave oral evidence before the HCDC inquiry, Mr and Mrs Benton being unable to attend for personal reasons. When pressed as to the need for a public inquiry, Mr James responded eloquently:

*"Everything comes back to accountability and confidence that whatever corrective actions are in place as a result of a suitable inquiry ... do everything that we are all capable of to prevent a recurrence ... Only when [a] transparent and thorough review and examination of what happened at Deepcut has completely been covered can we all relax."*²³

The establishment of this Review

- 1.27 On 30th November 2004, the Minister of State for the Armed Forces, the Rt. Hon. Adam Ingram MP, announced to the House of Commons that he proposed to commission, not a public inquiry but, a review. On 15th December 2004, the announcement of my appointment to conduct the Review was made, with the terms of reference noted in the letter to the Minister that prefaces this Report. The Minister made the following written statement to the House of Commons:

*"In commissioning this review I am well aware that its scope and nature may not satisfy all those, members of this House included, who have been calling for a formal public inquiry into some or all non-combat deaths in the Armed Forces or for a public inquiry into the deaths at Deepcut. These are very different demands. By concentrating on the circumstances of the four deaths at the Army base at Deepcut this review will focus on the issue at the heart of current public concern. The review will have the full co-operation of the Ministry of Defence and, I am pleased to say, Surrey Police. A review can analyse issues much more quickly than a public inquiry and would not interfere with other current investigations or proceedings. My expectation is that the rigour and independence of the review will produce value to all parties concerned. It is the right way to proceed and I would urge all those who may be sceptical of what the review can achieve to suspend their criticism and to lend it their full support. It is of the highest importance that a balanced and authoritative account of the circumstances surrounding the deaths should be put into the public domain, to sustain public confidence in military training."*²⁴

- 1.28 On the same day, the Minister appeared before the HCDC inquiry as its last witness and said:

*"I expect Mr Blake to provide an intensive, wholly independent and authoritative analysis of all relevant matters relating to the four tragic deaths at Deepcut."*²⁵

- 1.29 When questioned about the terms of reference of this Review, he noted:

²³ *Supra*, footnote 17, Question 1248.

²⁴ Commons Hansard, 15 December 2004: Column 132 WS.

²⁵ House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev 207, Question 1272.

“As I have said, I am not being prescriptive; I am not being restrictive. I am being prescriptive in one sense in giving [Mr Blake] terms of reference but we are not being restrictive in the application of the way in which that will then be interpreted and looked at by him. Clearly, he is going into this cold. He does not have the experience and the knowledge base that all of us share because of the intensity with which we have been looking at these things...”²⁶

And later, when asked whether the Review could look at deaths at Catterick and elsewhere, the Minister responded:

“I make this point again: I am not being prescriptive of the man in the definition of the terms of reference because I want that spotlight on that particular period at that particular depot in relation to those four tragic deaths. I think that is an important aspect of this. This will give an impetus to perhaps what we need to do.”²⁷

The Review and the inquest into the death of James Collinson

- 1.30 Although the terms of reference of this Review refer to the “*circumstances surrounding*” four deaths, it was decided at an early stage that the Review could not examine the full circumstances of James Collinson’s death whilst the inquest into his death remained outstanding.²⁸ As will be apparent from the next Chapter, where the legal regime governing inquiries into violent deaths is examined, the Coroner’s inquest is the statutory inquiry into how the deceased met his death. That inquest should not be usurped or interfered with by a non-statutory review appointed by a Minister in the MOD, whose actions could potentially be the subject of exploration at the inquest.
- 1.31 The interconnection between the inquest into the death of James Collinson and this Review has been a matter of some complexity throughout 2005. At first, there was some hope that the inquest could be completed by June 2005 and the Review would be able to report thereafter. When this proved to be unlikely, the Review decided that it would proceed with its task but exclude the particular circumstances of James Collinson’s death from its ambit. In so doing, it was conscious that a full inquest was to follow. Some of the reasons why the Coroner felt unable to proceed immediately with the inquest, after he received Surrey Police’s report into James Collinson’s death in September 2003, also had implications for this Review.
- 1.32 The consequence has been that, even with excluding any consideration of the circumstances surrounding James Collinson’s death, the Review was not able to complete its work and be in a position to publish this Report until February 2006. By that time, the inquest into James Collinson’s death was about to begin, and the very short gap between the intended publication date and the start of the inquest might well have led to publicity unduly influencing the jury (the Coroner having decided to sit with a jury) or overshadowing the evidence they were about to hear. After anxious consideration, and notwithstanding intentions previously communicated, the Review decided that it would be prudent to defer the publication of this Report until the first available date after the conclusion of the inquest into James Collinson’s death. Save for the final Chapter, the Report has, therefore, been written before the inquest has been completed and it remains the Review’s intention that this will be its single and final Report.

²⁶ *Ibid*, Question 1275.

²⁷ *Ibid*, Question 1285.

²⁸ Mr and Mrs Collinson were made aware, in meetings with the Review, that the Coroner’s inquest into their son’s death would take precedence over the Review.

1.33 The primacy to be afforded to the Coroner's inquest was clear throughout. The inquest into James Collinson's death has been conducted with his family, the Army, Surrey Police and any other interested person represented and – subject to the rulings of the Coroner – able to ask questions of witnesses in order to explore how James met his death. This Review is not a substitute for an inquest. It is not an inquiry established under statute, nor is it the more usual modern formula of a non-statutory inquiry presided over by a senior judicial figure. This Review has no powers to compel witnesses to give information or to produce documents. It has no power to disclose documents that have been voluntarily provided to it by others. This Review has not conducted public hearings. It cannot make binding adjudications of fact. It cannot grant legal aid for the families or others to be represented before it, although funding has in fact been granted by the MOD to the families for written submissions.²⁹ Manifestly, if a public inquiry is required as a matter of law, or the exercise of sound political judgement, to resolve issues that form part of this Review, the Review itself will not be able to perform that function.

The issues considered by this Review

1.34 The Review indicated from an early stage that a broad view would be taken of the phrase "*the circumstances surrounding the deaths*" from its terms of reference, and that it would be prepared to examine anything that might reasonably be said to have caused, contributed to or materially promoted considerations that may have played a part in these deaths. Potentially, the "*circumstances surrounding*" could be interpreted so broadly as to include other deaths in Army establishments at any stage of a soldier's life. It is, however, the circumstances surrounding the four deaths at Deepcut that this Review is concerned with, not deaths in the British Armed Forces as a whole, or the training and posting of Army personnel generally.

The Deepcut and Beyond Group

1.35 In November 2003, a broader campaign was formed called 'Deepcut and Beyond'. This comprised families who had lost children in non-combat deaths in a variety of different circumstances in the Armed Forces over a broader period of time. Some of these deaths have never been the subject of an inquest or an Army Board of Inquiry, for various reasons.³⁰ Others of these deaths were comparatively recent and inquests were outstanding. Some of these cases concerned trainees and some concerned those who had finished training and joined the field army, including Non-Commissioned Officers (NCOs). Some were connected to allegations of bullying and some were not. The general demand of this campaign was for a broad ranging public inquiry.³¹

²⁹ The Review has only received submissions from Mr and Mrs Gray and Mr and Mrs Collinson. These submissions are reproduced in Appendices 1 and 2, respectively, to this Report.

³⁰ In contrast to the deaths of Geoff Gray and James Collinson where, as a result of the Surrey Police investigation, the BOI has been adjourned. For current practice, see Appendix A16.004, paragraph 7.15.

³¹ The breadth of the inquiry contemplated can be gauged from the Early Day Motion tabled before the House of Commons seeking the establishment of such a Tribunal under the Tribunals of Inquiry (Evidence) Act 1921 (now repealed by the Inquiries Act 2005) in the following terms:

"To propose that it is expedient that a Tribunal be established for inquiring into a definite matter of urgent public importance, that is to say the incidence of death and ill-treatment of members of HM Armed Forces in non-combat situations:

- to investigate allegations and circumstances surrounding particular deaths at barracks in Deepcut and elsewhere, with specific reference to deaths at Catterick barracks, in Northern Ireland, and deaths overseas;
- to provide otherwise for an appropriate response and effective remedy on request for all those families of deceased service personnel maintaining a reasonable suspicion that the death could have been prevented or was not subject to an effective investigation;
- to inquire into the action and performance of all public and private bodies, authorities and persons involved;
- to consider the issues arising, including the attribution of responsibility or blame where necessary;
- to consider how (a) to prevent such incidents in future, (b) to provide for the proper exercise of the Duty of Care; and (c) for the effective investigation of deaths of service personnel;
- to publish its findings as soon as practicable; to make such interim and final recommendations as may seem appropriate; and to lay its final report before both Houses of Parliament."

- 1.36 This Review does not have to consider whether such a far-reaching enterprise is necessary, as it is beyond any conceivable connection with Deepcut. Such an inquiry would, indeed, be a very far-reaching one, involving many hundreds of non-combat deaths over an indeterminate period of time and place. The logistical difficulties in investigating and managing such a broad spectrum of concerns would be enormous, making the evidence gathering problems faced by this Review look insignificant. Such an inquiry would last years. It would not sit comfortably with the primary responsibility of the inquest for investigating deaths of British military personnel, wherever they occur. The scale of such an endeavour would, possibly, be inconsistent with the duty to inquire fully but expeditiously into violent deaths with a view to ascertaining the causes and promptly learning any lessons to avoid repetition.
- 1.37 The draft terms of reference proposed by the Deepcut and Beyond campaign are helpful, however, in identifying, with clarity, one view of what needs to be done when a violent or unnatural death occurs. The overall object is to learn lessons from past events so as not to be condemned to repeat them. As will be apparent from Chapter 2, in certain cases, a fair and effective inquiry into a death in which the state may have some responsibility is required, in which family members can participate and contribute. Where appropriate, the account of the inquiry should enable those who may be responsible for wrongdoing or failures to be held to account in ways relevant to the conclusions. But to learn lessons from the deaths, it is necessary to focus on the circumstances of the deaths and relevant allegations made in respect of them, rather than the more nebulous inquiry, perhaps contemplated by Surrey Police's Fifth Report, into indications of harassment generally throughout the Army. If there is evidence that bullying or harassment has led, or contributed, to a death it is possible to determine whether anyone can and should be held to account for such things. It is not possible to do this where it is unclear whether harassment has indeed taken place or, if it has, whether it has a connection with any death.
- 1.38 'Bullied to Death?' may be an eye-catching title for a television programme,³² but it cannot be a presumption for this Review. A lawyer's task, whether in a review or a judicial inquiry, is to evaluate whether there is any evidence to support a proposition and, if so, assess whether it is credible and could be legitimately deployed to reach conclusions of fact.
- 1.39 Although this Review is confined to the four deaths at Deepcut, it may well be that evidence of events elsewhere could draw attention to factors that might be of significance in the deaths. Thus, the Review has benefited from visits to the Army Foundation College (AFC) Harrogate and the Army Training Regiment (ATR) Bassingbourn, that both train young soldiers from the age of 16. It has also benefited from a meeting and a discussion with Lieutenant Colonel Strutt, the Commanding Officer of the 4th Training Support Battalion at the Infantry Training Centre, Catterick.³³ At a meeting in June 2004 with the Deepcut and Beyond campaign, the participants were invited to draw to the Review's attention any evidence from other cases that may provide some insight into what happened at Deepcut. The following statement was issued by me at that meeting:

"As to the wider issues surrounding those deaths, it seems to me that the following questions may arise:

³² See paragraph 1.26 above.

³³ See Appendix 4/14 for the transcript of the meeting with Lieutenant Colonel Strutt.

1. *Are the procedures available to investigate non-combat deaths in the Army adequate to ensure a fair and effective investigation in accordance with contemporary standards and legitimate expectations and, if not, why not and what could reasonably be done to improve matters?*
2. *Is there sufficient sensitivity, experience and a protective regime in place to justify the recruitment into the Army of young people under 18, if not, why not and what can be done about it?*
3. *Are there measures in place to deter abuse by members of staff, of whatever kind, and were they in place in 1995? Was such abuse a factor in the 1995 or 2001/2002 deaths and, if so, does it remain unabated today?*
4. *Should any of these deaths have been foreseen or could they reasonably have been expected to have been prevented by measures taken by the Army?*

...

I am willing to receive written representations on any of the issues that relate to or may inform the questions outlined above. Families of those who died outside Deepcut may want to consider whether they can assist me with evidence that procedures to investigate, deter or prevent abuse are not working. I stress, however, I cannot investigate individual cases.”³⁴

- 1.40 Although the Review has met with a delegation of families who have lost children outside Deepcut, and has received regular press updates and some other correspondence from the campaign, save in one case, it has not received evidence from the Deepcut and Beyond group that addresses these criteria. The exception is the case of Alfred Manship that will be considered in Chapter 3.

What the Review has done

- 1.41 On 22nd March 2005, this Review was publicly launched with a press conference and the launch of its website.³⁵ An appeal was made to anyone who had information about the regime at Deepcut at any time relevant to the deaths to come forward and make contact with me, if need be in confidence. Information was given as to the likely approach the Review would take to its terms of reference. Shortly thereafter, advertisements to similar effect were placed in the RLC Journal ‘The Sustainer’ and other military magazines of interest to serving or former soldiers, including ‘Soldier’ magazine. Only two people who had not already given statements to Surrey Police came forward as a result of this publicity.
- 1.42 The Review has obtained the available information from three principal sources. First, material relating to the Deepcut Barracks, and the response to the deaths, still in the possession of the MOD and the Army, including from the AG’s headquarters and the RLC. Army material also included a list of each RMP investigation since 1994 into disciplinary and self-harm cases and the case papers of those investigations that were identified by the Review to be potentially relevant.³⁶ The Review has also obtained access to the personnel files of individuals considered to be of significance to its task.

³⁴ Statement dated 7th June 2005.

³⁵ www.deepcutreview.org.uk

³⁶ The Review had unrestricted access to the RMP’s main Redcap Database at the Central Criminal Intelligence Records Office (then in Chichester) and examined all entries relating to Deepcut-based personnel during the period 1994 to 2002 to determine potential relevance.

- 1.43 Secondly, the Review has received a large quantity of material from Surrey Police, including the four unpublished reports into the deaths prepared for the Coroner, the material behind the Duty of Care Schedules and other material specifically sought by the Review relating to particular aspects of the re-investigations into the deaths of Cheryl James, Sean Benton and Geoff Gray. Due to the disclosure restrictions mentioned earlier in this Chapter, some of the material has been provided in an anonymous format with appropriate edits. Although this has added to the task of making links in the material and pursuing lines of enquiry, the Review is satisfied that, with the assistance of Surrey Police, it has been possible to put all the material in its proper context. Other material has been seen by members of the Review team, although not copied to the Review for retention. Where informants have been unwilling to consent to the disclosure of their witness statements, or other material produced from contact with them, the Review has been able to ascertain the reasons for this and make a judgement accordingly. For the avoidance of doubt, save for the case of James Collinson, the Review is satisfied that it has seen, or been made aware of, all relevant police material to fulfil its terms of reference.
- 1.44 The nature of all the relevant material and, particularly, the nature of much of the evidence supporting the Duty of Care Schedules pose problems for a reviewer. Should account be taken of hearsay, or second, or even third, hand hearsay? Should unsubstantiated allegations of abuse be referred to in this Report, naming complainants (where anonymity had not been specifically requested) and persons complained against, where great and unfair harm may be done to their professional reputation and private life as a result? How should the Review approach apparently – or potentially – credible evidence of an allegation that is denied by the person complained of, given that the Review is not a court of law and cannot make a finding of fact in the absence of a fair hearing? The approach the Review has taken to these issues will be discussed later in this Chapter.
- 1.45 Thirdly, the Review has proceeded by a series of interviews and visits to key personnel.³⁷ The AG had written to Commanding Officers instructing them that serving officers and soldiers should co-operate with the Review and that information could be supplied in confidence without prejudice to military careers. A number of officers made spontaneous contact with the Review. Other officers and soldiers were written to by the Review. The Review is extremely grateful to all those who assisted in these conversations, ranging from two to six hours in length, during which valuable information was obtained and, from March 2005, retained in transcripts of the taped recordings. The Review has sought to encourage both a frank exchange of information and, to the extent consistent with that, transparency in making an account available to readers of this Report. No one presently serving in the Army has failed to respond to a request for an interview. No one who has been interviewed expressed unwillingness for the conversation to be recorded. The meetings were not recorded with future publication in mind but for accurate capture of information to be considered by the Review. However, the Review identified certain meetings as being particularly informative and sought consent from those it met to publish the resulting transcripts. With one exception,³⁸ all consented for the transcripts to be published in the Appendix to this Report (see Appendix 4). The edits made to the transcripts have been proposed by the Review to delete lines of enquiry that proved to be irrelevant, or based on misapprehension, or to protect the legitimate interests of third

³⁷ Annex B to the Report notes those visits the Review conducted and the individuals it met. Appendix 4 includes transcripts of those meetings recorded and considered particularly worth publishing.

³⁸ Major Gascoigne, the Officer Commanding B Squadron at Deepcut in 1995, exercised his right not to have his transcript published due, essentially, to concerns as to what use others could make of it. The Review respects his decision and has explained to him, and other confidential informants, that where there is a conflict, frankness should trump transparency. It would, however, be particularly unfair and unfortunate if this decision were to lead to speculation that he had something to hide. This is not the case. The views expressed by Major Gascoigne in his meeting with the Review have informed the Review's work and, where appropriate, are noted in the Report. In addition, the Review considered certain extracts from the transcript of the meeting with Major Gascoigne to be particularly pertinent and he has consented to the publication of those requested extracts without exception.

parties who were the subject of the discussion. The Review appreciates that the style of the exchanges is frequently conversational and that informants might have used more considered language in a more formal context. Nevertheless, the Review concludes there is a great value in letting informants speak for themselves and in the proper context rather than their information being summarised, where loss of nuance and misrepresentation might occur.

- 1.46 Where accusations of bullying or other improper conduct have been made against named individuals, either in meetings the Review conducted or, in the vast majority of cases, in the evidence behind the Duty of Care Schedules, the Review has relied on the interviews of those named individuals conducted with Surrey Police during their investigations from which a response to these allegations has been obtained. Furthermore, even where allegations were put to named individuals by Surrey Police, the Review has written to those against whom allegations have been made in order to afford them with an opportunity to comment. Their responses have been noted in this Report. Similarly, as the Review came to its conclusion, in the interests of fairness, it wrote to those individuals that it was minded to criticise, notifying them of the nature of the possible criticism. An opportunity for comment was afforded and those responses have been noted where appropriate.
- 1.47 The Review was not conducting a criminal or disciplinary investigation but primarily reviewing the work of others. Interviews that have been conducted have been without legal advisers present and have not sought to replicate public hearings of the kind associated with a public inquiry. With two exceptions, members of the families have not been present at meetings with Army personnel. The exception was an agreement between the relevant parties, in response to an invitation from the Review, for Mr and Mrs Gray to meet Lieutenant Colonel Laden, the Commanding Officer of the Training Regiment at the time of Geoff Gray's death, and for Mr and Mrs James to meet Colonel (formerly Lieutenant Colonel) Josling, the Commanding Officer of the Training Regiment at the time of Cheryl James's death. An edited copy of these meetings is included in Appendix 4 to this Report.

Frank Swann

- 1.48 One person who informed the Review that he was not willing to provide information to it was Frank Swann, an independent forensic expert, who is understood to have conducted tests to determine whether there are inconsistencies in the available scientific evidence and the hypothesis of self-harm. It is a matter of regret that the Review has not been provided with Mr Swann's evidence, particularly given that it played some role in the initial press reporting of the Deepcut story in 2002 and 2003. However, in light of the independent and authoritative scientific material commissioned by Surrey Police that has been provided to it, the Review is confident that it has not been unduly handicapped by not having the benefit of Mr Swann's opinions.³⁹ An exchange of correspondence between the Review and Mr Swann is set out in Appendix 3. The particular contribution that science can play to the proper understanding of these deaths will be discussed when each death is considered in turn in later Chapters.

³⁹The Review was aware that Mr Swann was a potential witness at the inquest into the death of James Collinson. Following a pre-inquest hearing, at which he was compelled to attend and answer questions, the Review understands that the Coroner decided not to call him as a witness.

The timing of the Review

- 1.49 The issues noted above in relation to the nature of the material considered by the Review give some indication of why the Review, initially envisioned by the MOD as likely to last six months, has taken longer than anticipated to complete. There are further factors that affected both timing and related issues arising from the restrictions on disclosure within which the Review has operated.
- 1.50 In the light of representations received early on from the families and its own reading of the material, the Review concluded that, although it was not re-investigating the deaths or reviewing the totality of the Surrey Police investigation, it had to have sufficient information available to it as to the immediate circumstances of the deaths in order to see how other factors may have contributed.⁴⁰ As noted, this brought about a potential conflict with the outstanding inquest into the death of James Collinson. One anxiety of Surrey Police was that access by this Review to all the material behind the investigation into James's death would conflict with the primacy of the Coroner for investigating that death.
- 1.51 Tragically, for Mr and Mrs Collinson and all the other interested parties, that inquest did not hear evidence until very recently, some four years after James's death. The delay in proceeding to this inquest was based on the understandable concern that the Coroner should have the advantage of the fullest possible police investigation into all the deaths before setting the terms for the inquisition into the last one. This police investigation could not be considered complete until the Chief Constable of Surrey, and his responsible officers, concluded that they had explored all available and legitimate avenues of enquiry, although any investigation into suspicious deaths may be liable to be re-opened in the event of credible new evidence coming to light. While Surrey Police had delivered their report on James Collinson's death to the Coroner on 19th September 2003, along with their reports into the three earlier deaths, they shortly thereafter had also commissioned the Devon and Cornwall Review into certain aspects of their investigation, discussed in more detail below. The Coroner, therefore, decided to wait until the Devon and Cornwall Review has been completed before continuing with arrangements for the inquest into James's death.

The complaint by Mr and Mrs James in 2003

- 1.52 At various times during the Surrey Police investigations, the families raised a number of concerns about the conduct of their investigations. The first concern that manifested in an official complaint was that of Mr and Mrs James in around September 2003. That complaint to Surrey Police was that they had been misled about the involvement of MOD police officers in the investigations of the deaths. Surrey Police asked Thames Valley Police to investigate this complaint and also asked the then Police Complaints Authority (PCA) to supervise the investigation. That investigation was concluded in May 2004 and the PCA confirmed, in an interim statement dated 5th July 2004, that the investigation had been properly conducted. The result was that it was accepted that an Assistant Chief Constable of Surrey Police had unintentionally misled Mr and Mrs James and an appropriate apology was made to them on 19th July 2004.

⁴⁰ The circumstances surrounding the deaths of Sean Benton, Cheryl James and Geoff Gray are considered in Chapters 5, 6 and 10, respectively. As this Report was nearing publication, in response to requests for clarification on certain aspects of the evidence, Surrey Police, in good faith and mindful that the Review was not reviewing the totality of their investigations, offered to verify those Chapters for any factual errors. Whilst the Review is grateful for this offer of assistance, it took the view that in order to preserve its independence it was preferable to decline it. Any errors made in evaluating this material are the responsibility of the Review.

The Devon and Cornwall Review

- 1.53 As a result of further concerns expressed by the families, the Chief Constable of Surrey Police, as noted earlier, requested officers from Devon and Cornwall Police in September 2003 to conduct a focused review of certain aspects of the Surrey Police investigation (the Devon and Cornwall Review, also known as 'Operation Stanza'). The Devon and Cornwall Review delivered their Report to Surrey Police in August 2005. This Review has seen the full report.
- 1.54 The terms of reference of the Devon and Cornwall Review covered five issues.⁴¹ The fifth issue concerned the specific conduct of two Surrey Police Detective Constables employed in witness statement taking in the early days of the investigations. The second, third and fourth issues touched on similar issues to the one that had been the subject of the previous complaint made by Mr and Mrs James. The significant issue is whether contact with the Army or the use of the two Detective Constables adversely affected the integrity and quality of Surrey Police's investigation. It is a matter of record that the Devon and Cornwall Review found no evidence to this effect. Nothing seen by this Review would in any way cause doubt on such a conclusion.
- 1.55 That leaves the first issue of the Devon and Cornwall Review's terms of reference, the question of 'mindset', on which some critical comments were made by Devon and Cornwall Police.⁴² If the Devon and Cornwall Review had concluded that Surrey Police's investigations were incomplete or had been so deficiently performed that it needed to start again, this would have had some serious impact on this Review and its ability to fulfil its terms of reference. This is not the case.
- 1.56 The Devon and Cornwall Review did not suggest that any apparent line of enquiry relevant to how any of the four soldiers died at Deepcut was missed or not diligently pursued. Their Report did consider that Surrey Police's investigations did not always follow the criteria for investigating possible homicides, established by the Murder Investigation Manual and

⁴¹The terms of reference of the Devon and Cornwall Review were:

Mindset

1. To review the investigation to determine whether it has been thorough and impartial in testing an appropriate range of hypotheses that may explain the deaths of James Collinson, Geoff Gray, Cheryl James and Sean Benton.

The review should focus on policy file entries, office meetings, minutes and other documentation that may provide evidence of the direction and control of the investigation. The review should seek to quality assure key statements and, as deemed appropriate, re-interview any witnesses to ensure evidence was not elicited in favour of a particular hypothesis at the exclusion of another.

Independence

2. To review the independence of the investigation to ensure that it has been free of any improper influence or interference from the Army. The review must report on any material found that may indicate any element of collusion between the Army, MOD and Surrey Police to hide any evidence or facts pertaining to any of the four deaths under investigation.

Contact

3. The review should seek to ensure that the investigative team has had no contact with the Army other than that necessary to discharge an investigative role (i.e. questioning, interviewing etc.). The review should also evaluate the contact between the Chief Constable and other chief officers and the Army to ensure this contact has been ethical, professional and appropriate and necessary to conduct the investigation within the terms of reference set in policy documents (i.e. policy to establish a Learning Account to minimise risks to trainee soldiers as soon as possible).

Use of MOD Police

4. To review the use of two MOD Police Detective Constables on the investigation to ensure they have been independent of Army influence and have not, during the course of the investigation, had reporting lines back to the MOD, MOD Police or any part of the Army. The review should seek to quality assure their work against national standards of investigation and these officers should also be included in the assessment as to the impartiality with regard to different hypotheses.

[Two Surrey Police Detective Constables]

5. The review should assess whether [two Detective Constables] have acted to prejudice the investigation by failing to elicit relevant evidence or eliciting evidence in a way which is prejudicial against witnesses giving an open account of their knowledge.

⁴²See Executive Summary of the Devon & Cornwall Review's report published by Surrey Police on 4th November 2005.

recognised as best practice, and that no or, insufficient, reasons for any divergence were identified. This Review has had the advantage of speaking with the investigators from Devon and Cornwall Police to consider the implications of this conclusion.

- 1.57 The Devon and Cornwall investigators had assured Surrey Police at the outset that if their review found any fresh evidence, or a line of enquiry that had not been pursued, it would bring it to the attention of the Chief Constable of Surrey Police. As noted, it found none and confirmed this to Surrey Police on delivery of its report. There may be differences between Devon and Cornwall Police and Surrey Police as to how far the Murder Investigation Manual was applied in practice, or needed to be, or what justification there was for any divergence. These are not matters of direct concern to this Review. The Devon and Cornwall Review is a sufficient degree of closure for this Review to be able to reflect on what the existing evidence yields in terms of material as to how or why, and the circumstances in which, the deceased met their deaths.
- 1.58 After delivery of the Devon and Cornwall Report, Surrey Police needed time to consider its findings and brief the families on it before announcing their response, which they did at a press conference on 4th November 2005 publishing only the three page executive summary.⁴³ In the absence of fresh evidence coming to light, Surrey Police now regard their homicide investigation into the four deaths as concluded. Following the Devon and Cornwall Review, the position as at 19th September 2003 remains – the Surrey Police investigations have uncovered no evidence of third party involvement in the deaths.

The Independent Police Complaints Commission's involvement

- 1.59 Devon and Cornwall Police were not re-investigating the deaths, nor conducting a full review of the procedures adopted by Surrey Police, but reviewing, strictly within their terms of reference, certain aspects of how the investigation was conducted. The Devon and Cornwall Review had been expected to report in the early part of 2005, but the complexity of their review, as well as other factors, resulted in their report not being completed until August 2005. One reason why their report was delayed was that, in April 2005, Mr and Mrs Gray found a memorandum dated 30th April 2002, the same month that Surrey Police's re-investigation was launched, on their son's personnel file suggesting what the result of the re-investigation was likely to be. The investigation of whether the contents of that memorandum can be attributed to Surrey Police, and, if so, with what consequences, has been referred to the Independent Police Complaints Commission (IPCC), the successor to the PCA, by Surrey Police. Subsequently, one other finding of the Devon and Cornwall Review relevant to the issue of 'mindset' has also been referred to the IPCC. This Review understands that the IPCC will report in 2006 on both issues referred to it.
- 1.60 Until the Devon and Cornwall Review had reported, and therefore Surrey Police could announce that their investigations were complete, the Coroner could not begin to make arrangements for the outstanding inquest into James Collinson's death. During that period, Mr and Mrs Collinson had no sight of Surrey Police's report into their son's death, the statements on which it was based, or the benefit of a Board of Inquiry by the Army into their son's death. However, once the Devon and Cornwall Review had reported and once the inquest into James Collinson's death was announced, disclosure of the material relevant to his death could proceed according to usual inquest procedures. It should also

⁴³ The Review is aware that unsuccessful applications have been made to Surrey Police under the Freedom of Information Act 2000 for disclosure of the Devon and Cornwall Review's report. The Review is also aware that Surrey Police wrote to the families on 20th January 2006 to inform them that the issue of the disclosure to interested families of material gathered during major crime investigations has been referred to the Association of Chief Police Officers (ACPO) for consideration.

be noted that when Surrey Police advised the Army in April 2002 that they would be re-investigating Geoff Gray's death, they indicated that they considered it inappropriate that a Board of Inquiry by the Army into Geoff's or James Collinson's death should take place until their investigations were completed. There has thus been an information logjam affecting the Coroner, the families, the Army and this Review.

Related reports and investigations

- 1.61 It will be evident that during the course of this Review a number of other reports relating to issues at Deepcut have been produced. We have noted the Devon and Cornwall Review's report of August 2005. We have also noted the HCDC report in March 2005, which is extremely useful for any student of the duty of care owed to young people, not least because it is a compendium of valuable evidence as to current practices and concerns, and what the Armed Forces are seeking to do by way of redress. However, the HCDC made it plain that they were not investigating the deaths at Deepcut themselves, nor the factors that may have contributed to them.
- 1.62 In addition, in May 2004 the Minister of State for the Armed Forces commissioned the Adult Learning Inspectorate (ALI) to conduct an independent inspection of military training establishments. Their report was published on 21st March 2005.⁴⁴ Such an inspection of the learning environment is, again, a helpful, transparent and independent audit of how well training is delivered today. However, as will become apparent in this Report, the learning environment in Army training from 2003 onwards is rather different to that that existed from 1995 to 2001/2.

The influence of the media and the need for fairness to all

- 1.63 It is fair to say that the first three deaths did not attract an unusual level of media attention. It was only after the death of James Collinson, so soon after the inquest into Geoff Gray's death, that the media have, understandably, been persistently interested in the events at Deepcut. That interest manifested itself in a number of ways. It was BBC Scotland who first commissioned Frank Swann to conduct some forensic examinations for their Frontline Scotland series. While investigations into the deaths were ongoing by Surrey Police, the media continued to attempt to investigate for themselves what had happened. Former trainees and members of staff were interviewed and their accounts ventilated, usually in sensationalist tones, in the national press. Various allegations against staff and other trainees were reported as fact. A number of theories as to how each of the four deaths had occurred were reported: the trainees were murdered by a killer on the loose; that Deepcut was a 'death camp'; that there was a gang of bullying NCOs tormenting trainees and that those who died were bullied or harassed and, ultimately, driven to death. It was only a matter of time before Deepcut became synonymous with bullying in the Army. The more frequently that message was communicated and repeated, the more likely it was to be believed. Unsurprisingly, the events at Deepcut have since been identified as a cause of lower levels of recruitment into the Army.

⁴⁴ 'Safer Training – Managing risks to the welfare of recruits in the British armed services', April 2005.

- 1.64 The accounts portrayed in the media were often from former trainees who had themselves already been interviewed, or were to be interviewed, by Surrey Police. As these accounts were put into the public domain, Surrey Police had to re-interview individuals they had already seen, or track down others not yet identified at that time, who were making allegations that may have been of relevance to explaining any of the deaths. While some of these allegations were of general treatment, others directly involved the four young soldiers. When some individuals were interviewed, Surrey Police found that their accounts in interview differed significantly from that in the media articles. Sometimes this was a result of exaggerated claims by the individual in question; at other times it was a result of selective reporting and distortion of those accounts.⁴⁵
- 1.65 The more sinister headlines doubtless raised real anxiety and anger in the minds of parents of trainees generally, and those who died in particular. The allegations have not been substantiated by Surrey Police, as the warnings attached to the publication of the Duty of Care Schedules made clear. They are not based on a fair evaluation of all the material evidence. Sometimes they depend on accounts to the media by informants who have themselves been guilty of discreditable conduct or have interests of their own to advance. Some of these conclusions have had considerable impact on the private lives of those accused of wrongdoing of a serious kind without fair investigation or trial.
- 1.66 Undoubtedly, the events at Deepcut have raised issues which the media are entitled to investigate and pursue in the public interest. There are many penetrating questions for the police and the Army to respond to. Responsible reporting can clearly bring to light evidence of abuse. Ideally, there should be a mutual interest between the media and the investigative authorities in pursuit of truth and justice according to law. Such a mutuality of interest ought to lead journalists to direct their sources to the police for investigation, rather than prejudge their accuracy and reliability and report their accounts as if they were established fact.
- 1.67 The intense media scrutiny has had an impact on all the agencies concerned with these events. Anxious not to prejudice any pending investigations, inquests or reviews, the Army has generally kept a low profile in responding to these matters, to the understandable frustration of some, many of whom are working or have worked at Deepcut, including Commanders and Commanding Officers of the Training Regiment.
- 1.68 Surrey Police, for their part, have been anxious that witnesses are not deterred from coming forward by the possibility that their accounts are leaked to the media and splashed over newspapers, which in turn deters others from coming forward. Understandably, in addition to legal considerations, this has affected Surrey Police's disclosure strategy with respect to statements and reports. As has been described, that strategy has, in turn, led to difficulties for the Army in investigating allegations of abuse, for the families in gaining access to sensitive reports and statements and for this Review in relation to the terms on which material it has seen can be used. Often the reasons cited for non-disclosure of material has stemmed from concern that the media would get hold of them. No doubt the experiences of some of those named in the press in the past, who have been the subject of unfair, unbalanced and intrusive reporting of allegations made against them, illustrate the real nature of this concern. These very experiences were to influence this Review's decision on anonymity, as discussed below.

⁴⁵ See also paragraphs 6.127 and 6.157 ff below.

- 1.69 Nevertheless, it would be invidious to portray the media attention as without benefit. As explained further in Chapter 11, at paragraphs 11.85 to 11.87, there is no doubt that in today's media conscious environment, those in authority, in both Surrey Police and the Army, kept their minds on the issues at Deepcut in no small part due to the relentless media attention following the death of James Collinson. That focus has sustained critical analysis and, ultimately, ensured significant changes have been implemented to address the issues of concern arising from these deaths.

Use of the Surrey Police material

- 1.70 The origins of the disclosure policy of Surrey Police have already been noted. In fact, as early as July 2002, senior investigators identified that some witnesses being approached were not willing to have their details passed to the Army. By September 2003, in the absence of any criminal or judicial proceedings, including fresh inquests in relation to the first three deaths, the ability of Surrey Police to freely disclose the evidence they had gathered was in doubt. On legal advice, it was recognised that informants had a legitimate expectation that their evidence would not be used outside formal legal proceedings. Surrey Police thereafter wrote to the informants requesting their permission to disclose their statements to 'interested parties', including the families. Unsurprisingly, when offered the option, some witnesses chose not to permit their statements to be released to any party. Others allowed limited access, for instance only to the Army or to the MOD. As noted, many specifically refused any access to the media, or used that as justification for imposing restrictions. Others did not reply to letters at all. The result has been that disclosure considerations have accounted for a disproportionate level of consideration in this Review than might have ideally been the case.

The Review's decision on anonymity

- 1.71 The disclosure considerations were to influence the writing of this Report. A number of informants, when given the option, had clearly allowed their concerns regarding disclosure to the media to influence their consent to disclosure to other parties. In the same vein, the naming of certain characters linked to the four soldiers in the media, and the consequential public vilification of their character as a result of unsubstantiated allegations, caused this Review some concern that the naming of individuals against whom allegations had been made would, similarly, result in unacceptable intrusion into their personal lives. The Review was influenced, in particular, by the experience of one individual, referred to as Sergeant B in this Report, who suffered such intrusion after the BBC Panorama Programme in December 2002.⁴⁶ Further, it had become apparent by the time this Report came to be written that the real concerns that have led to the recommendations and conclusions in Chapter 12 are more of failure of the system rather than individual culpability, although such systemic failures are best illustrated by specific examples where the material enables it. The Review did find such compelling specific examples from the period 1996 to 2001, which have informed its conclusions, although they did not relate directly to any of the four deaths. This information is considered in Chapters 7 to 9.
- 1.72 The Review, therefore, took the decision when writing this Report to anonymise all individuals referred to in it against whom allegations have been made or who have made allegations against others. Those who do not fall into either category, and who have met

⁴⁶ See paragraphs 5.102 and 5.130-132 (including footnote 114). Indeed, as will become apparent from Chapter 5, a significant proportion of the allegations contained in the 1995 Duty of Care Schedule concern Sergeant B. See also paragraph 6.128 below. He has also inaccurately been linked in the media to the death of Sapper Alfred Manship. The true position is clarified in Chapter 3, see paragraph 3.53 ff below.

with and engaged with the Review or whose identification, by virtue of their senior position, it was considered could not be avoided, are named. Each anonymised individual is attributed their rank at the time they were at Deepcut and a letter of the alphabet, or combination of letters, assigned in order of appearance in Part 2 of the Report (i.e. A to Z, then AA to AZ, then BA to BZ, etc). In order to identify females, a reference of '(f)' is inserted after the rank.

- 1.73 The Review recognises that the names of certain individuals against whom allegations have been made, or who themselves make allegations, are already in the public domain. However, given that such identification has not always been at the consent of those named, the Review has nonetheless chosen to afford anonymity without distinction. The naming of individuals, no matter how unconnected with the deaths, would inevitably result in disproportionate publicity and intrusion. As will become clear to a fair-minded reader on completing this Report, the identification of individuals is not a factor that contributes any significant value to its conclusions.

How this Report proceeds

- 1.74 With this lengthy preamble explaining some of the challenges encountered in reviewing the circumstances behind four deaths over seven years, it is necessary to explain this Review's own approach to the task before it. The Report is divided into three parts followed by four annexes. Annex A sets out the members of the Review Team. Annex B is a list of meetings and key visits which the Review has undertaken. Annex C is a report commissioned by this Review from Fiona Murphy, a solicitor experienced in representing families at inquests. Annex D is a draft disclosure agreement. Annex E is a glossary and Annex F is the list of Appendices contained in Volume 2 to this Report. The appendices include both edited transcripts of meetings, correspondence with the Review and certain core documents. The appendices to the Report themselves are published in CD format and will also be available on the Review's website following publication.
- 1.75 Part 1 of the Report consists of preliminary matters, and includes this introductory Chapter. Chapter 2 considers the law relating to inquests and other inquiries into deaths, and how past practice may be affected by human rights considerations following the coming into force of the Human Rights Act 1998. A concern in that Chapter is whether, when and how disclosure should be made to families to enable them to understand the events surrounding their child's death and to participate effectively in any investigation or inquiry. It was in this context that the Review commissioned Fiona Murphy, solicitor of Bhatt Murphy, to assist on the practicalities of how and why families can and should be involved, without frustrating criminal or other investigations.⁴⁷
- 1.76 Chapter 3 outlines the policies between the RMP and the civilian police governing the investigation of deaths. The issue of primacy for the investigation of the deaths at Deepcut is discussed and the role of the RMP in deaths abroad is considered. Further, this Chapter considers the case of Alfred Manship, wrongly connected with Deepcut but illustrating the importance of an effective inquiry.
- 1.77 In Chapter 4, the background to the four deaths is set out by way of explanation of the Army's policy decisions relating to rationalisation of the recruitment and training process, the formation of the RLC and the command structure at Deepcut. This Chapter examines information relevant to what the Army thought it needed to do to protect the welfare of trainees. Specific discussion of Army policy on guard duty is deferred until Chapter 11.

⁴⁷ See Annex C to this Report.

- 1.78 In Part 2 of the Report, the Review considers the material about the specific deaths and some incidents at Deepcut between 1996 and 2002. In Chapter 5, the Review considers the material available to explain the death of Sean Benton and the circumstances surrounding it. This will look at what has come to light since the original inquest and what impact that may have. In Chapter 6, a similar task is performed with respect to the death of Cheryl James. In Chapters 7, 8 and 9 the response of the Army to these first two deaths will be analysed, as well as other material throwing light on the circumstances of trainees at Deepcut. In Chapter 10, the circumstances surrounding the death of Geoff Gray will be reviewed.
- 1.79 In Part 3 of the Report, the Review will reach its conclusions. In Chapter 11, the events leading up to the death of James Collinson will be noted, along with the response of the Army to his death. Discussion of Army policy on guard duty is reserved to this Chapter and the Review reaches conclusions that are the basis for the recommendations in the final Chapter. As explained, the individual circumstances of James Collinson's death will not be commented on as they have been matters for consideration at the inquest.
- 1.80 In Chapter 12, the Review draws together the conclusions it has reached on the individual deaths and the circumstances surrounding them. It formulates 34 recommendations based on the discussion in the previous Chapters and considers whether there is now a case for a public inquiry into the deaths at Deepcut.

2 The Law Relating to Inquests and Public Inquiries

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Introduction

- 2.1 Before considering the circumstances surrounding the deaths at Deepcut and the issues raised by the material that has been generated, it is appropriate to review the legal framework in which deaths in England and Wales are investigated and subject to a judicial inquiry. This Chapter will also consider how far human rights considerations affect the issues of concern to this Review.

The inquest

- 2.2 The principal judicial officer concerned with inquiring into deaths in England and Wales is the Coroner. The office of Coroner is an ancient one, originating in the prerogatives of the Crown, although the functions of a Coroner are now regulated by a contemporary statute.
- 2.3 S. 8(1) of the Coroners Act 1988 provides:

"Where a coroner is informed that the body of a person ("the deceased") is lying within his district and there is reasonable cause to suspect that the deceased—

- (a) has died a violent or an unnatural death;*
- (b) has died a sudden death of which the cause is unknown; or*
- (c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act,*

then, whether the cause of death arose within his district or not, the coroner shall as soon as practicable hold an inquest into the death of the deceased either with or, subject to subsection (3) below, without a jury."

The wording "shall" in the above section emphasises the Coroner's duty to hold an inquest when either of criteria (a) to (c) are met and the deceased "is lying within his district."

- 2.4 S.8(3) of the Coroners Act identifies when a Coroner must sit with a jury. The circumstances are where there is reason to suspect:

- "(a) that the death occurred in prison or in such a place or in such circumstances as to require an inquest under any other Act;*
- (b) that the death occurred while the deceased was in police custody, or resulted from an injury caused by a police officer in the purported execution of his duty;*
- (c) that the death was caused by an accident, poisoning or disease notice of which is required to be given under any Act to a government department, to any inspector or other officer of a government department [...]; or*
- (d) that the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public."*

- 2.5 In other cases a Coroner has discretion whether to sit with a jury. An inquest, once convened, may be adjourned pending a criminal investigation and prosecution¹ and, on conclusion of those proceedings, the inquest may be resumed if, in the opinion of the Coroner, there is "*sufficient cause to do so.*"²
- 2.6 An inquest may also be adjourned without resumption (unless the Coroner is of the opinion there are exceptional reasons for resuming) where the Coroner is informed by the Lord Chancellor that a public inquiry is being held into the events surrounding the death and the cause of death is likely to be adequately investigated by the inquiry.³
- 2.7 The deaths of Sean Benton, Cheryl James, Geoff Gray and James Collinson by gunshot wounds were all deaths which there were clear grounds to believe were violent or unnatural. It was, therefore, necessary to hold an inquest into each death. The inquests into the first three deaths were held without a jury. They were short affairs, concluded shortly after the deaths⁴ and completed well inside a day. As will be seen, most of the statements taken for use in those inquests were taken by officers of the Special Investigations Branch (SIB) of the Royal Military Police (RMP).
- 2.8 The inquest into the death of James Collinson has been substantially different. The Coroner has sat with a jury. The inquest was expected to last some two weeks. Interested parties, including the family, the Army and Surrey Police, were represented. There were pre-inquest meetings and advance disclosure of certain relevant evidence to the legal representatives of the interested parties so they could effectively participate in the inquest. It may be that the view was taken by 2005 that there was "*reason to suspect*" that the death had occurred "*in circumstances ... prejudicial to the health ... of any section of the public*" in circumstances that could possibly recur.⁵ Alternatively, with the completion of the Surrey Police investigations, and the attendant public profile of the events to be examined, it may have been considered that sitting with a jury was necessary and appropriate as a matter of discretion. Further, HM Coroner for Surrey concluded in 2005 that the scope of the issues to be inquired into at the inquest were broadened by the judicial case law resulting from the coming into force of the Human Rights Act 1998 and the requirement on public authorities to act compatibly with Article 2 (Right to Life) of the European Convention on Human Rights (ECHR).
- 2.9 It is likely that each of the families of Sean Benton, Cheryl James and Geoff Gray would have benefited from the much more extensive inquest applied in the case of James Collinson. In conversation with the Review and in written representations,⁶ it is apparent that for each family there are many questions still unresolved in their minds about how their son or daughter met their death. The Review has no doubt that contemporary standards of involving the families in the police investigation and statutory inquest into their child's death represent a significant advance from previous practice. Without a full and informed opportunity to understand the circumstances of the death and what the investigations have revealed by way of evidence, the prospects of this process putting minds at rest are seriously diminished. As the Lord Chancellor has made plain in a recent speech to the Coroner's Society:

¹ See the Coroners Act 1988, s.16(1) as to the specific criteria and the relationship between the offence being investigated or prosecuted and the death.

² *Ibid.*, s.16(3).

³ *Ibid.*, s.17A(1) and (4).

⁴ The Review understands that delays of 4-6 weeks was the norm for the time and that, in the case of Cheryl James, there may have been particular reasons to complete the inquest before Christmas.

⁵ *Supra*, footnote 1, s.8(3)(d). See paragraph 2.4 above

⁶ Mr and Mrs Gray and Mr and Mrs Collinson made written representations to the Review when invited to do so. Mr and Mrs James and Mr and Mrs Benton decided not to. The submissions of Mr and Mrs Gray and Mr and Mrs Collinson are reproduced in Appendices 1 and 2, respectively.

"The fact that bereaved people are treated as interested parties in coroner investigations – and have the opportunity to ask questions and to contribute both to investigations and to inquest proceedings – is vital. The involvement of the bereaved is likely to lead to a better overall investigation and a more accurate conclusion.

"That must continue and be enhanced in a reformed service.

"It will not eradicate grief or pain, but it can go some way towards mitigating it. It will give the bereaved the opportunity to get the answers to questions, some of which may be simple and straightforward. Left unchecked these could fester and lead to a sense of injustice – dealt with promptly and courteously they can help make a difficult situation bearable."⁷

- 2.10 The subsequent re-investigations into the first three deaths at Deepcut have certainly raised new issues, new concerns and produced substantially more material than was available to the Coroner in 1995 and 2001. Later in this Chapter, the Review will examine whether this is sufficient, in itself, to justify setting aside the previous inquisition and enabling a fresh inquest to be undertaken in which the family can review the material and the conclusions to be drawn from it for themselves.

Territorial Jurisdiction to hold an inquest

- 2.11 There is a preliminary issue to be noted, however. In each of the four cases an inquest was required and, for the first three deaths, a fresh inquest remains a possibility. This is not always the case with respect to soldiers who die in the service of the British Army. It is worth noting that the Coroner's jurisdiction is territorial in that it depends on being informed of the presence of a body in his or her district. The death does not have to have occurred in the district,⁸ but the body does need to present in it. Historically the focus of jurisdiction has been the body, rather than the death. This may have focused the inquiry on the physical injuries, and the causes of them, rather than wider considerations.
- 2.12 It was decided some years ago in the case of *R v West Yorkshire Coroner ex parte Smith*,⁹ by a divided Court of Appeal, that a duty to hold an inquest arises where the death occurs abroad and the body is repatriated to England and Wales. The plea that Coroners would face practical difficulties investigating deaths abroad did not succeed before the Court of Appeal.¹⁰
- 2.13 The practical difficulties of investigating overseas deaths in the Armed Forces are very different. Wherever the Army is deployed, units of the RMP are available and, depending on the circumstances of the deployment and the arrangements made with the civilian police in bases overseas, they are likely to have to conduct an investigation into any military death. Where it is known that the body of the soldier will return to England and Wales, and that there will, therefore, probably be an inquest, the SIB of the RMP will assist the Coroner to perform this duty.

⁷ 30th September 2005. The text is available at www.dca.gov.uk/speeches/2005/lc300905.htm

⁸ *Supra*, footnote 1, s.8(1).

⁹ [1983] QB 335.

¹⁰ *Ibid.* At paragraph 21 E – F it was noted: *"Inevitably a coroner conducting an inquisition into a death abroad will be faced with difficulties of evidence and so on, but that must have been so ever since the statute of George II. Such difficulties are indeed by no means confined to death occurring overseas. Coroners are well experienced dealing with such problems. Indeed the same difficulties would have arisen if Miss Smith had survived her fall long enough to be brought back to England to hospital and had died in hospital or elsewhere in England."*

- 2.14 As the law stands at present, however, it seems that the application of this duty in the context of service in the British Armed Forces may lead to some inconsistency. A soldier who dies abroad and whose body is not brought back to England and Wales will not come within the statutory scheme of s.8 of the Coroners Act.
- 2.15 In Scottish cases the Coroners Act does not apply.¹¹ There is no automatic inquest system, but a suspicious death may either be investigated by the Procurator Fiscal, as a criminal matter, or a Fatal Accidents Inquiry may be held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. There are at least two distinctions from the position in England and Wales. First, the circumstances where there is a duty to hold an inquest into a violent death in England and Wales is to be distinguished from a power to hold a Fatal Accidents Inquiry under s.1(1)(b) of the Scottish Act. This provision gives the Lord Advocate a power to order an inquiry where "*it is expedient in the public interest ... on the ground that it [the death] was sudden, suspicious or unexplained or has occurred in circumstances such as to give rise to serious public concern.*" Secondly, it appears from s.1(2) of the Scottish Act, and Scots practice to date, that the inquiry can only be held into deaths in Scotland and not for those outside. The practice was reflected in the concession made by counsel for the Petitioner in *Al Fayed v Lord Advocate*.¹² In that case, the body was never brought back to Scotland and the only connection with Scotland was as a place of residence of the Petitioner father. Whether such a consensus might in the future be revisited where a body is repatriated to Scotland, in the light of arguments based on the English case law and practice and the implications of the Human Rights Act 1998, it is not necessary to consider at present.
- 2.16 In light of the above, it appears that it may be a matter of happenstance whether a soldier whose body is released for burial in Scotland is the subject of an inquiry or not. This is profoundly unsatisfactory for the families of those who do not have an inquest or inquiry into the death of their child. Of the four soldiers at the heart of this Review, James Collinson was born in Scotland, was ordinarily resident there and was buried there. Both his parents reside in Scotland today. His death in March 2002 at the Deepcut Barracks in Surrey was reported to HM Coroner for Surrey and, as noted, has been the subject of an inquest by him conducted in 2006. James Collinson's death would not have been subject to an inquest, or necessarily an inquiry, if he had died at an Army barracks situated in Scotland or had died abroad and his body brought back to Scotland directly.
- 2.17 For example, in Chapter 9 the Review notes the death of Private CR in Scotland in 1999, where, following a civil police investigation into the violent death, no criminal charges were brought and no Fatal Accidents Inquiry was held.¹³ The subsequent Board of Inquiry held internally by the Army was concerned whether the Private had been correctly assessed as fit for the performance of guard duty. If a similar death were to happen today, in the opinion of this Review, the families of the deceased soldier should be able to participate in the investigation as to whether lessons learned from previous cases had been appropriately applied.
- 2.18 Further, the Review has been made aware of the case of Sapper Alfred (Alfie) Manship who died in April 1992 whilst on military service at Osnabrück, Germany. His body was repatriated to Scotland via England. His death was never the subject of an inquest, a criminal investigation or a Fatal Accident Inquiry by the Procurator Fiscal. Conflicting information has been given to Sapper Manship's mother, Ms Manship-Milligan, over the

¹¹ The Coroners Act 1988 states at s.37(3): "*this Act extends to England and Wales only.*"

¹² [2004] Scot CS 66 (12 March 2004) Times Law Report 22nd March 2004. A decision of Lord Drummond Young in the Outer House. The practice is noted at paragraph 4(5).

¹³ See paragraph 9.24 ff below.

years about whether an inquest had¹⁴ or could have been held into his death. Understandably, his mother has had concerns and questions about the death of her son that have never been answered in any formal proceedings. One of her concerns is why some Scottish born and resident soldiers have an inquest into their deaths, while others do not. Another concern might well be why some soldiers who die abroad have inquests when their bodies are brought back to the United Kingdom and others do not. It will be necessary to return to the facts of Sapper Manship's death in Chapter 3,¹⁵ where a fuller account will be given. It is sufficient to note that, apart from being illogical and inconsistent, the absence of a proper inquest or inquiry – at which the families of the deceased can be present and participate – creates problems that may never have occurred had such proceedings been held.

- 2.19 A recent example of a case where an inquest has been held in England in respect of a death of a young serviceman abroad is that of David Shipley. David was a young soldier of the Royal Logistic Corps (RLC) who had been trained at Deepcut before being posted to Germany in 2002. He was found drowned in a shallow pool of water after the Regiment's summer fête in June 2002. The RMP conducted an investigation into his death. His body was repatriated to England where HM Coroner for Cumbria held an inquest into his death in July 2005 and returned an open verdict. In reaching his reasoned conclusions, the Coroner expressed some concern as to the reliability of some of the evidence from soldiers relating to the events immediately preceding David's death.¹⁶ For present purposes, it is sufficient to note that the inquest system did give rise to a statutory inquiry where the evidence could be tested and the family could participate.
- 2.20 It appears that in some cases of death abroad where the soldier concerned is to be buried in Scotland an inquest can be held in England and Wales, if the Coroner is pre-notified that the body will be flown to a place where he or she has jurisdiction. The inquest process is opened before the body is released for burial and jurisdiction is retained.
- 2.21 The need for consistent practice in respect of inquests or inquiries into deaths of soldiers that occur outside the United Kingdom is underlined by recent recruitment patterns into the British Army. These reveal an increasing number of recruits from the Commonwealth, as well as the continued existence of the Brigade of Gurkhas who are recruited in Nepal. If such soldiers die on attachment abroad and their bodies are repatriated straight home, there may be no opportunity to hold an inquest or inquiry and local laws and practices may not require it, irrespective of the practical ability of a Coroner in, for example, Fiji, Jamaica or Ghana to inquire into a British Army death. It is surely important that the families of every British serviceman or woman receive equal treatment with respect to a statutory inquiry into the death, irrespective of nationality, place of residence or place of burial.
- 2.22 The Review is aware that the issue of whether the Coroner should always be under a duty to hold an inquest into a death abroad is under consideration following the Luce Report, 'Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003.'¹⁷ The specific example of soldiers serving abroad may not have featured as a distinct consideration hitherto but, in the light of the examples given

¹⁴ House of Commons, Hansard 12 December 2002; Column 427W, where the then Parliamentary Under-Secretary of State for Defence, Dr Lewis Moonie, stated in a Written Answer that an inquest had been held into the death of Sapper Manship and that a verdict of 'suicide' had been returned.

¹⁵ See paragraph 3.36 ff below.

¹⁶ The Review has seen the transcript of the summing up, kindly provided by the Coroner. See also paragraph 10.23 ff below.

¹⁷ Cm 5831, June 2003. The legislative response to the Luce Report is outstanding at the time of writing of this Report. A Department for Constitutional Affairs Briefing Note was issued in February 2006 in which the Annex notes that the proposal in the Luce Report that "*Coroners should have discretion to investigate deaths abroad where the body is returned to England and Wales (rather than automatically investigate if the body is returned)*" will be taken forward in the draft Bill.

above and others brought to the attention of this Review by the Deepcut and Beyond Campaign, it is opinion of this Review that it is important that violent and unnatural deaths of soldiers in the British Army continue to be the subject of an independent inquiry regardless of wherever they die or are buried. A similar standard of inquiry with effective participation by the families of the deceased should be afforded to all families. This is a conclusion heightened by the human rights considerations that will be considered below.

- 2.23 The Review therefore recommends that an inquest or equivalent inquiry is held into every violent or unnatural death of every soldier serving in the British Army.¹⁸ Such a duty should remain part of the coronial law in England and Wales, and be achieved for Scotland either under the 1976 Act or other provisions of law. Where Commonwealth soldiers die abroad and are to be buried outside the United Kingdom, the Army will need to make arrangements to ensure either a local inquiry is held or the body is first brought back to the United Kingdom for an inquest to be held there.

The role of the inquest

- 2.24 Where an inquest is held, s.11(5) of the Coroners Act 1988 sets out what the inquiry is into. It provides that the inquisition, or the formal record of the results of the inquest, shall set out, so far as such particulars have been proved, "*how, when and where the deceased came by his death.*"¹⁹ This is repeated in rule 36(1)(b) of the Coroners Rules 1984, and rule 36(2) prevents both the Coroner and the jury from expressing an opinion on any other matters. As the leading textbook on coronial law 'Jervis on Coroners'²⁰ puts it, "*for this purpose 'how' means 'by what means', rather than 'in what broad circumstances.'*" There is a line of case law to this effect of which only the decision of the Court of Appeal in *R v North Humberside Coroner ex p Jamieson*²¹ need be here cited. It should be noted that the decision in *Jamieson* was a binding authority on the scope of the inquisition at the time of the inquests held into the deaths of Sean Benton, Cheryl James and Geoff Gray. It did restrict the ability of the Coroner to look at contributory factors that may not have been directly causative of the death and it also diminished the ability of the inquest to address the question that arises in certain cases as to 'why' the deceased met his death.

The 'how' question

- 2.25 Traditionally, inquests have been able to answer the 'how' question using one of a number of well established conclusions set out in the notes to the prescribed form of inquisition,²² although the notes are not part of the rules and use of these conclusions is not compulsory. These conclusions range from unlawful killing, lawful killing and suicide to accident/misadventure, dependence or other abuse of drugs, industrial disease, disasters the subject of public inquiries, various conclusions relating to still-born, aborted or recently born infants, or natural causes. These conclusions are usually referred to as verdicts, although this label is better described as the whole narrative findings of fact following the inquest in view of the Coroners Rules 1984 rule 42.²³

¹⁸ See paragraph 12.109, Recommendation 30 below.

¹⁹ *Supra*, footnote 1, s.11(5)(b)(ii).

²⁰ 'Jervis on the Office and Duties of Coroners', Paul Matthews, 12th Edition, Sweet & Maxwell Limited, 2002. *Ibid*, at para 13-01.

²¹ [1995] QB 1.

²² Coroners Rules 1984, Schedule 4, Form 22: Inquisition.

²³ Rule 42 precludes the verdict from being "*framed in such a way as to determine any question of – (a) criminal liability on the part of a named person, or (b) civil liability.*"

- 2.26 The Coroners Rules and the extensive case law make plain that an inquest is not a trial and no one can be individually blamed for a death by an inquest's findings. Where no other cause of death can be established, an open verdict is returned. Unlawful killing, as the means by which a person met his death, includes any form of homicide, whether murder or manslaughter. Manslaughter may itself be the unintended consequence of an unlawful act, such as assault and battery or breach of some particular statutory duty, or it may be gross negligence manslaughter, that is to say where death occurs as a result of a failure of a duty of care that is really gross or serious. This Review is not the occasion to explore controversial and difficult areas in this area of the law, such as the true test of causation to be applied, nor to examine the reach of corporate manslaughter, where death may have been contributed to by a number of individual errors by different actors none of which, taken alone, would have been decisive.
- 2.27 Despite the clear distinction from a verdict returned in a criminal trial, and the fact that the true focus of the inquest is on how the deceased died, rather than with criminal or civil responsibility for death, Jervis on Coroners points out that since 1977 the case law has required a conclusion that death was the result of a criminal act to be reached on the criminal standard of proof: that is to say, satisfaction beyond reasonable doubt or so that the fact finder is sure of the conclusion in hand.²⁴
- 2.28 Even though suicide has not been a crime since 1961, as high a standard of proof is also required to reach the conclusion of suicide as it is to reach a conclusion of unlawful killing. Like unlawful killing, suicide must never be presumed and a verdict of suicide can only be reached where there is evidence of suicidal intent or any other reasonable possibility has been excluded.²⁵ Thus, in one case a young man of 19 years, with no apparent problems or concerns, was found dead at home as a result of a gunshot wounds inflicted by a weapon in close proximity to his head whilst his family were away on holiday.²⁶ The Coroner, sitting without a jury, returned a verdict that the deceased had taken his own life (suicide) but the verdict was quashed on appeal because as Mr Justice Pill (as he then was) put it:
- "The facts and circumstances in this case did not, in my judgment, point irresistibly to the existence of a suicidal intent. The possibility that the discharge of the gun was accidental could not be excluded as a reasonable possibility."*
- 2.29 The consequence of these rules may represent some tension between the principle that an inquest should endeavour to reach as full and accurate a conclusion as to the means of death, where that is possible, and a concern to avoid a conclusion of unlawful killing or suicide unless that is established to the criminal standard. In civil litigation, in internal inquiries or, indeed, in a Review such as the present one it is generally possible to establish a cause of death by the ordinary rules of the civil standard of proof: namely, the balance of probabilities. This standard is flexible enough for the person making the decision to take into account that deaths resulting from homicide and suicide are less probable than accident, misadventure or unexplained deaths. But the balance of probabilities is not enough where unlawful killing or suicide is concerned. It is, thus, perfectly possible, indeed necessary in some cases, for an inquest to reach an open verdict where suicide or, indeed, unlawful killing is the most probable explanation but it is not possible to exclude other

²⁴ *Supra*, footnote 20, at paragraph 13-32. See for example *R v West London Coroner ex p Gray* [1988] QB 467, DC; *R v Inner North London Coroner ex p Diesa Koto* (1993) 157 JP 857, DC.

²⁵ See *R v City of London Coroner, Ex parte Barber* [1975] 1 WLR 1310.

²⁶ *R v Essex Coroner ex p Hopper* (unreported, 13th May 1988, Divisional Court).

possibilities such as an unintended self-inflicted death. In any event, it is an error for anybody examining a Coroner's verdict to conclude that because there is no verdict of suicide it must be a case of homicide or vice versa.

- 2.30 Open verdicts are not particularly helpful for those responsible for the management and operation of a location where an unexplained death has occurred who are anxious to review their practices to reduce or eliminate risk of repetition. It may be that open verdicts also operate to prevent closure for grieving family members of a deceased person, who are understandably anxious to discover all they can about the death and how it occurred. On the other hand, however, suicide may be a conclusion that a family member will wish to avoid if there is any room for doubt. Whether this is the result of religious, moral or social stigma, or a residual sense of responsibility – however irrational – that one could have done more to help, it is not necessary to consider. The undoubted misery that a conclusion of suicide creates for families and friends is perhaps reason enough to believe a loved one would not deliberately take their own life in the absence of very strong evidence establishing that there is no other rational conclusion open to the fact finder.

The 'why' question and broader considerations

- 2.31 In addition to the 'how' question, historically determined by use of the conclusions referred to above, inquests have been the occasion for exploration of somewhat broader circumstances, including in some cases the question 'why' a person died. The legitimacy of such an inquiry is constrained by the nature of the statutory inquiry of an inquest, the Coroners Rules, preventing attribution of criminal responsibility and of civil responsibility in negligence or breach of statutory duty, and the case law.
- 2.32 Two features of coronial law and practice invited an inquest to examine systemic or other serious failures of a regime in which death occurred where the death might have been preventable. First, there was the possibility for the tribunal of fact, whether a Coroner or a jury, to add a 'rider' that the death was aggravated through neglect or lack of care in certain cases. Such a rider most usually arises where a death has occurred in a hospital or prison or police cell, where the circumstances were such that someone had a duty to provide supervision or medical care to the deceased and failed to perform that duty adequately or at all. Such a rider could be applicable to self-inflicted deaths, as well as deaths from injuries of natural causes, where supervision and intervention would, or could, have prevented the death from occurring. Secondly, rule 43 of the Coroners Rules 1984 provides that "*a coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held*" may report the matter to a "*person or authority who may have power to take ... action.*" This suggests that a Coroner should be aware of circumstances where death has occurred through a combination of factors putting someone at risk of harm or self-harm and such factors could be addressed to prevent a similar recurrence.
- 2.33 Further, there were cases of undoubted suicides of those held in prison or police custody where the inquest was able to return a qualification or rider to the verdict that the death was aggravated by lack of care. Prior to the coming into force of the Human Rights Act 1998, however, there was judicial authority that such a rider could only be added where death resulted a direct consequence of some breach of duty to look after the person concerned.²⁷

²⁷ *Supra*, footnote 21.

Fresh inquests

- 2.34 Where an inquest that ought to have been held has not been held, or where the inquest that has been held has been flawed in law in some material way, there are two possibilities for redress at the hands of an aggrieved party.
- 2.35 First, an application can be made for judicial review to quash the inquisition in whole, or in part, and this may require a new, or fresh, inquest to be held. An application for judicial review will need to be brought promptly and, in any event, within three months of the decision to be quashed, unless there are good reasons to extend the period. Judicial review may be appropriate where there has been serious unfairness in the conduct of the proceedings, or error of law in respect of the conclusions open to a tribunal of fact as a result of the evidence heard.
- 2.36 Secondly, a person who has the authority of the Attorney General's consent may apply to the High Court under s.13 of the Coroners Act 1988 for an order that a new, or fresh, inquest be held. Where a previous inquest has been held, the High Court must be satisfied that:

*"... whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise, it is necessary or desirable in the interests of justice that a fresh inquest be held."*²⁸

This is a broad and salutary jurisdiction governed by a combination of a wide variety of statutory grounds and the interests of justice.

- 2.37 In the past, there has been some debate as to whether there needs to be a likelihood of a different verdict being returned if a fresh inquisition were to be established. The older authorities are reviewed in *Jervis on Coroners*²⁹ and cover too wide a variety of circumstances to be readily summarised into a single test. A serious procedural failure or inadequate inquest may leave the families with such a sense of dissatisfaction that a re-hearing should be ordered even if there is a high probability that the result would be the same.³⁰
- 2.38 It has been noted in Chapter 1 that in October 2003 HM Coroner for Surrey reviewed the contents of the Surrey Police reports into the first three deaths following their re-investigation and concluded that there was no case to apply to set aside the previous inquests because there was no sufficient likelihood of a different outcome resulting.³¹ He did invite disclosure of the material in Surrey Police's reports to the families so that informed representations could be made on this issue. This in turn prompted Surrey Police to adopt a policy on disclosure of the material they had gathered during their re-investigations, now that it was not to be used for formal forensic proceedings such as either a criminal trial or fresh inquest. This Review understands from Surrey Police that a number of witnesses who made statements were not willing for their statements to be provided to one party or another for a number of reasons. Amongst these was the concern that statements may come into the hands of the media where they might result in unwelcome publicity without any of the safeguards of a formal process. This issue has

²⁸ Coroners Act 1988 s.13(1)(b).

²⁹ *Supra*, footnote 20, paragraphs 19-11 and 19-12.

³⁰ See *Re Rapiere* [1988] QB 26 and *R v West Sussex Coroner ex p Edwards* (1991) 156 JP 186. In *ex p Edwards*, Watkins LJ observed: "It may be that where no opportunity is given to persons who are in close relationship with the deceased to take part in an inquest so that there is a material irregularity in the proceedings that that alone should be enough for this court to quash the inquest."

³¹ See paragraph 1.9 above.

been the subject of comment in Chapter 1. The Review recommends that agreement should be reached, if necessary with undertakings, whereby the families and their legal representatives are able to see and study the relevant material on the understanding that it is provided solely for the purpose of making representations as to whether a fresh inquest is necessary.³²

- 2.39 The Review is unaware whether representations were, indeed, made to the Coroner as to whether a fresh inquest should be convened, and of precisely what information was available to the families and their legal advisers on which such representations could be made. The Review is aware that Surrey Police have briefed the families on a number of occasions about the outcome of their re-investigations, but recognises that there is likely to be an important distinction between a briefing, where someone else's conclusions are explained, and full disclosure of the evidence to enable the family and their advisers to reach their own conclusions.
- 2.40 In any event, recent legal developments in the field of inquests and human rights law suggest that the question of whether a fresh inquest is necessary or desirable, or legally possible, should be re-examined.

The impact of the Human Rights Act 1998

- 2.41 The scope of what an inquest can inquire into and what conclusions it can reach have been very substantially affected by the enactment of the Human Rights Act 1998, which came into effect from 2nd October 2000. The Act essentially requires public authorities to act in a manner compatible with relevant provisions of the ECHR, unless primary legislation prevents them from doing so.³³ It also introduces a new principle of statutory construction that requires legislation to be interpreted compatibly with the same provisions of the ECHR where it is possible to do so.³⁴
- 2.42 In two seminal decisions, the House of Lords has reviewed the extensive jurisprudence from the European Court of Human Rights relating to Article 2 of the ECHR and the duty on a state to protect life and to cause effective investigations and inquiries to take place into certain deaths.
- 2.43 In the case of *R (Amin) v Secretary of State for the Home Department*,³⁵ a prisoner of Asian ethnicity had been murdered by a white racist prisoner with whom he had been assigned to share a cell. The inquest was adjourned pending the bringing of murder charges and was not resumed following a conviction for murder. The prison service had held an internal inquiry into why the racist had been placed in the same cell as the deceased and had acknowledged its failures. On an application for judicial review, the first instance judge concluded that, notwithstanding the above, Article 2 of the ECHR meant that an independent public investigation into the broader circumstances whereby the death occurred was required having regard to some element of state responsibility for the death. The Court of Appeal reversed this decision concluding that the causes of the death had been adequately investigated by the police through the murder trial and through the prison inquiry. The House of Lords disagreed and restored the order for an independent public inquiry in light of the human rights requirements. In doing so, it reviewed the extensive jurisprudence³⁶ and noted that, where an inquiry was required by this case law,

³² See paragraph 12.112 ff and Recommendation 33 below. See also Annexes C and D.

³³ Human Rights Act 1998, s.6.

³⁴ *Ibid*, s.3.

³⁵ [2003] UKHL 51; [2004] 1 AC 653.

³⁶ *Ibid*, Lord Bingham at [20] distilled propositions from the case law into ten propositions that are not here repeated. The interested reader can access the judgment on the House of Lords website at: <http://www.publications.parliament.uk/pa/ld200203/ldjudgmt/jd031016/amin-1.htm>.

it was essential that the family of the deceased were properly informed and involved in the inquiry and able to make an effective input into its conclusions.

- 2.44 Lord Bingham pointed out that in the case of *Edwards v United Kingdom*,³⁷ the European Court of Human Rights applied these principles in a case of death in custody at the hands of a fellow prisoner, where there was no basis for a belief that the state or state agents had been the means whereby the deceased met his death. Even so, the Court stressed the need for an independent inquiry in which the family of the deceased were able to effectively participate, and held the United Kingdom to be in breach of its investigative obligation despite a very thorough inquiry and report by an experienced QC. The reason for such an inquiry was expressed as:

*"The essential purpose of such investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility."*³⁸

- 2.45 In *Amin*, Lord Bingham reached his conclusions in the following terms:

"30. A profound respect for the sanctity of human life underpins the common law as it underpins the jurisprudence under articles 1 and 2 of the Convention. This means that a state must not unlawfully take life and must take appropriate legislative and administrative steps to protect it. But the duty does not stop there. The state owes a particular duty to those involuntarily in its custody. As Anand J succinctly put it in *Nilabati Behera v State of Orissa* (1993) 2 SCC 746, 767: "There is a great responsibility on the police or prison authorities to ensure that the citizen in its custody is not deprived of his right to life." Such persons must be protected against violence or abuse at the hands of state agents. They must be protected against self-harm: *Reeves v Comr of Police of the Metropolis* [2000] 1 AC 360. Reasonable care must be taken to safeguard their lives and persons against the risk of avoidable harm.

"31. The state's duty to investigate is secondary to the duties not to take life unlawfully and to protect life, in the sense that it only arises where a death has occurred or life-threatening injuries have occurred: *Menson v United Kingdom* (Application No 47916/99) (unreported) 6 May 2003, p 13. It can fairly be described as procedural. But in any case where a death has occurred in custody it is not a minor or unimportant duty. In this country, as noted in paragraph 16 above, effect has been given to that duty for centuries by requiring such deaths to be publicly investigated before an independent judicial tribunal with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous

³⁷ (2002) 35 EHRR 487.

³⁸ *Ibid*, paragraph 70.

practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."³⁹

- 2.46 No party to the litigation in *Amin* was suggesting that the adjourned inquest should be resumed. Lord Bingham thought this was unfortunate, as inquests were capable of providing the means whereby the state discharged its duty of holding a thorough and independent inquiry as required by the terms of Article 2 of the ECHR. Lord Hope, at paragraph 60 of his speech, concluded that, in Scotland, a Fatal Accident Inquiry conducted into a death in a Scottish prison could, similarly, comply with the Article 2 obligation, although it is unlikely that the problem of a death abroad was then being considered (see paragraph 2.15 above).
- 2.47 Lord Bingham was not impressed with the Court of Appeal's conclusion that a fresh inquiry was unlikely to discover new facts, although the extent that the material had been previously examined was relevant to the method of the inquiry to be conducted. Lord Steyn added his own observations on this topic:

"The Court of Appeal posed the question: What would be the benefit of a further inquiry? The investigations conducted so far do not, either singly or together, meet the minimum standards required to satisfy article 2. But, in any event, it is vital that procedure and the merits should be kept strictly apart otherwise the merits may be judged unfairly: Wade & Forsyth, Administrative Law, 8th ed (2000), pp 501-503. In John v Rees [1970] Ch 345, 402, Megarry J observed about the argument that "it will make no difference":

"As everybody who has anything to do with the law well knows, the path of the law is strewn with examples of open and shut cases which, somehow, were not; of unanswerable charges which, in the event, were completely answered; of inexplicable conduct which was fully explained; of fixed and unalterable determinations that, by discussion, suffered a change."

*"This observation is apposite to the assumption that, although there has not been an adequate inquiry, it may be refused because nothing useful is likely to turn up. That judgment cannot fairly be made until there has been an inquiry."*⁴⁰

- 2.48 Further consideration has been given to whether a Coroner's inquest can achieve all that which is required by the terms of Article 2 ECHR in the case of *R (Middleton) v West Somerset Coroner*.⁴¹ This was a case of an undoubted suicide in prison and the issue was whether the Coroners Rules and the previous case law on the narrow circumstances when a rider of 'lack of care' could be attached to the inquisition, prevented the inquest from performing the functions of an Article 2 inquiry as required by human rights norms.
- 2.49 By way of preamble to the analysis of the relevant law in the decision, it is notable that Lord Bingham, who delivered the single judgment giving the opinion of the Appellate Committee, recognised that suicide in prison was a matter of national concern as rates of suicide amongst young prisoners were rising, while suicide in society at large was falling:

³⁹ [2003] UKHL 51; [2004] 1 AC 653 at [30] – [31].

⁴⁰ *Ibid*, at [52].

⁴¹ [2004] UKHL 10; [2004] 2 AC 182.

*"Unhappily, this is not a rare event. The statistics given in recent publications, (notably "Suicide is Everyone's Concern, A Thematic Review by HM Chief Inspector of Prisons for England and Wales" (May 1999), the Annual Report of HM Chief Inspector of Prisons for England and Wales 2002-2003, and Evidence given to the House of Lords and House of Commons Joint Committee on Human Rights (HL Paper 12, HC 134, January 2004)) make grim reading. While the suicide rate among the population as a whole is falling, the rate among prisoners is rising. In the 14 years 1990-2003 there were 947 self-inflicted deaths in prison, 177 of which were of detainees aged 21 or under. Currently, almost two people kill themselves in prison each week. Over a third have been convicted of no offence. One in five is a woman (a proportion far in excess of the female prison population). One in five deaths occurs in a prison hospital or segregation unit. 40% of self-inflicted deaths occur within the first month of custody. It must of course be remembered that many of those in prison are vulnerable, inadequate or mentally disturbed; many have drug problems; and imprisonment is inevitably, for some, a very traumatic experience. These statistics, grim though they are, do not of themselves point towards any dereliction of duty on the part of the authorities (which have given much attention to the problem) or any individual official. But they do highlight the need for an investigative regime which will not only expose any past violation of the state's substantive obligations already referred to but also, within the bounds of what is practicable, promote measures to prevent or minimise the risk of future violations. The death of any person involuntarily in the custody of the state, otherwise than from natural causes, can never be other than a ground for concern. This appeal is concerned with the death of a long-term convicted prisoner but the same principles must apply to the death of any person in the custody of the prison service or the police."*⁴²

- 2.50 Lord Bingham's judgment concluded that in light of the human rights obligation to attribute responsibility where the factual conclusions in an inquiry into a death merited it, the existing inquest system was deficient in some cases. The constraints imposed by the definition of the 'how' question in *Jamieson*,⁴³ where no reference had been made to human rights norms, needed modification by judicial interpretation, but such modification was available without doing violence to the statutory regime or pre-empting future legislation pending as a result of the 2003 review.⁴⁴
- 2.51 In the event, only a modest adjustment was necessary to achieve compatibility with human rights norms. Henceforth, a narrative verdict setting out the material findings of fact without determining civil or criminal liability was a means of attributing responsibility in whole or in part for a death, including an undoubted suicide by someone for whom the state was responsible. The scope of the inquest should be broadened so that the 'how' question meant "*by what means and in what circumstances.*"⁴⁵
- 2.52 There is no doubt, therefore, that the inquest procedure can be reinvigorated to incorporate and satisfy the procedural requirements of the ECHR. Questions of the practical ability of the families to participate in an inquiry by inquest will still remain but can be satisfied by public officials, including the Coroner and any senior investigating

⁴² *Ibid*, at [5].

⁴³ *Supra*, footnote 21.

⁴⁴ See paragraph 2.22 above.

⁴⁵ *Supra*, footnote 41 at [35].

police officer, acting compatibly with the principles set out in *Amin* when considering: the granting of legal aid to enable effective participation; disclosure of sufficient information in advance to enable effective questioning to take place; and other practical details surrounding the length, location, scope and means of inquiry.

- 2.53 It appears to this Review that where a public inquiry into a controversial death is required, it is preferable that the established mechanism and procedure of an inquest be used, provided that it can legitimately inquire into what requires to be addressed. Some questions will remain outside even the scope of an inquest enlarged by these human rights considerations. However, the concerns mentioned to the Review in meetings with, and written submissions from, the families were as to how their son or daughter met their death. These are very much the issues that an inquest is designed to explore.

The application of the Human Rights Act to deaths at Deepcut

- 2.54 Two questions remain. First, do the principles elaborated in *Amin* and *Middleton* have any application to the four deaths at Deepcut where the deaths were not of people detained in custody and, on the findings of the Coroner in the original inquests, there was no reason to believe that the deaths were inflicted at the hands of state agents, or, indeed, by anyone else whom had been identified as a threat to any of the four young people and whom the state had a particular obligation to guard them against?
- 2.55 Secondly, do the human rights obligations apply to the first two deaths in 1995 at a time when the Human Rights Act was not in force and any complaint of a failure to comply with Article 2 of the ECHR should have been pursued to the European Court of Human Rights in Strasbourg within six months of the original inquests?

Deaths before October 2000

- 2.56 The answer to the second question appears at first blush to have been decided in the negative. In *Middleton*, the Appellate Committee of the House of Lords was at pains to leave open the question of the class of deaths to which the judgment had to apply in the future. It was a question that was directly addressed in *Re McKerr*⁴⁶ in a judgment handed down on the same day, 11th March 2004, as *Middleton*. In *McKerr* the Appellate Committee of the House of Lords concluded that for the investigative obligation under Article 2 to apply in domestic law the death in question had to be after the 2nd October 2000.⁴⁷
- 2.57 *McKerr* expressly disapproved of the decision of the High Court in *R (Hurst) v HM Coroner for Northern District London*,⁴⁸ where a Coroner had refused to continue with an inquest into a death that had occurred in March 2000 following adjournment for criminal trial pursuant to s.16 of the Coroners Act. The Coroner had, on any view, erroneously concluded that if Article 2 applied to his inquest it did not require it to be resumed, as the criminal trial and investigation had been a sufficient inquiry. In *Hurst*, the High Court had held that the Coroner was under a duty pursuant to s.6 of the Human Rights Act 1998 to act compatibly with Article 2 when exercising his discretion whether to continue the inquest. The House of Lords held in *McKerr* that this was a misdirection and the Coroner was under no such duty as the death had occurred before 2nd October 2000.

⁴⁶[2004] UKHL 12; [2004] 1 WLR 807.

⁴⁷*Ibid*, at [89].

⁴⁸[2005] 1 WLR 3892.

- 2.58 However, on the 21st July 2005 the Court of Appeal delivered its judgment in *Hurst*.⁴⁹ In a closely reasoned judgment, the appeal of the Commissioner of Police for the Metropolis (one of the interested parties in the Divisional Court) was dismissed on two grounds, despite the misdirection by the Divisional Court. First, the Coroner had misdirected himself as to the exercise of his s.16 of the Coroners Act discretion to resume an inquest in the light of the considerations provided by human rights law. Secondly, that, even if there was no statutory duty to act compatibly with human rights in respect of a death before October 2000, as decided in *McKerr*, the interpretative obligation under s.3 of the Human Rights Act applied in any event to require the Coroner to interpret the scope of the s.11 of the Coroners Act inquiry compatibly with human rights norms.⁵⁰
- 2.59 If this involved a certain amount of retrospective application of the Human Rights Act, this was not contrary to principle or decided authority because there was no interference with vested rights. In that sense the *Middleton* interpretation of s.11 of the Coroners Act was binding on the Coroner through a route not under discussion in *McKerr*.⁵¹
- 2.60 The implications of all this for the present cases are as follows. If an application is made to the High Court with the consent of the Attorney General under s.13 of the Coroners Act 1988, then the scope of judicial discretion may be informed by human rights considerations, interpreting the interests of justice compatibly with the Article 2, as required by the decision in *Hurst*. The fact that the families of the deceased soldiers may not have been able to participate effectively in the inquest and raise issues arising from the Surrey Police re-investigation may be sufficient, in a case of this degree of public concern, to justify setting aside the previous inquisitions and ordering new ones, irrespective of the prospect of a different conclusion on the 'how' question.
- 2.61 The Review cannot prejudge what the result of any such application would be. It is sufficient to note that s.13 of the Coroners Act 1988, construed either with or without the benefit of the Human Rights Act 1988, provides a basis for vindication of the concerns of interested parties. A fresh inquest can be obtained where the court is satisfied that, in the light of subsequent events, it can be shown that interested parties have not been able to participate in the inquiry, test all available material and explore any legitimate areas of uncertainty or concern. In the case of the family members of the deceased, it is hoped that such participation enables a measure of closure and peace of mind.⁵²
- 2.62 The Review is aware that if a fresh inquest is ordered into all or any of the first three Deepcut deaths, there may be resource implications for whoever has to conduct them. There does not appear to be a statutory provision for joint inquests into deaths that occurred at different times. It would doubtless be sensible for a single Coroner to conduct an inquest into related deaths. If pressure of regular work did prevent an expeditious re-hearing, there is always the possibility of appointing a judge as a deputy Coroner.⁵³

Do the deaths engage the standards set by human rights law?

- 2.63 It is necessary to return to the first question (posed at paragraph 2.54 above), although a final answer may only be possible once the contentious facts of the Deepcut deaths are themselves examined. On the face of the previous inquest findings into the deaths of Sean

⁴⁹ *Commissioner of the Police for the Metropolis v Hurst* [2005] EWCA Civ 890; [2005] 1 WLR 3892.

⁵⁰ *Ibid*, paragraph 62.

⁵¹ *Ibid*, paragraph 54.

⁵² The Review notes that the Briefing Note on Coroners Services Reform published by the Department of Constitutional Affairs in February 2006 indicates that "bereaved people will have a right to contribute to coroner's investigations".

⁵³ See Annex C, footnote 13 to this Report.

Benton, Cheryl James and Geoff Gray, these appeared to be three cases of young soldiers who either did, or may have, inflicted injuries on themselves in the course of undertaking armed guard duties at the Barracks. On this basis, they were neither cases of deaths at the hands of state agents nor deaths in custody, where the state was under a particular duty of care to take reasonable steps to protect the health of a prisoner, including protecting a prisoner from self-harm where a reasonable risk of self-harm was known to the state.

- 2.64 On the other hand, these same findings indicated that each of the three soldiers had probably died as a result of the discharge of a lethal weapon assigned to them, or accessible by them, in the performance of their guard duties when they were young and had yet to complete Phase 2 of their training. They were subject to military discipline throughout their residence at the Barracks, distinguishing them from a normal employment relationship in civilian life. It is known that the regime at the Barracks, the staffing ratios and other matters were subsequently investigated by Surrey Police and led to substantial changes by the Army, as we shall examine in later Chapters. In those circumstances, there was, at the least, the possibility of a defective system operated by the state that may have failed to afford adequate protection to life.
- 2.65 Further, the narrative account of the events leading to this Review, as outlined in the previous Chapter, demonstrates the existence of public concern at what happened at Deepcut and one purpose of an investigation is to allay concerns, as well as to substantiate wrongdoing. This is, indeed, one salutary purpose of a public inquiry generally, as the Appellate Committee of the House of Lords concluded in *Middleton*:

*"The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."*⁵⁴

- 2.66 The Review is conscious that recent decisions have tended to indicate that deaths at the hands of the uniformed services, whether civil or military or deaths in custody, are in a special category when compared to deaths in, for example, hospitals where there may be no *prima facie* case of negligence or neglect.⁵⁵ However, in the light of the matters considered in subsequent Chapters, this Review considers cases concerning the deaths of young people who are trainees in the Armed Forces, and who in the course of their activities are supplied with lethal weapons, are also a special category of cases imposing particular investigative obligations. The Review is particularly impressed by the consideration that three of these four deaths were of young people who were either under 18 years of age or, in the case of Cheryl James, had just reached their 18th birthday.
- 2.67 A recent decision of the European Court of Human Rights in the case of *Kilinç v Turkey*⁵⁶ is in point. That case concerned a conscript who died from gunshot wounds while assigned to guard duty, after doubts had been raised as to his fitness to do so. The Court found Turkey in violation of obligations to take all reasonable steps to protect the life of the trainee under Article 2 of the ECHR. The question for the Court in this case was to

⁵⁴ *Supra*, footnote 41, at [31].

⁵⁵ See for example the cases *R (Takoushis) v Inner North London Coroner and others* [2006] 1 WLR 461 and *R (Goodson) v Bedfordshire and Luton Coroner* [2006] 1 WLR 432.

⁵⁶ 40145/98, 7th June 2005 (unreported). Judgment only available in French. The Review is grateful to Nuala Mole of The AIRE (Advice on Individual Rights in Europe) Centre for bringing the case and a loose translation of the French text to its attention.

establish whether the military knew, or ought to have known, that there was a real and immediate risk to the life of the individual concerned and, if so, whether the authorities had done everything in their power to prevent that risk materialising.⁵⁷ The informal English summary of the case reveals the reasons for the conclusion:

"The commandant, relying on the judgement of the hospital authorities who saw no problem in sending Mr Kiliñç back to his garrison, despite the medical examination previously ordered not having taken place, gave him a weapon and assigned him to guard duty. However, in doing so, the commandant failed to appreciate that Mr Kiliñç had still not undergone any decisive diagnosis and there was therefore no reason to believe that Mr Kiliñç would be able to handle a solitary mission or that he would not take advantage of such a situation to commit suicide. (Paragraph 54). (Powell, above).

"The Court considered that the only explanation for this outcome was the absence in Turkish legislation of clear provisions concerning those whose fitness for military service was in doubt, or, more importantly, the duties and responsibilities of their superiors towards those with mental illness, such as Mr Kiliñç. (Paragraph 55).

"Therefore, the regulatory framework contained weaknesses as regards the procedure to establish and monitor the psychiatric ability of Mr Kiliñç, before and after his conscription. Moreover, that situation created uncertainty regarding the nature of activities that could be assigned to him. In this way, it played a decisive role in the causation of the suicide, as the authorities had not done everything in their power to protect Mr Kiliñç from the danger he posed to himself, which was as well known as it was avoidable. (Paragraph 56). (Tanribilir, para. 71, Keenan, para. 89)."

- 2.68 In the present cases, the Review is concerned with the procedural obligation inherent in Article 2 to enable the families to inquire into whether there was evidence of a failure to protect their children from harm, or self-harm, or any other systemic failure relevant to their deaths. An issue for this Review will be an examination of the new material that has come to light since the original inquests were held into the first three deaths, and whether the families have hitherto been able to effectively participate in the examination into "by what means and in what circumstances"⁵⁸ their children met their deaths.

Public inquiries

- 2.69 An inquest is not the only method whereby the state can discharge its obligations under Article 2 of the ECHR. In the case of *Amin*, the outcome was a public inquiry into the circumstances surrounding the death. In that case, itself, reliance had been placed on an earlier decision of the High Court in the case of *R (Wright) v Secretary of State for the Home Department*⁵⁹ where a prisoner had apparently died of insufficient medical care, and there was evidence of a persistent problem that could not be addressed in an inquest or a civil action where liability was admitted. As a result of the direct state responsibility for the medical treatment of prisoners, a public inquiry was ordered.

- 2.70 A more recent case where a public inquiry was ordered is the case of *R (on the application of D) v Secretary of State for the Home Department*.⁶⁰ In that case, a prisoner had

⁵⁷ *Ibid*, paragraph 43.

⁵⁸ *Supra*, footnote 45.

⁵⁹ [2001] LLR (Med) 478.

⁶⁰ [2006] EWCA Civ 143.

attempted suicide but failed, leaving him with debilitating injuries and, therefore, the option of an inquest was not available. It was common ground on the particular facts of that case that an Article 2 inquiry into why the prisoner was able to attempt to take his own life was necessary. The issue was whether the proposed use of the Prison Ombudsman in an informal inquiry, not conducted in public sessions but with input from the families and a commitment to publish the results of the investigation, sufficed to meet those standards. The learned judge concluded that it did not and directed that the Secretary of State should instead hold an inquiry in public, compelling the witnesses to attend and giving the prisoner the opportunity to cross-examine them. On appeal, the Court of Appeal agreed that an inquiry should be held in public but held that compliance with Article 2 did not require the prisoner to be able to cross-examine witnesses. That was an issue for the chairman of the inquiry, who had an obligation to act fairly. Similarly, there are other cases where a public inquiry was not deemed necessary despite there being issues beyond the scope of the inquest that needed addressing.⁶¹

2.71 It should be noted that it is clear from the cases of *Amin* and *D*, and the ECHR case law recited therein, that if human rights norms requires a public inquiry then this Review cannot, itself, satisfy that obligation given the limitations placed on it. Nor, indeed, could an internal Army review such as a Board of Inquiry established under the Army Act 1955. However, if attention moves on from circumstances where a public inquiry is required as a matter of law to where it may be merely a possible outcome, the fact that other means exist of investigating and evaluating material may be relevant to the overall exercise of judgement.

2.72 Leaving aside the imperative requirements of human rights or other legislative provisions for the holding of a public inquiry, the Review is unaware of any settled criteria for determining when such an inquiry should be held. The Cory Collusion Inquiry Reports into the deaths of Patrick Finucane, Robert Hamill, Billy Wright and Rosemary Nelson⁶² spelt out in the very title the criterion for holding an investigation. Judge Cory wrote a common foreword to these four reports in which he explained:

*"It is important that I make clear what I have taken my task to involve. My task was not to make final determinations of fact or attributions of responsibility. I had the preliminary role of assessing whether there is a case to be answered as to possible collusion, in a wide sense, by members of the security forces in these deaths such as to warrant further and more detailed inquiry."*⁶³

2.73 This Review is clear that if material comes to light to suggest there is a case to answer of collusion in a killing, or of a cover up by the state of discreditable conduct relevant to any of the Deepcut deaths, public confidence would demand that a public inquiry be held to substantiate or dismiss such a suggestion.

2.74 Similarly, if the evidence established a *prima facie* case of death through state negligence, a public inquiry might well be necessary if questions of attribution of responsibility took the case outside the permissible purview of the Coroner's powers. However, a high degree of foresight is needed that a particular individual is at risk of harm or self-harm before a breach of the legal duty to protect that person could be made out.⁶⁴ Accountability in

⁶¹ See, for a recent example, *R (on the application of Yvonne Scholes) v Secretary of State for the Home Department* [2006] EWHC 1 (Admin) in which it was held that where the inquest did not bring within its scope sentencing policy and broad issues of government funding or policy, it was not incumbent upon the state under Article 2 to set up a public inquiry.

⁶² HC 470, HC 471, HC 472 and HC 473, respectively. All published on 1st April 2004.

⁶³ Page 3 of HC 470, HC 471, HC 472, HC 473.

⁶⁴ See *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52; [2004] 1 AC 309; *Kilinç v Turkey*, *supra* footnote 56 above; and *Osman v United Kingdom* (1998) 29 EHRR 245.

human rights practice must be accountability according to law, with full and fair opportunity afforded to anyone accused of misconduct or wrong doing to respond to the allegation.

- 2.75 The Inquiries Act 2005 was enacted partly to give effect to the Cory recommendations, where there was some tension between the interests of national security and open investigation of matters of legitimate concern. The provisions in the Act enabling a Minister to control access to certain classes of material have been the subject of comment and expressions of concern, particularly in the sensitive context of Northern Ireland. This Review is fortunate that security issues, whereby those setting up the inquiry have been unwilling for the person appointed either to see or use relevant material, have not arisen and would be unlikely to arise if a statutory inquiry into these deaths were to be held.
- 2.76 The Inquiries Act came into force in June 2005, following the setting up of this Review, and would be a statutory regime available to the Minister to give effect to any recommendation for a public inquiry arising from the Review. Section 1 of that Act indicates that:

"A Minister may cause an inquiry to be held under this Act in relation to a case where it appears to him that–

...

(a) particular events have caused, or are capable of causing, public concern, or

(b) there is public concern that particular events may have occurred."

This is clearly a very broad power within the discretion of a Minister that does not afford much assistance as to the threshold of concern to be applied.

- 2.77 The statutory formula nevertheless serves to indicate that if there is to be a coherent public inquiry, it is necessary to examine precisely what are the matters causing public concern. There has to be a clear and precise perspective as to what are the events in question and what are the legitimate public concerns resulting from the events that require to be substantiated or allayed.
- 2.78 A public inquiry is not to be convened merely to rebut stories in the press that raise concerns as to harassment or abusive behaviour. Such matters need, first, to be the subject of proper investigation and resolution by the available procedures, whether criminal, civil or disciplinary. It may also be relevant to ask: who is primarily seeking an inquiry into such matters? What are the prospects of reaching any conclusions on disputed facts into incidents that may have happened years ago? What are the overall benefits to the public of such a course?
- 2.79 It may also be necessary to examine whether there are alternative remedies to a public inquiry under the statute. Where the events are connected with a death, then the discussion in the preceding paragraphs indicates that the primary focus of the inquiry is likely to be the inquest where there is an established set of rules and case law to guide the examination and determination of the issues. If, on the other hand, the events are unrelated to any of the deaths and so the inquest procedure is not available, other questions may arise as to the likely efficacy of any such inquiry, and any balance between the resources needed in setting it up and the likely benefits to be achieved from it.

- 2.80 For this Review, if the material justifies it, the advantage of using a re-opened inquest into a particular death is that it provides a coherent focus to what is being inquired into and a set of rules and procedures to be applied in reaching a conclusion. As Fiona Murphy has pointed out,⁶⁵ the question of representation and funding can be addressed by the Lord Chancellor's Department and, in a case of this level of public interest, there must be a strong case for public funding to enable the families to pose the questions that they need to.
- 2.81 The use of a reconvened inquest to give effect to the right of interested parties to participate in the investigation also has the advantage that a public inquiry is not foisted on those who are satisfied with the information presently known to them and who do not want to re-open an investigation into which further clarity may not be possible. The Review is conscious that it is looking at four deaths where the families may have different interests and concerns, as opposed to a single death or a single incident that caused multiple deaths.
- 2.82 In Chapter 12, the Review will reflect on the material discussed in later Chapters and answer the question: is there a sound case for a public inquiry today?

⁶⁵ See Annex C, paragraph 22.1 ff.

3 The Civilian Police, the Royal Military Police and the Investigation of Deaths

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The Investigation of military deaths

3.1 The deaths of the four young trainees at Deepcut have given rise to some debate as to which police force, military or civilian, had primacy in respect of the investigations of the deaths. In September 2005, the Ministry of Defence (MOD) and the Association of Chief Police Officers (ACPO) were party to a joint Protocol establishing the position with absolute clarity (reproduced as Appendix 16 to this Report). Paragraph 4.1 of the Protocol reads:

“Primacy for conducting the investigation of all deaths (on MOD premises) rests with the Chief Officer of the Home Department Police Force under whose jurisdiction the death occurs.”

3.2 The Army officers with whom this Review has spoken believe that this Protocol reflects long established practice. Surrey Police have welcomed the Protocol as clarification of an issue that had been raised through the Learning Account, established between the Army and Surrey Police during their investigations.

3.3 Thus Brigadier Elderton, the officer in charge of the Defence Logistic Support Training Group at Deepcut from 2001 to 2003, in evidence to the Review,¹ and in a written loose minute dated 26th October 2004, believes Surrey Police had *“long standing primacy for investigations into sudden death on MOD property.”* He was concerned that this may not always have been clear in the media reports that were critical of the original investigations into the deaths at Deepcut. There has been some tension between the Army and Surrey Police as to who was responsible for the limited investigations that were originally conducted into the deaths.

3.4 There is little doubt that civilian police in the United Kingdom have jurisdiction to investigate serious crimes, such as homicide, occurring within their geographical jurisdiction, irrespective of the nature of the premises in which the death may have occurred, or the status of the victim or, indeed, any suspect. There is no military privilege that prevents them entering a military base or conducting investigations there.

3.5 The military standing orders at the time of each of the four deaths required the Commanding Officer to ensure that his staff notified the civilian police of every sudden death. There is no doubt that in the case of each of the four deaths at Deepcut the notification was given as the civilian police were called to the scene, as was the Coroner's officer.

3.6 An issue in the cases of Sean Benton, Cheryl James and Geoff Gray is to understand what happened after the civilian police arrived at the scene and how they came to relinquish jurisdiction and leave the conduct of the investigation to the Royal Military Police (RMP).

The Royal Military Police

3.7 The RMP is the Army's police force, with responsibility for law enforcement and the maintenance of good order and military discipline in peacetime and on operations. The head of the RMP is the Provost Martial (Army). The Review has benefited from dialogue with the Deputy Provost Martial (Army) during the course of the Review.²

¹ See Appendix A4/3.008 A - B for Brigadier Elderton's understanding of how Surrey Police relinquished primacy following the death of Geoff Gray.

² See Appendix 4/15.

3.8 The RMP website describes its functions as:

- “1. To provide operational support.
2. To prevent crime.
3. To enforce the law within the military community and assist with the maintenance of military discipline.
4. To provide an assistance, advice and information service to the military community and public.”³

3.9 The majority of RMP personnel (85%) are employed in the uniformed General Police Duties (GPD) branch that performs roles similar to the uniformed civilian police, such as crime prevention and detection, responding to enquiries, investigating crime and traffic control. The RMP also has a dedicated investigative service, the Special Investigations Branch (SIB), which, like the Criminal Investigations Department (CID) of the civilian police, investigates serious or unusual offences. Under Army standing orders, cases of self-harm and bullying are to be reported to the RMP for investigation.⁴

3.10 The SIB are trained in civilian detective practices and standards.⁵ They have Scenes of Crime Officers (SOCOs) trained in preserving and recording crime scenes. The SIB has had, historically, a close relationship with civilian police forces with respect to training and best practice. Its investigators aim to apply civilian police standards of investigation, including ACPO guidance in investigating deaths. The SIB also liaises with civilian police forces conducting investigations relating to the Army. By arrangement with the civilian police, its officers can take statements, secure exhibits and such like.

The Ministry of Defence Police

3.11 In addition to the RMP and the military police branches of the other two Armed Services, the MOD also has its own dedicated civil police force, the Ministry of Defence Police (MDP). The MDP was created in 1971.⁶ The various regulations, statutory provisions and instructions which provide the MDP's legal authority were consolidated in 1987 in the Ministry of Defence Police Act.

Guidelines and Protocols as to primacy for investigations

3.12 In 1987, a Home Office Circular was issued to Chief Officers of Police to draw attention to the new Act and to provide ‘Guidelines on the respective responsibilities of the Ministry of Defence Police and 1964 Act Police Forces’.⁷ The Circular stated (with emphasis added by this Review):

- “1. Primary responsibility for the maintenance and enforcement of the criminal law throughout England and Wales rests with the chief officers of the “1964 Act” police forces (hereinafter described as “local chief constables”)”

...

³ <http://www.army.mod.uk/rhqrm>

⁴ Land Command Standing Order 3203, paragraph 5.

⁵ See Appendix A4/15.056 E, where the Deputy Provost Martial (Army) explained to this Review that their Senior Investigating Officers are trained to Home Office accreditation in civilian centres.

⁶ Prior to that date, each of the three Armed Services had their own constabulary, with its own Chief Constable.

⁷ Home Office Circular 65/1987 dated 16th October 1987.

"5. Responsibility for the investigation of any incident in which terrorism is suspected, of serious offences against the person, of sexual offences (except minor offences or acts which are offences under Service law only), of domestic burglaries and of sudden deaths will rest with the appropriate local chief constable.

"6. If an incident, crime, or suspected crime of the kind identified in paragraph 5 above comes first to the attention of the Ministry of Defence Police, that force will take any immediate action that may be necessary. At the same time, the Ministry of Defence Police will inform the local chief constable about the incident. The local chief constable will then decide how it is to be controlled or investigated. The Ministry of Defence Police will continue to be ready to provide further assistance if the local chief constable so requests."

3.13 This Circular would have been applicable at the time of the deaths of Sean Benton and Cheryl James in 1995. It clearly states that any "sudden deaths" that "comes first to the attention of the MDP", most obviously by occurring on MOD property, are to be reported to the local Chief Constable of the civilian police who has the responsibility for deciding how the incident is to be controlled or investigated.

3.14 A new Home Office Circular was issued in March 1999,⁸ with a Co-ordinated Policing Protocol that replaced the 'Guidelines on the respective responsibilities of the MDP and 1964 Act Police Forces'. This Co-ordinated Policing Protocol stated (with emphasis added by this Review):

*"Responsibility for the investigation of criminal offences committed within the jurisdiction afforded by the Ministry of Defence Police Act 1987 will rest with the Chief Constable of the Ministry of Defence Police. However, in relation to any crime or suspected crime of terrorism, or any incident involving sudden death within Ministry of Defence property, that force will take any immediate action necessary whilst simultaneously informing the local Chief Constable. Thereafter, the local Chief Constable in consultation with the Chief Constable of the Ministry of Defence Police will determine how the investigation should proceed."*⁹

The words underlined essentially re-affirm the 'Guidelines' under the earlier 1987 Home Office Circular. This would have been the policy in force at time of the death of Geoff Gray in 2001. A further Home Office Circular was issued in March 2002 but the primacy issue in relation to "sudden deaths" remained unchanged.

3.15 Therefore, at the time of all four deaths at Deepcut, it was for the Chief Constable of Surrey Police to determine how the investigation into a reported sudden death should proceed. The internal arrangements as to which officers should arrive on the scene of a sudden death, and at what level of seniority responsibility for the investigation should rest, were all matters for him alone.

3.16 Not all sudden deaths will be crimes or give rise to a suspicion of crime. As responsibility rests with the local Chief Constable for the investigation of a sudden death, it will be his officers who decide whether there is suspicion attached to the death. If the death is

⁸ Home Office Circular 17/1999 dated 25th March 1999.

⁹ *Ibid*, paragraph 3.

suspicious, then a criminal investigation is undertaken to see whether the hypothesis of homicide can be confirmed or eliminated. If the death is not considered suspicious, then the civil police's common law duties to prevent crime and preserve life may yield to a duty, or a responsibility voluntarily undertaken, to assist the local Coroner in making enquiries into how the death occurred. In such cases, the liaison person will be the Coroner's officer, who is usually a police officer from the local civilian police force on secondment, or an ex-police officer, although not necessarily with experience as a detective.

- 3.17 The confusion regarding primacy, or jurisdiction, for investigating a sudden death is reflected in Surrey Police's internal policy, as of 2002 which states: *"in cases of suspicious death on MOD property, by agreement Surrey Police has primacy."* That statement is incorrect. It does not accurately reflect the current Protocol or the previous Home Office Circulars, cited above, that talked of primacy in a case of a *"sudden death"*, not a *"suspicious"* one. It is important that Chief Constables ensure the 2005 protocol is reflected in internal policy.
- 3.18 By contrast, a former Regional Regimental Sergeant-Major of the RMP, interviewed by Surrey Police during their investigations, was accurate when he stated that:
- "Whilst in the UK the SIB do not have primacy jurisdiction in cases resulting in death or serious sexual offences."*¹⁰
- 3.19 In the event, the practical consequences are probably the same from whatever standpoint the issue is analysed. If a death occurs on MOD property, the civilian police are informed. They respond to the call in accordance with their force instructions. Once called to the scene of a death, the senior civilian police officer at the scene will have to make the judgement as to whether the death is suspicious, that is to say that it might be the result of a crime. If the judgement is made that the death is not considered suspicious, it is then that a problem can occur.
- 3.20 Under current arrangements, most recently agreed in the September 2005 Protocol, the civilian police retain primacy but are there to assist the Coroner's officer. The civilian police will doubtless now have ACPO-approved procedures for deciding whether the death is considered suspicious; which senior officer makes the decision; what record is made of the decision and the reasons for it. It seems that at the time of the first three deaths, at least, no formal procedures were in place or were being applied by the civilian police who attended the scenes, as to these matters.
- 3.21 The decision on who would investigate the deaths, and how and to whom the final report and witness statements should be delivered, appears to have been taken *ad hoc* at the scene between the civilian police, the Coroner's officer and the RMP.
- 3.22 Where the civilian police hand the investigation to the RMP, they are necessarily making a statement that they do not consider the death to be suspicious. It follows that, thereafter, the RMP are investigating, by definition, a death that the civilian police force with primacy considers to be a non-suspicious death. The rigour with which such a death may, thereafter, be investigated will, quite legitimately, be less than in a case where no such initial decision has been taken at all. There may be little point in conducting ballistics or forensic tests to confirm or exclude the hypothesis of third party involvement if the only reason the RMP have an investigative role is because the civilian police are satisfied the death is not suspicious and the hypothesis of third party involvement can be excluded.

¹⁰ 19th February 2003.

The issue of primacy for the investigations of the deaths at Deepcut

- 3.23 When the Learning Account was set up between Surrey Police and the Army in August 2002, one of the issues that arose for consideration was whether the arrangements as to primacy were unclear or had been misapplied by either Surrey Police or the RMP.
- 3.24 As noted, in due course this appears to have been the source of some tension. Surrey Police have subsequently accepted that they should have retained primacy, but, at the time, they handed it to the RMP and, therefore, assert that the responsibility for the quality of the investigation lay with the RMP. The RMP by contrast concluded that Surrey Police had never formally handed responsibility for investigating the death to them. They assert that they were only acting in support of Surrey Police and the Coroner's officer and that the reason why more extensive enquiries were not undertaken was because no one asked the RMP to do any. As far as the RMP were concerned, they were only doing what was asked of them in support of a civil investigation and they were not conducting an investigation of their own.
- 3.25 Neither the RMP nor Surrey Police claim that the original investigations actually conducted into the first three deaths were sufficiently rigorous by contemporary standards to have proceeded as a methodical elimination of the hypotheses of a suspicious death. Under current best practice, the Review understands that the starting point in a sudden death is 'think murder', unless and until the evidence, or a policy assessment, leads to a different conclusion. Examples of enquires that were not undertaken at the time will be noted when the circumstances of the first three deaths are examined in Chapters 5, 6 and 10.
- 3.26 As noted in Chapter 1, in their press release issued on 19th September 2003, Surrey Police stated (with emphasis added by the Review):
- "Surrey Police apologised to the families last year for not properly challenging early assumptions that these young soldiers had taken their own lives and for our failure to overturn the custom and practice of the day which allowed for the investigation to be delegated to the Army. We have recognised that we should have maintained primacy for these investigations over the Army."*
- 3.27 Two comments on this statement are appropriate. First, it appears from the evidence reviewed that any "early assumptions" made in the first three deaths were early assumptions of the civilian police who attended the scene, rather than anybody else, although these assumptions may have been shared by others. Secondly, "custom and practice of the day" appears to have been a local one. Although, the Review has confined its specific attention to the four deaths at Deepcut, it has seen material relating to other deaths prior to 2002 elsewhere in the United Kingdom, where there seems to have been no difficulty in applying the Protocols noted above that the decisions on the investigation of a "sudden death" are made by the local Chief Constable and not the military.
- 3.28 In the Chapters that follow, questions of military practice and procedure that are of concern to the Review will be noted. It is only right to state at the outset that a misinterpretation of the Protocol by the Army or the RMP is not one of them. There is no evidence that the Army or the RMP had a local custom to assert primacy in investigations in Surrey. There is no reason to believe that the RMP sought improperly to persuade the civilian police as to a view of the death and sought to assert primacy based on that view. There is no reason to believe that evidence that would have been of assistance to the civilian police at the scene in making an informed judgement was kept from them. Moreover, the absence of ballistic or other forensic examination is not unique to RMP investigations at Deepcut.

- 3.29 However, it could be said that, whoever thought it had primacy, the RMP must have been aware that important enquiries, that would be considered part of any competent investigation, were apparently not being undertaken by others. Perhaps the most striking example is the death of Geoff Gray, where it seems that there was no civilian police officer scheduled to attend the post-mortem, and two RMP Non-Commissioned Officers (NCOs) attended to fulfil training requirements. Once there, they happened to come into possession of an important exhibit, Geoff's mobile phone. From the RMP case diary, and similar material seen by the Review, it is odd that the RMP could have believed that any one of the investigations into the first three deaths was being conducted at the instigation of the civil police when there was so little evidence of a controlling mind ordering the investigations inside that force. The question of primacy should never be allowed to assume the importance of an excuse for failing to point out that best practice standards are not being met.
- 3.30 Undoubtedly, the revised Protocols, the liaison with ACPO and Surrey Police's press statement make plain how investigations should be conducted in the future if the need for them arises. The investigation must be an independent one conducted according to the directions and satisfaction of the local Chief Constable or the designated officer, if, in the future, there is to be any accountability, and public confidence in the integrity of the investigative process is to be maintained. If this is understood, there is no reason why both forces, military and civilian, should not have a mutual commitment to ensuring that the highest professional standards appropriate for the investigation in hand are deployed.
- 3.31 There is no reason why the RMP, through the SIB, cannot assist in taking statements or conducting other enquiries under the direction of the civilian police. The RMP is independent of the Commanding Officer of the particular base it works in. It can perform a valuable service in investigating matters where military witnesses have to be traced and military protocols understood. Although the need for independence in the lines of responsibility is clear, this does not mean that any RMP assistance to the civilian police is to be regarded with suspicion. High professional standards should be common to both forces.
- 3.32 Indeed, there is a particularly good reason why RMP investigators ought to be able to have the experience of conducting good quality investigations at the direction of their civilian colleagues. First, the RMP will have responsibility for investigating cases of bullying, harassment and assault in the United Kingdom, below the level of severity where the civilian police retain primacy, and similar techniques of preservation of crime scenes and obtaining evidence from witnesses will be relevant in such cases. Best practice is learned by example rather than simply from textbooks. Secondly, the RMP will be the police force called on to investigate deaths abroad where circumstances may be very different.

Deaths abroad

- 3.33 If a death occurs abroad, there may be no civilian police at all with jurisdiction, or none available to properly investigate the death. The RMP may have to operate in difficult conditions in occupied territory. The recent judgment of the Court of Appeal in the case of *R (Al-Skeini and others) v Secretary of State for Defence*¹¹ demonstrates the very real security problems in such investigations and the extent to which the RMP may need to rely on the very units being investigated for the practical facilities to conduct such investigations.

¹¹[2005] EWCA Civ 1609, judgment handed down 21st December 2005.

- 3.34 The average RMP investigation abroad, however, will be conducted in less stressful circumstances: thus disciplinary offences or sudden deaths in British barracks in Germany¹² or elsewhere will have to be the subject of RMP investigations through agreements negotiated with the Host Nation. If the RMP cannot obtain the necessary experience of quality investigations into offences, abuse or self-harm in the United Kingdom, it will be handicapped in its ability to perform this role elsewhere when the RMP is the only possibility of effective investigation and accountability.
- 3.35 This Review has seen examples of full investigations that have been conducted by the SIB of the RMP which have provided valuable insight into the nature of the trainees' experiences at Deepcut and elsewhere. These will be considered in Chapters 7 and 8. The question of whether the standards of investigation that the RMP apply can be improved by further training, particularly into investigations into sexual offences, or forensic techniques in homicide cases, and whether accountability and supervision by a civil inspectorate of police is considered desirable, are questions of policy that will be addressed in Chapter 12.

The death of Sapper Alfred Manship

- 3.36 By way of conclusion to this Chapter, and introduction to the following Chapters examining the circumstances surrounding the deaths of the four trainees at Deepcut, the Review will first consider an example of the RMP pursuing its function to investigate a death of a British soldier abroad, the case of Sapper¹³ Alfred Manship of the Royal Engineers, referred to by his mother and hereafter as Alfie Manship, who died in Osnabrück, Germany in April 1992.
- 3.37 The Review has been invited to consider a number of deaths of soldiers outside of Deepcut. Family members have pointed out, particularly in respect of deaths occurring abroad some years ago, that there has been a significant shortage of information and access to the product of any investigation. Individual investigation of these deaths was beyond the resources and the scope of this Review. However, it appeared that the death of Alfie Manship may have had a nexus to the deaths at Deepcut and so some specific enquiries have been made.
- 3.38 The Review was initially approached by Sandra Osborne MP to examine the circumstances of Alfie's death. The Review was subsequently contacted by his mother. The information provided by his mother suggested a potential connection with Deepcut and Sergeant B, an NCO who was based there, whose role in the events surrounding the death of Sean Benton will be considered in Chapter 5. That connection had been made following coverage of the BBC Panorama programme 'Bullied to death?' broadcast on 1st December 2002. There were broad similarities in the circumstances of Alfie Manship's death with the deaths at Deepcut which, even if not directly connected to those events, nevertheless provide a valuable insight into the Army's handling of a death which fell unambiguously within the jurisdiction of the RMP, by virtue of having occurred abroad.
- 3.39 Alfie Manship died of a single gunshot wound to the head in the early hours of 6th April 1992. He was then aged 20 and had been attached to 23 Engineer Regiment at Woolwich Barracks, Osnabrück, Germany. He was on armed guard duty at the time of his death. The death was investigated by the RMP, as the authority having primacy for a death of a soldier

¹² See Appendix A4/15.056 F - 057 B, where the Deputy Provost Martial (Army) explained to this Review how the RMP dealt with a recent death in Germany, in terms of sending in expertise from the United Kingdom and conducting the *in situ* investigation.

¹³ A Sapper is the equivalent rank in the Royal Engineers of a Private in the Royal Logistic Corps.

in a British barracks in Germany. Witness statements were obtained. The material obtained in the course of those statements suggested that the gunshot wound was self-inflicted some 24 hours after an argument between fellow soldiers in which Alfie had been peripherally involved. According to the statements taken by the RMP, he had been sent on a lone prowler patrol of the perimeter fence at this Barracks with an SA80 rifle and 30 rounds of ammunition. The SIB's report indicated that such a lone prowler patrol was in contravention of his unit's own standing orders. A number of other soldiers had similarly been sent out on lone prowler patrol in breach of standing orders that night. Three observations emerge from the material seen by this Review.

- 3.40 First, the report discloses the limited nature of the SIB investigation. No tests were made of the weapon found with Alfie Manship, other than to establish that it was in working order. This was to be consistent with the practice adopted at Deepcut at the time of the first three deaths.
- 3.41 Where the RMP has primacy for the investigation of a death abroad, it should be using investigative techniques at least equivalent to the best practice of the civilian police in the United Kingdom. That should include sufficient ballistics and other forensic tests to confirm or exclude the hypothesis that a suspect weapon was indeed the instrument by which death was occasioned.
- 3.42 Secondly, the RMP report noted:

"The procedure laid down in the Woolwich Bks Guard Orders had not been adhered to in respect of the handling, loading/unloading of weapons, correct location of the guard and the manning requirement of the Prowler guard."¹⁴

The Report continued:

"Remedial action to rectify the foregoing has been implemented by the unit. There is nothing to suggest that even if the orders had been strictly complied with that they would have had any effect on the apparent decision by Spr Manship to take his own life."¹⁵

- 3.43 The RMP conclusion that the outcome would have been unlikely to have been different had procedures been correctly followed is speculative. A soldier who has a determination to take his or her own life will find a variety of occasions during service life to do so, which cannot ultimately be prevented by standing orders or other supervisory measures. By December 2002, the Army had, nevertheless, come to realise that one of the important constituent factors in self-inflicted deaths by gunshot wounds is the affording of opportunity.¹⁶ It must, therefore, be a possibility that compliance with standing orders for two soldiers to be on armed prowler patrol would have reduced an opportunity for self-harm. Depending on other circumstances, there is no reason why such a reduction in opportunity could not have contributed to reducing the risk of a death that may have been the result of transitory rather than long standing concerns.
- 3.44 Further, it would appear that the Army should have ensured accountability by further investigation in a Board of Inquiry (BOI) or disciplinary proceedings for the breach of standing orders which allowed Sapper Manship to be on lone prowler patrol in the first place. The Review has seen no information to suggest that anyone was disciplined as a

¹⁴ Paragraph 10, RMP Final Report 47037/92 dated 16th April 1992.

¹⁵ *Ibid.*

¹⁶ See Appendix 15, 'Deepcut Investigation' – the Deputy Adjutant General's Final Report dated 3rd December 2002.

result of this breach. This, itself, is a pattern that is reflected in relation to the deaths at Deepcut that are of primary concern to this Review. If such standing orders are to serve a purpose, and the unit reminded of the importance of adhering to them, then some form of local inquiry with a view to some appropriate sanction would appear to have been needed.

- 3.45 No BOI was ever held into this death by the Army. In an internal MOD minute, which provided draft text for a letter to Alfie Manship's mother in response to correspondence received, it was stated that:

*"... this probably reflects procedures at the time when deaths of this nature were not normally subject to an inquiry."*¹⁷

- 3.46 The Review finds the absence of a BOI disappointing. There was at least one issue for a BOI to consider in this case, namely why Sapper Manship was on lone prowler patrol at the time of his death. An inquiry into this issue might have prompted a general instruction to units of the British Army to ensure that the dangers of a nocturnal prowler patrol by a single soldier armed with a weapon were emphasised and the importance of compliance with standing orders preventing this underlined. Equally, a BOI might have noted another danger that sole prowler patrols at night by an armed guard provided an opportunity for any soldier minded to self-harm to inflict lethal force on himself.
- 3.47 Thirdly, the need for internal proceedings is emphasised by the fact that there was no inquest held. Alfred Manship's body was repatriated via Luton Airport to Scotland, where his mother lived at the time. No inquest was held into his death by HM Coroner for Bedfordshire and Luton who thought any statutory inquiry fell to be conducted at the end destination in Scotland. No criminal investigation or Fatal Accident Inquiry has been conducted by the Procurator Fiscal. The difference in the law in Scotland and England and Wales has already been noted in Chapter 2.¹⁸
- 3.48 Alfred Manship's mother has corresponded with the MOD and others for many years about his death raising various concerns she had. She became aware of an inaccurate Parliamentary written answer by the Parliamentary Under-Secretary of State for Defence, Dr Lewis Moonie, on 12th December 2002 to a question posed by Kevin McNamara MP, which suggested that Alfie Manship had received an inquest that had returned a verdict of suicide.¹⁹ The correct position, as set out above, was only publicly acknowledged in a letter from Don Touhig MP, the current Parliamentary Under-Secretary of State for Defence, in August 2005 to the former Member of Parliament Kevin McNamara. The Review notes that there is a danger of inconsistent treatment of families of service personnel according to the happenstance of where the parents live and which airport is used to repatriate the body of a soldier who died abroad.
- 3.49 Further, the Review doubts whether even Mr Touhig's letter accurately stated the position with respect to Scottish practice. That letter stated (with emphasis added by the Review) that *"contrary to HM Coroner's practice in England and Wales, the Procurator Fiscal rarely convenes an Inquiry into deaths that occur outside Scotland."* Information provided to Sandra Osborne MP in January 2005, on behalf of Alfie Manship's mother, by the Solicitor General for Scotland, however, explains (with emphasis added by the Review) that where a death occurs abroad and the body is repatriated to Scotland *"the Procurator Fiscal has no jurisdiction to hold a Fatal Accident Inquiry"*. There is still the possibility of a criminal

¹⁷ D/AGSec108/1 dated 14th January 2005.

¹⁸ See paragraph 2.15 ff.

¹⁹ Commons Hansard, 12th December 2002: Column 427W. *"Coroner's verdicts, in those cases where an inquest has been held, are as follows: ... Name ... Sapper Alfred Manship ... Verdict ... Suicide."*

investigation, but the Procurator Fiscal would be “*unlikely to intervene*” where the investigation conducted by the appropriate military and civilian authorities reveals no evidence of homicide. The position then for soldiers who die abroad and whose deaths are governed by Scottish law is that the conclusions of the RMP are likely to be final. If there is no evidence that a crime has been committed, then subject to duties under the Human Rights Act and consequential re-interpretation of Scottish statutes, there is no power to hold an inquiry into the circumstances in which the death occurred. Factors giving rise to the death cannot be examined in an inquiry in which the family can participate.

3.50 The Solicitor General for Scotland points out that an inquest can be conducted by a Coroner in England and Wales if the body arrives there from abroad en route to a burial or cremation in Scotland. However, whether an inquest can be held depends on the presence of the body being reported to the Coroner before it is moved out of the jurisdiction. It is not the case that a British Army base in Germany is deemed to be part of the United Kingdom. This means that an inquest cannot in fact be held in Germany, despite this suggestion being made to Alfie Manship’s mother in an email of 25th August 2005 on behalf of the present HM Coroner for Bedfordshire and Luton.

3.51 The Army Casualty Procedure 2000 makes clear:

“In Germany, Coroner’s courts are not held. All unnatural deaths occurring to military and UKBC [United Kingdom Based Civilians] personnel, or their dependants, are investigated by the SIB RMP. Similar rules apply to some other areas. Elsewhere inquests or other civil investigations into a death may occur.”²⁰

3.52 It is not surprising, in the light of these conflicting explanations as to the regime for an inquest, that Alfie Manship’s mother has become suspicious as to the circumstances of her son’s death. If she had been afforded an inquest in the United Kingdom, as she should have been, such concerns might never have arisen. As it is, in the absence of such an inquest, serious misconceptions into the circumstances surrounding Alfie Manship’s death have been permitted to take root to the detriment of all concerned.

Sapper Alfred Manship and Deepcut

3.53 On 11th December 2004, shortly before my appointment to conduct this Review was announced, the Daily Mail published an article concerning the death of Alfie Manship under the heading ‘The First Victim of Deepcut’. The article proceeded on the basis that Sapper Manship had been trained at Deepcut in 1992 prior to his posting in Germany and that, whilst at Deepcut, he was assaulted by an NCO there who was the subject of disciplinary proceedings for the assault. The article suggested that the NCO who assaulted him was later himself transferred to Germany and was present in Germany at the time of Alfie Manship’s death a short time later. The article further explained that, following the BBC Panorama programme ‘Bullied to Death?’ broadcast on 1st December 2002, Alfie Manship’s mother believed she had identified the assailant of her son as Sergeant B, the NCO at Deepcut identified in that programme as an alleged bully.

²⁰ Chapter 4, paragraph 0425 (Overseas Deaths).

- 3.54 The enquiries undertaken by this Review have demonstrated that most of the primary facts on which the link between Alfie Manship and Deepcut Barracks were made in the Daily Mail article are misconceptions. First and foremost, Sapper Manship never undertook a training course at Deepcut Barracks at all. There is no evidence that he ever visited there, let alone was assaulted there. Deepcut Barracks is located at Blackdown, Surrey and, as noted in Chapter 1, was sometimes referred to as 'Blackdown Barracks'.²¹ As explained in the next Chapter, in 1991 Deepcut (or Blackdown) was a Royal Army Ordnance Corps (RAOC) establishment. Alfred Manship was a Royal Engineer and would have had no reason to be at 'Blackdown' to undergo training there. He was, however, at the Royal School of Military Engineering, Blackwater, near Camberley in Surrey. This is a completely different Barracks and location, in spite of the similarity in name.
- 3.55 Secondly, Sapper Manship was assaulted by an NCO at Blackwater (not Blackdown, or Deepcut) Barracks and sustained injuries resulting in him being admitted to the military hospital in Aldershot where his mother visited him. This hospital was used for casualties from military bases in Surrey, including Deepcut. However, the assault took place in April 1991, a year before Alfie Manship's death in Germany. The NCO who assaulted him was not Sergeant B and the NCO was successfully prosecuted at a Court Martial at which he was sentenced to be reduced in rank. Furthermore, the records reveal that the NCO concerned was not anyone named or referred to in the Panorama programme broadcast in December 2002. The Review has uncovered no evidence of a link between the NCO concerned in the Blackwater incident with Alfie Manship and Deepcut.
- 3.56 Thirdly, as noted, the NCO mentioned in the BBC Panorama programme and the Daily Mail article was Sergeant B. Sergeant B's service file reveals that he was not serving at Blackwater Barracks at the time, or anywhere near it, and there is no reason to believe he had visited there or had any connection with Alfie Manship in England or Germany. He could, therefore, not have been recognised as being the NCO responsible for assaulting Alfie Manship in 1991. Although Sergeant B did a tour of duty in Germany in 1992, this was not at, or near, Woolwich Barracks, Osnabrück and there is no reason to believe that he would have had any contact, or any reason for contact, with Sapper Manship when he was on duty in Germany, or that he had any connection with his death.
- 3.57 From every angle, the hypothesis that Alfie Manship's death was a 'Deepcut death' or a Deepcut-connected death is a false one. There is no connection by place or personnel. The Daily Mail article also demonstrates the dangers of accusation of misconduct not based on reliable evidence following fair investigation and proper evaluation. Since the BBC Panorama programme, Sergeant B has been associated in the public mind with bullying, and bullying is widely believed to have caused the four deaths under review. Subsequent informants may believe that they are merely adding to a case already soundly established by the evidence. The true picture is more complicated and less amenable to quick judgements, as will be seen in the following Chapters, and particularly in Chapter 5.
- 3.58 However, for different reasons, the death of Alfie Manship does serve as a suitable prologue to consideration of the four deaths at Deepcut under review. Alfie Manship died whilst being alone at night with a lethal weapon assigned to him by his employer to perform guard duty. He should have been prowling on patrol at night in a pair but was ordered to do it alone. The opportunity accordingly provided, enabled him to use his weapon on himself. All four deaths at Deepcut subject to this Review were of young soldiers who apparently died from gunshot wounds whilst alone and on guard duty.

²¹ See, for example, paragraphs 6.40, 6.114 and 6.180 below.

- 3.59 If there had been a proper inquiry following Alfie Manship's death, not only would some of the misconceptions as to the circumstances surrounding his death never have arisen, but the Army might have become alerted, earlier than it did, to the dangers of lone unsupervised prowler patrols being undertaken by young soldiers with a weapon and ammunition.

4 Recruitment and Training, the Royal Logistic Corps and the Army Training and Recruiting Agency

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The British Army today

4.1 The British Army is a unique and extraordinary institution. It is a fully professional army based on voluntary recruitment. At the time of the first of the tragic deaths at Deepcut in 1995, it had a strength (both trained and untrained) of some 111,690 soldiers,¹ a level significantly reduced from the early 1990s. For the past decade or more it has been sent on a wide variety of operational deployments in many parts of the world, to great personal danger and regular personal sacrifice.

4.2 Service in the Army involves a mutual compact of self-sacrifice and fair training and support in the public interest, known as the Military Covenant:

“Soldiers will be called upon to make personal sacrifices – including the ultimate sacrifice – in the service of the nation. In putting the needs of the nation and the Army before their own, they forgo some of the rights enjoyed by those outside the Armed Forces. In return, British soldiers must be able always to expect fair treatment, to be valued and respected as individuals, and that they (and their families) will be sustained and rewarded by commensurate terms and conditions of service. In the same way, the unique nature of military land operations means that the Army differs from all other institutions, and must be sustained and provided for accordingly by the nation. This mutual obligation forms the Military Covenant between the nation, the Army and each individual soldier; an unbreakable common bond of identity, loyalty and responsibility which has sustained the Army and its soldiers throughout its history.”²

4.3 The Army thus represents a very special kind of career and employment for all of its members. As the Core Values of the Army make clear, plain courage, self-sacrifice and the subjugation of the interests of the individual to those in the unit is required on the one hand, while on the other it:

“... requires those in positions of authority to discharge in full their responsibilities and their duty of care to subordinates.”³

4.4 The Army today comprises a multitude of specialist roles and functions, which work together to deliver defence capability. The various branches of the Army are divided into different Regiments (such as the Parachute Regiment) and also larger Corps, such as the Royal Logistic Corps (RLC). What distinguishes the different branches, amongst other things, is their unique ‘cap-badge’. Consistent with many of the Army documents received, the Review will use the term ‘cap-badge’ to denote different branches of the Army.

4.5 The focus of this Review is the RLC, which is a Corps of the Army that uses different terminology to denote sub-divisions from some other branches. The RLC is composed of different Regiments which comprise a number of Squadrons, which in turn are subdivided into Troops. These last two equate to a Company and a Platoon, respectively, in some other branches of the Army.

¹ As at 1st April 1995. This figure is for United Kingdom Regular Forces (officers and soldiers) and, therefore, excludes Gurkhas, Full Time Reserve Service, R Irish Home Service and mobilised reservists. Figure provided by Defence Analytical Services Agency.

² Army Doctrine Publication, Volume 5, Soldiering – The Military Covenant, paragraph 0103.

³ *Ibid*, paragraph 0306.

- 4.6 The Army consists of soldiers and commissioned officer ranks. Officers are commissioned after completing their training at the Royal Military Academy Sandhurst (RMAS), having joined from school or university or, exceptionally, having been selected from the soldier ranks (known as 'being commissioned from the ranks'). The soldier ranks consist of Privates, Non-Commissioned Officers (NCOs) and Warrant Officers (WOs). Officer and soldier ranks are shown in Figure 4.1. A soldier is generally known as a 'recruit' during initial or basic training, known as Phase 1, and as a 'trainee' in specialist trade training, known as Phase 2, although they continue to hold the rank of Private. On completing their Phase 2 training, a trainee joins a unit from their own cap-badge in the field army.

Figure 4.1: Officer and soldier ranks

<h2>Army Ranks</h2>	
Commissioned officers:	
General	¹ Rank held by the Adjutant General
Lieutenant General ¹	² Rank held by the Director General of Army Training and Recruiting (DGATR) and the Deputy Adjutant General (DAG)
Major General ²	³ The rank held by the Commander of Deepcut Garrison
Brigadier ³	⁴ The rank held by the Commanding Officer (CO) of the RLC Training Regiment
Colonel	⁵ The rank held by the Officers Commanding (OC) of the Squadrons within the Training Regiment
Lieutenant Colonel ⁴	⁶ The rank held by the Adjutant of the Training Regiment
Major ⁵	⁷ The rank held by the Troop Commanders within the Training Regiment
Captain ⁶	
Lieutenant ⁷	
2nd Lieutenant	
Non-commissioned ranks:	
Warrant Officer (Class 1) ⁸	⁸ The rank held by the Regimental Sergeant-Major of the Training Regiment
Warrant Officer (Class 2) ⁹	⁹ The rank held by the Squadron Sergeant-Majors in the Training Regiment
Staff Sergeant	
Sergeant	
Corporal	
Lance Corporal	
Private	

The British soldier today

- 4.7 The people the Army recruits as Privates are predominantly young. They must be, or quickly become, fit and highly disciplined people as they will, in due course, be required to trust each other with their lives. Like the Royal Navy and Royal Air Force (which together with the Army form the Armed Forces), the Army has had to adapt to modern social conditions and expectations, and broaden its horizons to reflect who its recruits are likely to be and where they come from.

- 4.8 Many of the young people who are, or were, accepted as recruits into the Army have had very challenging personal lives as children. The House of Commons Defence Select Committee (HCDC) Duty of Care report⁴ noted that some studies found a high proportion of recruits came from single parent homes, and some had left school with no qualifications at all. Some join the Army with distressing histories of abuse from a young age, and have a greater familiarity with social workers than parents. Many of those accepted as soldiers on Single Entry (described in more detail later in this Chapter) into the Army have low levels of intellectual achievement. The observations of the HCDC were reinforced to this Review when it visited the Army Training Regiment (ATR) at Basingbourn. The Commanding Officer's presentation disclosed that 85% of recruits joining his establishment for Phase 1 training had a deficit in basic skills,⁵ compared with a national average of 23%, an average for Phase 1 trainees generally of 47%, and the average for the United Kingdom prison population of 75%.⁶
- 4.9 It is a remarkable challenge to turn these young people, who, for whatever reason, may not have led happy, structured and fulfilling lives, into effective soldiers forming part of a disciplined and inter-dependent team. To do so against the rival lifestyles of civilian life in modern Britain, and to the scale of the general recruiting requirement identified above, is a very considerable achievement. Deepcut alone has been sending into the field army an average of some 1,000 to 1,800 trainees per year from 1995 to date.
- 4.10 Like the members of the HCDC, the Review team visited ATR Basingbourn and the Army Foundation College (AFC) in Harrogate, the two principal locations which today provide training for the youngest recruits who join the Army. Each member of the Review team was impressed with what can be achieved in a short space of time. We were informed on a number of occasions, and there is ample evidence, of the pride the Army engenders in recruit and family members alike at the Phase 1 'passing out' parade, held on successful completion of the first phase of a soldier's training, approximately 12 weeks after joining. It is impressive that the training regime can turn a young person of sometimes questionable fitness, personal skills, discipline and educational and social attainment into a focused, determined soldier in so short a time. The Review notes in this context the observation of Professor Simon Wessely to the HCDC that the Army:
- "... does address a socially excluded group which very few other people can tackle."⁷*
- 4.11 There is much by way of success story that the Army has not always succeeded in getting across, faced as it has been, with the barrage of negative publicity resulting from the tragic events at Deepcut and the related media coverage. Throughout this Review, lurid accounts of initiation rituals, mistreatment and sexual misbehaviour in a number of famous units have been reported. The truth of these matters are the subject of investigation by the Royal Military Police (RMP). As will be seen, the Army has publicly denounced such activities and proclaimed a zero tolerance policy on bullying. It can be said that if the modern Army was composed of a substantial number of bullies, sexual harassers or personnel indifferent to the welfare of recruits, trainees and young soldiers, it is difficult to imagine that anyone would join in the first place or stay for any time, let alone do well on active service which, of course, many do. Furthermore, individual employment rights now

⁴House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol I, paragraphs 41, 44 and 45.

⁵Basic Skills are "the ability to read, write and speak in English and to use mathematics at a level necessary to function at work and in society in general", as defined by the Department for Education and Skills.

⁶For the cohort for autumn 2004, 45% and 49% had literacy and numeracy skills, respectively, at Entry Level 3 (11 year old); 45% and 35% had such skills at level 1 (GCSE Grades D-G). The remainder were below this level of attainment.

⁷House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev 75, Professor Wessely's response to question 408.

exist to enable those aggrieved to take the Army to an Employment Tribunal for failing to repress misbehaviour. If there are serious grievances, it would be reasonable to expect litigation or the payment of compensatory damages.

- 4.12 However, the fact that there are many successes in different parts of the Army's training system does not mean that there are no problems or issues to address. In particular, this Review is satisfied, for reasons that will become apparent, that 'all quiet' does not necessarily mean 'all well'. The absence of contemporaneous complaint is a factor to consider but may not be conclusive. There may be a number of reasons why apparent abuse of power is not the subject of formal complaint, investigation or effective resolution. We will return to these themes later in the Report.

The Royal Logistic Corps

- 4.13 This Review is concerned with events in the Training Regiment of the RLC at Deepcut. The RLC is the youngest Corps in the Army and was created on 5th April 1993 following a review of service support functions across the Army. The RLC was formed by the merging of five other Corps in the Army: the Royal Corps of Transport (RCT); the Royal Army Ordnance Corps (RAOC); the Royal Pioneer Corps (RPC); the Army Catering Corps (ACC); and the Postal and Courier Service of the Royal Engineers. When the RLC was formed, it had over 1,700 officers and approximately 15,000 soldiers (14% of the total trained strength of the Army at the time) and was, and remains today, one of the largest and most diverse Corps in the Army.
- 4.14 Each of the five forming Corps had their own training regiments and depots. The Training Battalion & Depot of the RAOC was at Deepcut. Deepcut was selected as the new home of the RLC and the RAOC Training Battalion and Depot became the Training Regiment & Depot of the new RLC in April 1993.
- 4.15 Within the RLC there are a wide variety of trades: driver, supply specialist, supply controller, air dispatcher, ammunition technician, pioneer and the like, all requiring different personal skills and intellectual aptitudes. Academic requirements for recruitment to many of the RLC trades are not demanding. Other branches of the Army, such as the Intelligence Corps, the Royal Corps of Signals, the Royal Electrical and Mechanical Engineers, and the Royal Engineers, may require considerable technical expertise and aptitude to perform their trades. Therefore, academic qualifications and higher scores in general intelligence testing on recruitment are sought. By contrast, as a matter of broad generality, those being recruited to the Infantry and most of the general trades within the RLC require the lowest levels of academic or intellectual attainment,⁸ although people with higher attainments are welcomed, particularly to what is often considered the most demanding of the RLC's trades, that of ammunition technician.⁹
- 4.16 The RLC accepts women soldiers to all of its trades,¹⁰ by contrast with some other branches of the Army, notably the Infantry. Until 1992, women were generally recruited into the Women's Royal Army Corps (WRAC) and trained separately, although they had long served alongside male soldiers in the field army. From 1990, the process of absorbing WRAC

⁸ See Appendix A4/13.006 B – C, where Lieutenant General Palmer says the standard of educational requirement is lower in the RLC and the Infantry than elsewhere.

⁹ See Appendix A4/1.019 E – F, where Brigadier Brown pointed out to this Review that the aptitude of RLC recruits was probably the broadest ranging in the Army. By analogy, he stated, this would apply similarly to RLC officers.

¹⁰ There was a time when women were not accepted into the pioneers because this trade required its soldiers to train as Infantry, in addition to its specialist construction skills. The Review understands this is no longer the case.

personnel into other branches of the Army began, and was completed when the remaining elements of the WRAC were absorbed into the newly formed Adjutant General's Corps (AGC) in April 1992.

- 4.17 One of the principal trades of the RLC is that of driver. Young people, men and women, who qualify for this trade are not only trained at public expense to drive an ordinary motor car, they also acquire, at an earlier age than would be possible in civilian life, an HGV (Heavy Goods Vehicle) licence and substantial experience in operating large goods supply vehicles. Understandably, such training and enhanced skills may be an attractive incentive to join the Army. Furthermore, trainees receive a respectable wage with accommodation and food requirements catered for whilst a valuable trade is learnt.
- 4.18 Most of the 20,000 or so trainees that have been through Deepcut since 1993 have served with skill and distinction. Many of those who joined the RLC in 1995 and after are still in service. Even those who leave the Army to return to civilian life some time after the completion of their training may do so with enhanced personal discipline and improved employment-related skills. Indeed, some of those who leave the Army subsequently apply to rejoin.
- 4.19 The narrative of events examined by this Review is concerned with trainees and the training environment. This is an early stage in a military career where military values are still being learned and things may seem strange, unfamiliar and, occasionally, unwelcome. This Report is concerned with four people who, tragically, did not make it through Phase 2 training to join a unit in the field army and whose lives were cut short, causing immeasurable grief to their families, loved ones and comrades. For reasons outlined in previous Chapters, the focus of this Report is to seek to identify what may have caused or contributed to those deaths.
- 4.20 To introduce the reader to the military background to the events at Deepcut, it is first necessary to give a brief account of changes in Army recruiting and training practice that were taking place shortly before the first of the deaths that is the subject of this Review.

Army recruiting and training

- 4.21 The early 1990s were a time of significant change and upheaval for the Army, which was restructuring and reducing in size to adapt to the post-Cold War era. A number of fundamental reviews and studies were commissioned at this time, both by the Government and by the Army, and many of these have relevance to events at Deepcut. One such review, the 'Front Line First' Defence Costs Study¹¹ is particularly relevant, placing, as it did, an emphasis on the field army, rather than on less well-defined support functions:

*"... the Study will allow us to proceed with programmes to redirect expenditure to more important areas and enhance the operational capability of our armed forces."*¹²

- 4.22 The emphasis on the front line was at the probable expense of the less appealing and less glamorous support areas of military life. This is a theme which emerges from interviews with those involved in training in the wake of this study and the work that followed, as well as the perceptions of instructors and trainees alike gathered in the investigations into the four deaths. The Review has been left in no doubt that, in the mid-1990s, employment

¹¹ Ministry of Defence 'Front Line First – the Defence Costs Study', HMSO 1994.

¹² *Ibid*, paragraph 121.

in the training function of the Army was seen as less desirable than service in the field army.¹³ It was less likely to enhance a soldier's career prospects. Whatever the present position, it was keenly felt by those involved in training at the time. The consequence was that the training function did not always attract the most gifted or dynamic officers and NCOs. By contrast, those whose skills made them most suited to delivering the challenging task of turning young people into effective soldiers were not the most enthusiastic to take on such an important, if undervalued, role.

- 4.23 Many of the organisations and structures now in place, including the RLC itself and the Army Training and Recruiting Agency (ATRA), were the product of one or more of these studies, most of which built on the 1990 'Options for Change' defence structure review.¹⁴
- 4.24 A common theme within the studies undertaken was that of restructuring to meet the demands of the post-Cold War world, improving cost effectiveness and reducing duplication and waste. One such review was concerned with restructuring the training base. Before September 1993, recruitment to the Army as a soldier (not officer) was age-based and recruits were classified as either 'Junior Entry' or 'Adult Entry' and trained separately.
- 4.25 Adult Entry, however, did not mean entry of those who were adults, i.e. over the age of 18, but had its own specialist meaning in the Army of those who were over 17 on enlistment.

Junior Entry

- 4.26 Junior Entry in 1992 had three strands: Apprentices, Junior Soldiers and Junior Leaders. Apprentices were those intending to join the technical Corps.¹⁵ They could join the Army at a minimum age of 15 years and eight months, pursue a two-year apprenticeship, and further education, and then join their assigned cap-badge at 17½ to 18. Entry as a Junior Soldier, the second strand of Junior Entry, had a minimum entry age of 16½ years. The period of training was for six months and, thereafter, training would proceed as for an Adult Entry soldier. The third strand of Junior Entry was for those admitted as a Junior Leader, from the age of 15 years and 11 months. This was the recruitment route for promising young people with the personal qualities likely to make a long-term successful career in the Army. They were the future NCOs and leaders of the soldiers. A full 22-year service career was in prospect and the best Junior Leaders might expect to be commissioned as officers from the ranks. The training provided was for 12 months, enabling a soldier to join their cap-badge from around 17. The Review has spoken to many senior officers in the Army over the past 12 months and most were highly enthusiastic about (and, indeed, some had themselves been) Junior Leaders and praised the quality of training it provided.
- 4.27 The Review understands that the following features of the Junior Leader scheme contributed to the high respect and regard in which that strand of Junior Entry was particularly held. The Junior Leader joined a specific cap-badge and was trained through all phases of military education by personnel from their own cap-badge. A strong attachment to the cap-badge was, therefore, inculcated at an early stage, and, equally importantly, the Corps and the training staff assigned came to know the recruit and any strengths or weaknesses that needed addressing. The training extended over a year in an

¹³ See Appendix A4/16.042 C – E. Major Whattoff (Ret'd), former Adjutant at Deepcut, informed this Review that being posted into a training environment could have been viewed by the more capable NCOs as a poor career move. Several other officers with knowledge of an Army training environment have confirmed this to the Review.

¹⁴ See 'Britain's Army for the 90s' (Cm 1595, July 1991) for the impact of the review on the structure of the Army.

¹⁵ For example, the Royal Electrical and Mechanical Engineers or the Royal Corps of Signals.

atmosphere designed to understand the sensibilities of young adolescents in a regime that had some similarities to a highly disciplined boarding school. These young recruits were part of a formed Troop, or Platoon, where the normal ratio of NCO to soldier was approximately one Corporal and Lance Corporal per section of 12 soldiers, and one Sergeant per Troop, or Platoon, of approximately 36. Being trained separately from adult soldiers, these young people had time to grow up personally while, at the same time, learning to be professional soldiers before being absorbed into the field army. For most of them, the onset of military training would be the first experience of living away from home.

- 4.28 The 1991 study 'Restructuring the Training Base'¹⁶ noted that there had been over 100 official studies into military training in the preceding decade.¹⁷ The aim of the Restructuring paper was:

"... to enable ECAB [Executive Committee of Army Board]¹⁸ to issue direction for improving output in the training base of the Army within a reduced resource ceiling, by 1995."

Essentially, it sought to achieve economies in the delivery of Army training as a consequence of the 'Options for Change' defence structure review that reduced the size of the Army by approximately one third. The 1991 Restructuring paper aimed to preserve NCO to soldier ratios for initial training but combined male and female training and the training for different cap-badges in distinct training Battalions.

- 4.29 As late as September 1992, there were proposals for retaining a six-month Junior Entry training regime alongside standardised Adult Entry training. However, by November 1992 the ECAB had taken the step to abandon separate Junior Entry training (except Apprentices), replacing it with effect from September 1993 with a standardised Single Entry system for those aged 16 years and three months, or over.

Single Entry

- 4.30 The Single Entry system, at its inception, provided ten weeks of initial Phase 1 training for all recruits (except Apprentices), irrespective of age at a number of ATRs throughout the country. Apprentices were to be retained but moved to a single training establishment. The Single Entry Implementation Plan acknowledged the limitations on the employment of those under 17 year olds who would be recruited and complete their ten week training before reaching their 17th birthday:

"As they cannot start driver training until age 17, and be deployed to units overseas until 17.3 (N. Ireland 17.6 restricted to barracks and 18 full duties), numbers in this category will be restricted."¹⁹

- 4.31 The Single Entry Implementation Plan anticipated a requirement of 800 to 1,000 under 17 year olds per year, in addition to Apprentices, capable of expansion or retraction according to the manpower needs of the Army if adult recruitment proved difficult to sustain:

"Some recruiting from the SSL [Secondary School Leavers] pool is necessary to avoid high quality mature under 17 year olds being lost to other careers."

¹⁶ CTAB 804/1 dated 30th January 1991.

¹⁷ The Review is aware that the future of the Junior Leader scheme was under review from at least 1988.

¹⁸ The Executive Committee of the Army Board is chaired by the Chief of the General Staff and its members are: The Second Permanent Under Secretary of State; the Adjutant General; the Quartermaster General; the Master General of the Ordnance; the Commander-in-Chief Land Command and the Assistant Chief of the General Staff.

¹⁹ Single Entry Implementation Plan, final draft 15th June 1993, paragraph 8.

*"In times of poor recruitment the Army will be likely to take an increased number from the SSL pool: when recruitment is buoyant it is probable that the Army will take fewer of the very young."*²⁰

4.32 These changes were prompted, in part, in response to an anticipated change in educational policy, when it was thought there would be general raising of the school leaving age,²¹ and a reduction of overall numbers in the Army to 119,000, with an estimated annual recruitment requirement of some 15,700.

4.33 It was recognised that Single Entry training of under-18s with those over 18 posed new challenges to which the Army would have to respond. The Single Entry Implementation Plan recognised that maturity and stamina could vary and:

*"... only those who display sufficient physical and mental maturity to cope with Phase 1 and Phase 2 training will be selected for enlistment under age 16.9¹/₂."*²²

Therefore:

"An important new task for DAR [Director Army Recruiting] and the RSCs [Recruit Selection Centres] is to set the criteria and then evaluate the physical and mental development and maturity of potential recruits to identify only those of high quality and maturity for enlistment."

4.34 The features of the new scheme were as follows. By contrast with the previous distinction between Junior and Adult Entry, training was now of all ages and both genders mixed together in the same training establishment. Phase 1 training, where a recruit undergoes the Common Military Syllabus (Recruit) (CMS(R)) to acquire basic skills as a soldier, was to be performed by ATRs throughout the country, irrespective of eventual cap-badge,²³ for approximately ten weeks, if fitness and success in each stage permitted. The responsibility for organising this training, recruiting the instructors and setting the standards fell to a branch of the Adjutant General's staff called the Individual Training Organisation (ITO). After this Phase 1 training, the recruit became a trainee and moved on to Phase 2 training with his or her own cap-badge to receive specialist trade training. After Phase 2 training, the trainee would become a fully trained soldier and be posted to a unit within the field army. Individual training of the soldier would still continue during their military career but this would be referred to as Phase 3 training, where the soldier would be sent back to training schools for limited periods to develop new, or enhance existing, skills.

4.35 This new scheme was the training structure in place in 1995 and is, very broadly, still the same today, although Phase 1 training is now 12 weeks rather than ten. It was, therefore, into this structure that each of the four trainees who died at Deepcut was recruited. In 1996, the ITO became a Defence Agency and was retitled the Army Individual Training Organisation (AITO). In 1997, the AITO was renamed and reorganised as the Army Training and Recruiting Agency (ATRA). Each of the four young people this Review is concerned with were assessed suitable for recruitment between the ages of 16 and 19 at a recruiting centre close to where they lived. Following attestation, each was then sent to ATR Pirbright, near Camberley in Surrey, for Phase 1 training. On successful completion of Phase 1 as recruits, they entered Phase 2 training as trainees with the RLC, whose Training

²⁰ *Ibid*, paragraph 7.

²¹ See Appendix A4/13.002 F.

²² *Supra*, footnote 19, paragraph 5. The Plan continues in the same paragraph to explain: "(The significance of age 16.9¹/₂ is that successful recruits will commence Phase 2 training at a minimum age of 17 (17 years – 10 weeks CMS(R) = 16.9¹/₂).")

²³ Although efforts were made to ensure that those from the same cap-badge were trained together.

Regiment was located at the Princess Royal Barracks, Deepcut, a short distance away from ATR Pirbright. Each of the four young people were waiting for, undergoing, or had just completed, Phase 2 training at the time they died.

The special position of those under 18

- 4.36 The 1993 Single Entry Implementation Plan recognised that it depended on establishing a suitable regime for young soldiers under 18 years of age. The Plan identified a number of features of this regime and recognised:

"A Commanding Officer and/or Officer Commanding is in 'loco parentis' for soldiers under age 18."²⁴

- 4.37 This Latin phrase "*in loco parentis*" (in place of the parent) is perhaps taken from the pastoral responsibilities of a headmaster at a boarding school or a tutor at university. It does not have a precise legal meaning in English law today. The Commanding Officer was certainly never a guardian or statutory carer of the minors placed under his control, but then neither is the headmaster of a boarding school.²⁵ In its evidence to the HCDC,²⁶ the Ministry of Defence (MOD) provided a legal memorandum explaining why Commanding Officers do not act "*in loco parentis*" and suggested that the phrase had no application to the existence of a duty of care, as this was owed to all trainees irrespective of age. The memorandum also pointed out that the law is not clear in providing a single definition of a minor or a child. For instance, in the Education Act 1996, a 'child' is defined as someone under compulsory school age (i.e. under 16). However, the Criminal Justice and Court Services Act 2000, which is concerned with the scope of enquiries into the criminal records of those seeking to work with children, defines a 'child' as those under 18, unless they are in full time employment, in which case only those under 16 are a child (i.e. a 17 year old in full time employment is not a child for the purposes of the Act).
- 4.38 For the Review, these legal submissions may, themselves, confuse and obscure the true position. In the United Kingdom, the age of majority is 18²⁷ and anyone under this age is a minor or a child.²⁸ International law is to similar effect. Under the United Nations Convention on the Rights of the Child 1989 (the Convention), a child is someone under 18, in the absence of special national rules as to the age of majority.²⁹ Domestic law and the Convention distinguish between different classes of children. After 16 years of age, children are permitted to do increasingly adult things such as drive, smoke, marry or have sexual relations without committing a crime. However, they remain minors or children for general purposes.³⁰ To avoid confusion, this Review will refer to those under 18 as 'minors', although in the opinion of the Review they could equally accurately be described as children, and are so defined in the international obligation under the Convention. A minor does not cease to be a minor by virtue of being permitted to take up employment and join the Army, although specific legal duties within the employment context may depend on

²⁴ *Supra*, footnote 19, paragraph 15b.

²⁵ While not a guardian or carer, statutory duties do exist. See paragraph 4.45 and footnote 31 below.

²⁶ House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev 262.

²⁷ Family Law Reform Act 1969, s.1.

²⁸ Halsbury's Laws of England (Fourth Edition Reissue, 2001) Volume 5(3) – Children and Young Persons. See also Children Act 1989 s.105, Protection of Children Act 1999 s.12 (1). Note, however, that in the Employment of Children Act 1973, which prohibits employment of children, a 'child' means a person who is not for the purposes of the Education Acts over compulsory school age or, in Scotland, 'school age' (see s.3(2)). See also Children Act 2004 establishing a Children's Commissioner with the functions set out in s.2 to that Act. In particular, see s.9 (2): "*Any reference to a child includes, in addition to a person under the age of 18, a person aged 18, 19 or 20 who – (a) has been looked after by a local authority at any time after attaining the age of 16; or (b) has a learning disability.*"

²⁹ The Convention was ratified by the United Kingdom on 15th January 1992. See also International Labour Organisation Convention No. 182, ratified by the United Kingdom in March 2000, that provides: "*For the purposes of this Convention, the term child shall apply to all persons under the age of 18.*" Note also that s.2 (11) of the Children Act 2004 requires the Children's Commissioner to have regard to the convention when considering what constitutes the interest of children.

³⁰ For instance in relation to the purchase of alcohol.

matters other than simply being under 18.

- 4.39 Clearly, a Commanding Officer has a legal duty of care towards all soldiers under their command to take reasonable measures to ensure that they are not harmed by others or do not harm themselves in the course of their military employment. The recognition in the 1993 Single Entry Implementation Plan, that a Commanding Officer is "*in loco parentis*" to the minors placed under his control, merely identifies a particular relationship of care owed to certain soldiers because they are minors for whom the Commanding Officer has responsibility, as the controller of the environment in which those minors live and work. It is the nearest the Plan comes to recognising a particular duty of care towards minors who are soldiers. In the opinion of this Review, it is helpful for Commanding Officers to be made aware of their additional responsibilities that arise simply because the trainee is a minor. Distinctions between moral and legal responsibilities, and between formal guardianship orders and the responsibility of a headmaster of a boarding school, are more likely to confuse.
- 4.40 However, in its evidence to the HCDC, the MOD, in a memorandum, referred to earlier, titled 'Commanding Officers: loco parentis', did make the point:

*"It is however the case that the care and welfare of those under 18 merit particular attention and Commanding Officers are well seized of this need. The Commanding Officer will always ensure appropriate involvement of the parents of a recruit or trainee taking into account the wishes of the recruit or trainee."*³¹

The United Nations Convention on the Rights of the Child

- 4.41 The same memorandum also noted the particular duties applicable to those under 18 as a result of the United Kingdom's adherence to the Convention.³² For much of the period of the events at Deepcut of interest to this Review, the minimum age for overseas service was 17 and three months. It is a striking fact that young people of that age, who are minors, could kill, or be killed, when they were not old enough to purchase or consume alcohol in a public place.
- 4.42 More recently, in September 2000, the United Kingdom signed an Optional Protocol³³ to the Convention, with an interpretative statement, and ratified the Optional Protocol in June 2003. Article 1 of the Optional Protocol provides that:
- "States Parties shall take all feasible measures to ensure that members of their armed forces who have not attained the age of 18 years do not take a direct part in hostilities."*³⁴
- 4.43 The United Kingdom's interpretation of "*feasible measures*" reserved the right not to withdraw under 18 year olds from a ship or unit where, by reason of the nature and urgency of the situation:

³¹ *Supra*, footnote 26.

³² *Supra*, footnote 29.

³³ Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict, signed by the United Kingdom on 7th September 2000, ratified 24th June 2003.

³⁴ *Ibid*, Art. 1.

*"(i) it is not practicable to withdraw such persons before deployment; or (ii) to do so would undermine the operational effectiveness of their ship or unit, and thereby put at risk the successful completion of the military mission and/or the safety of other personnel."*³⁵

- 4.44 At the same time, a declaration was made that the minimum age of recruitment was 16, together with safeguards to ensure that such recruitment was not coerced or forced. Effectively, this means that the United Kingdom cannot plan recruitment or assignment to the field army in the expectation that those under 18 will become engaged in hostilities. The precise meaning of hostilities in an era of unconventional warfare is not to be found in the Optional Protocol. In the course of this Review, the Adjutant General agreed that it was a moot question whether it may extend to armed guard duties in the United Kingdom, where the purpose of arming the soldier is to enable him or her to fire on anybody who is attacking the unit being defended.³⁶ It may not just be in respect of assignment to active service abroad that the Convention can provide a valuable source of guidance with respect to the specific content of duties to look after the welfare of minors.
- 4.45 Phase 1 training of 16 year olds at ATR Bassingbourn and AFC Harrogate today looks very much like a specialised part of continuing education in a boarding school environment. The Headmaster or Board of Governors of a boarding school owes a duty of care,³⁷ for example to ensure that pupils and staff do not harm themselves, or each other, by unrestricted sexual conduct. Further, in hiring staff at such a school, the employer is under a duty to make enquiries into criminal records and other relevant data to check whether someone is a risk to students because of proven or reasonably suspected previous conduct.³⁸ There is little doubt that, just as a residential school could be vicariously liable for sexual assaults committed on children by staff members in the course of employment, the school could, itself, be liable as a principal if it did not take responsible care to protect students from abuse of authority, seduction or similar acts by staff who were engaged to look after the students. In practice, if the Commanding Officer of an establishment such as AFC Harrogate knew that a member of staff, by reason of sexual proclivities, was a danger to a minor to whom the Commanding Officer owed a duty of care, there would be a breach of that legal duty if he or she did nothing about it. Moreover, the Army, like any responsible employer, would be expected to take prudent measures within its powers and resources to ensure that those engaged in the day-to-day supervision of minors are suitable to do so.
- 4.46 However, a specific statutory duty to make the enquiries noted above does not apply in relation to those minors over school leaving age who are in full time employment.³⁹ Consequently there is no right for such employers to access sensitive police information about their employees who work with such minors. It would be very unfortunate if it were thought that because the employment of those over 16 year olds is possible, no particular duty of care is owed in respect of the selection of instructors and the nature of the training. Further, AFC Harrogate and ATR Bassingbourn are much more akin to residential training institutions to which the statutory duty to investigate criminal antecedents of staff does apply, rather than a normal workplace environment.

³⁵ United Kingdom Declaration made upon signature and confirmed upon ratification of the Optional Protocol.

³⁶ See also Appendix A4/3.023 A – B, where Brigadier Elderton told the Review that *"in my own personal view, as soon as you give a serviceman or -woman a weapon and full ammunition outside the training scenario, then, by definition, it must be operations."*

³⁷ Children Act 1989 s.87(1): *"Where a school or college provides accommodation for any child, it shall be the duty of the relevant person to safeguard and promote the child's welfare."*

³⁸ The need to improve procedures in respect of school age minors has been extensively reviewed by the Inquiry into the Soham murders conducted by Sir Michael Bichard, HC 653, 22nd June 2004.

³⁹ Criminal Justice and Court Services Act 2000, s.35 prohibits certain individuals from seeking regulated employment; s.36 defines a 'regulated position' as including training establishments and certain other institutions where children are detained or placed but for general employment purposes uses the under 16 definition taken from employment legislation.

- 4.47 The Review recommends that the Army applies, as a matter of best practice, no less rigorous checks on the background of its instructors who will supervise recruits and trainees under 18 than would apply in civilian life, particularly in a residential boarding school.⁴⁰ Such information could no doubt be accessed through RMP files and personnel records. If the present state of the law proves an obstacle, the Review would recommend that military service is identified as an exception to the position of employers generally.
- 4.48 In Phase 2 training, the analogy with a civilian boarding school is less clear. The trainees may range in age from just under 17 to just under 30 years of age. However, bringing adults and minors together in a Single Entry regime heightens the need to take special protective measures to those who are under 18. Even if the Barracks at which Phase 2 training is conducted is seen as a workplace that happens to employ under 18 year olds, there is a duty to take reasonable measures to prevent such employment resulting in exploitation, risk or other damage to the moral, spiritual or bodily welfare of a minor.⁴¹
- 4.49 Of course it is not just minors who need to be protected from abuse or risk to health and welfare. Men and women of all ages should expect to have reasonable measures adopted to protect them from harassment or abuse. But minors are in a special position because they need and deserve supervision to guard themselves against the follies to which youth may be prone.
- 4.50 It is obvious too, as the HCDC helpfully observed,⁴² that Deepcut Barracks is a very different workplace from an office or shop, or other environment, in which a minor over 16 may be engaged. Few workplaces operate on a 24-hour basis, where the employer can dictate where the worker sleeps and lives. Few workplaces give the power of disciplinary sanction of such a wide-ranging kind as is given to NCOs and officers in the Army. Few workplaces require activities where young people of both genders will have to live and sleep next to each other in close quarters on field exercises, or similar activity, where the opportunity for harassment and abuse is increased.
- 4.51 Promoting the best interests and welfare of the child is an international obligation on all public authorities in the United Kingdom. In the opinion of the Review, the Convention is a helpful compendium of what duties are owed to minors and is, therefore, of assistance to policy makers and advisers.
- 4.52 Article 3 of the Convention eloquently encapsulates the relevant principles:
- "1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.*
- "2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.*

⁴⁰ See Recommendation 12 at paragraph 12.68.

⁴¹ See for example Article 32 of the United Nations Convention on the Rights of the Child which requires States Parties to protect the child from hazardous conditions of work or work that is harmful to the child's health or physical, mental, spiritual, moral or social development. The general part of Article 34 provides that States Parties shall undertake to protect the child from all forms of sexual exploitation and sexual abuse. The United Kingdom gives effect to these obligations by measures under the Health and Safety legislation, as well as the common law duty of care.

⁴² House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol I, paragraphs 69-74.

"3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision."

The practical content of a duty of care to those under 18

4.53 The real question is what does promoting the best interest of – or discharge of a duty of care to – a minor mean in practice? The 1993 Single Entry Implementation Plan acknowledged some issues that would need to be addressed. It directed specific attention to accommodation:

"As a general principle, but excepting very small units, Phase 1 recruits will be accommodated in 'recruit areas', with trained soldiers in clearly separated accommodation. Recruits under Phase 2 training will be accommodated in 'recruit areas', within which:

- (i) Trained soldiers do not share rooms with the recruits.*
- (ii) NCOs are accommodated in separate rooms in sufficient numbers and in such a manner to ensure that recruits are properly supervised and have access to advice and guidance."⁴³*

4.54 Another feature of the duty of care regime for those under 18 that was, and has always been, acknowledged was the issue of consumption of alcohol: *"Soldiers under age 18 may not buy or consume alcohol: non alcoholic recreational facilities should be made available."⁴⁴* Overall, the 1993 Plan recognised that: *"What is essential is that COs [Commanding Officers] must ensure adequate pastoral care and supervision"⁴⁵* and that those in Phase 2 should be in clearly identified and properly organised units with a: *"... command structure with clear responsibilities for all non-instructional matters."⁴⁶* The 'risks' inherent in transition to such a change of approach were to be addressed by a combination of communication with parents, physical training, remedial platoons, reinforcement of auxiliary welfare services and a clear structure for care through the chain of command.

4.55 The Plan was clear that:

"The interests and the requirements of the Army are paramount, particularly trainability and employability. Only those applicants of quality and maturity will commence training under 16.91/2, probably 800 to 1000 per annum."⁴⁷

4.56 Despite this clarity as to whose interests the change was promoting, the Plan noted:

"A positive PR policy is required to convince parents, schools and careers advisors of the many advantages of SE [Single Entry] over the former Junior Entry."⁴⁸

⁴³ *Supra*, footnote 19, paragraph 15a.

⁴⁴ *Ibid*, paragraph 15b.

⁴⁵ *Ibid*, Annex B, Terms and Conditions, paragraph 4d. See also paragraph 6.78 below.

⁴⁶ *Ibid*, paragraph 25a.

⁴⁷ *Ibid*, paragraph 35.

⁴⁸ *Ibid*, paragraph 29.

- 4.57 Whether it convinced others is not known, but it is clear that the Army failed to convince many senior officers commanding today of the benefits of abolishing Junior Entry.⁴⁹ The policy papers seen by this Review do not adequately address the beneficial features of the old system, noted above, or the policy risks to young people of combined training in an atmosphere that is not centred on their status as minors and the potential harm that they may come to at the hands of others or themselves. It is perhaps disappointing, given the strength of feelings of those with whom the Review has discussed the issue, that the policy papers at the time did not give greater consideration to the features of the old system that might be lost in the new one. Moreover, even on such questions as alcohol, it did not acknowledge the possible feelings of disadvantage that may be felt by the 17 year old unable to drink with his or her comrades in the NAAFI,⁵⁰ as well as the practicalities of enforcement.
- 4.58 These changes in training came into effect in 1993, with the adoption of the Final Version of the Single Entry Implementation Plan, and were, therefore, fully operational by the time Sean Benton and Cheryl James joined the Army in 1994 and 1995, respectively.
- 4.59 There has, subsequent to 1993, been a re-think about Junior Entry into the Army. It is understood by the Review that in the mid-1990s it was recognised that abolition of a separate Junior Entry was detrimental to the Army. At the least, due to restrictions on the numbers of 16 year olds able to be employed, it resulted in the potential loss of some minors of school-leaving age who might have been interested in training for a military career, but for whom other choices had arisen. Primarily, these other choices might have included more attractive civilian employment, but in areas of high unemployment they might also have included deteriorating social skills leading to criminality or other conduct rendering them unsuitable for future service. Subsequently, two specialist training regimes were established for 16 year olds, both of which have been referred to earlier in this Chapter.

ATR Bassingbourn and AFC Harrogate

- 4.60 The first and longer established is ATR Bassingbourn, in Royston near Cambridge. During the Review's visit, it was informed that recruits undergo Phase 1 training there for approximately 17 weeks before being assigned to Phase 2 training elsewhere, including Deepcut for those in the RLC. The minimum length of the training seems to have varied between 26 and 17 weeks in the past. It is intended to extend this training period by a week. The second establishment is AFC Harrogate, opened in 1999 with wholesale site redevelopment of an old Royal Signals Apprentice College site, enabled with a Private Finance Initiative. Recruits are trained for some 42 weeks in military and supplementary educational skills. The Review visited both establishments and the sense of energy, purpose and commitment amongst recruits and staff alike was impressive. The social and recreational facilities, the additional civilian remedial educational training and the quality of on-site supervision and care at AFC Harrogate were particularly impressive.⁵¹
- 4.61 These specialist institutions for soldiers under 18 avoid the problems of Single Entry. There is no alcohol available to junior ranks and, therefore, no need to distinguish between those over and under 18 years. The Barracks are 12 person dormitories separated between the

⁴⁹ Examples of this in the RLC context can be found in the transcripts of this Review's interviews with Brigadier Evans Appendix A4/4.025 D – E, Lieutenant Colonel Govan Appendix A4/5.017 F – G and Lieutenant Colonel Laden Appendix A4/10.031 A – B. See also paragraph 6.76 below.

⁵⁰ The Navy Army Air Force Institute. This is the official trading organisation of HM Forces, providing retail and leisure services, including junior ranks' clubs, which are generally referred to as 'the NAAFI'.

⁵¹ The Review is also conscious that there have been issues at AFC Harrogate regarding self-harm and bullying. From enquiries made, it is satisfied that these issues are monitored and recorded and suitable investigations made.

sexes but reflecting a Section to which the recruit belongs. The sleeping accommodation is supervised by a resident NCO who becomes the supervisory figure in the recruits' lives throughout their time there and who gets to know them well. The permanent staff know that they will be only dealing with minors and can adapt their approach accordingly. They receive some training for this purpose and acquire the experience to learn and understand the young soldiers' needs and problems and help them through the shock of family separation and loneliness. AFC Harrogate, in particular, provides additional education for the young soldier by virtue of a well-resourced further education centre with civilian staff. The soldier learns to develop as a young person at the same time as acquiring the military skills and discipline to make a success of army life.

Phase 2 – the training regime at Deepcut

4.62 With this background of change to the Army's training and recruiting regime generally, it is appropriate to return to Deepcut Barracks and describe how the command and training structure was organised in the period relevant to this Review.

4.63 In 1995, the most senior officer at Deepcut was 'Commander of the RLC Training Group'. The Commander held the rank of Brigadier. He, and the staff of his headquarters, were based at Deepcut. In August 2001, the 'RLC Training Group' became the 'Defence Logistic Support Training Group' and is today known as the 'Defence College Logistics'. The Brigadier in charge is now known as the Commandant, rather than the Commander. The Commandant is responsible for the RLC's specialist Phase 2 and 3 trade training schools throughout the country, at places such as Leconfield, Kineton, Aldershot, Marchwood and elsewhere. Each training school is under the direct command of a Commanding Officer who reports to the Commandant. Some trade training is done at Deepcut itself at the School of Logistics. Figure 4.2 shows the structure of the RLC Training Group in 1995 and Figure 4.3 shows the structure of the Defence Logistic Support Training Group in 2001/2.

Figure 4.2: The structure of the Royal Logistic Corps Training Group in 1995

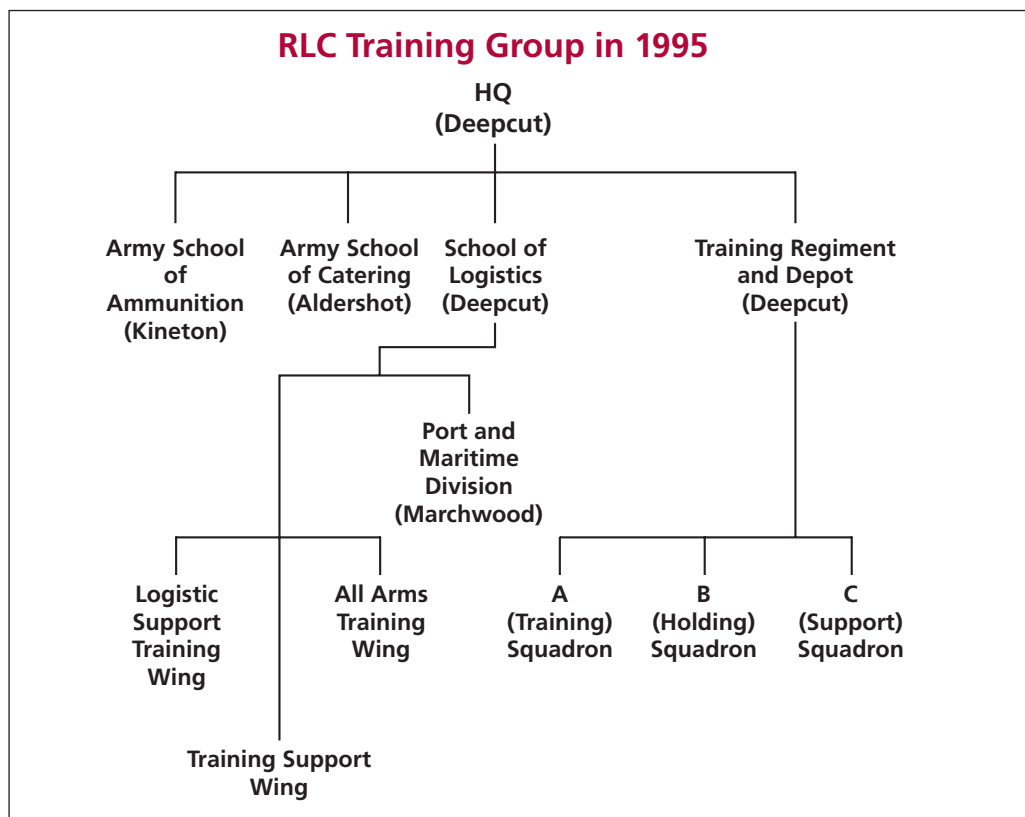
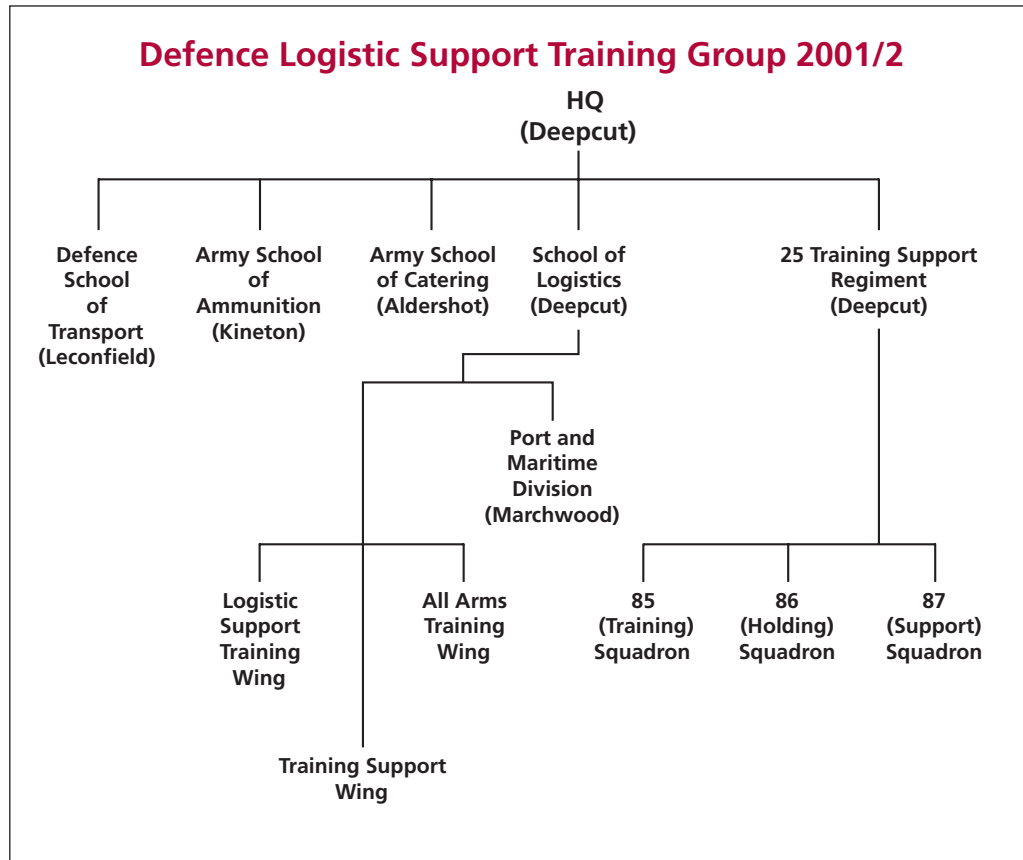


Figure 4.3: The structure of the Defence Logistic Support Training Group in 2001/2



- 4.64 The Commandant also has a linked function and a secondary role as Commander of Deepcut Garrison. The Garrison is a geographical command consisting of military units at Deepcut, Pirbright and Mychett. The Garrison falls under the responsibility of Headquarters 2 Brigade at Shorncliffe, near Folkestone. This Brigade reports, in turn, to the General Officer Commanding the 4th Division, based at Aldershot. The 4th Division reports up the chain of command to the Commander-in-Chief Land Command at Wilton.
- 4.65 Matters relating to the security of the Garrison, discipline of staff and funding for the development and maintenance of the estate are addressed by the Commander through the regional chain of command. Matters relating to training are channelled through the Commandant to the Director General of Army Training and Recruiting (DG ATR), based in Upavon, Wiltshire. The Brigadier, as Commandant, sits on the Management Board of ATRA along with other senior officers concerned with Army training and recruiting.
- 4.66 There is another Brigadier based at Deepcut whose function is of peripheral importance to the events considered by this Review. This Brigadier holds the post of Director of the RLC and is the functional head of the Corps, but has no command responsibility other than for the RLC Band. He is principally concerned with wider Corps issues, ceremonial matters and heads the Regimental HQ of the RLC. The Director RLC has no responsibility for the affairs of the Training Regiment, nor for security at Deepcut Garrison.
- 4.67 Much more significant to the events at hand is the Commanding Officer of the RLC Training Regiment and Depot. In about 1999, this was renamed the 25 Training Support Regiment (the Training Regiment). The Commanding Officer holds the rank of Lieutenant

Colonel and his Regiment comprised three Squadrons.⁵² In 1995, these Squadrons were known as 'A', 'B', and 'C' Squadron, but in 1996 had been changed to '85', '86' and '87' Squadron respectively.⁵³ Each Squadron has a Major as the Officer Commanding, a Captain as Second-in-Command and a Squadron Sergeant-Major of Warrant Officer Class 2 rank. The trainees in B (86) Squadron were distributed into two Troops each headed by a Lieutenant, with a Troop Sergeant and Section Corporals. A (85) Squadron was concerned with trained members of the Army who were on Phase 3 training. C (87) Squadron provided a depot function and housed a mixed bag of those who were long term sick awaiting medical discharge from the RLC, those facing Court Martial or confirmation of authority to dismiss from the RLC and those about to retire or re-engage.⁵⁴ The depot function has now been considerably reduced and those awaiting Court Martial, sentencing or dismissal following sentencing will remain with their unit in the field army, unless they can be transferred elsewhere other than Deepcut. However, this change only occurred sometime after 2002.

- 4.68 86 Squadron, or B Squadron as it was known in 1995, is the principal Squadron of concern to the events at Deepcut that are of interest to this Review. Its function was to support RLC soldiers in Phase 2 training within the Training Regiment up until their first posting into the field army. It did not provide trade training itself, but administered and accommodated trainees at Deepcut whilst they were trained there or awaited training elsewhere or, following training, awaited posting to a unit of the field army. Whilst soldiers were awaiting trade training they had to be occupied somehow. Continuation training was organised to ensure they did not forget the military skills learned at Phase 1, and sporting or other diversions were provided from time to time. Other activities were menial tasks concerned with the maintenance of the Barracks, or working in the Quartermaster's Stores. Certain soldiers were selected for trips out to help with events such as horse shows, or adventure training such as sailing expeditions. However, throughout the period under review, the principal function of soldiers who were in B (86) Squadron, and not actually undergoing trade training, was to provide a pool of soldiers from whom the roster was made up to provide the necessary 24-hour guard duty of the Garrison. This is an activity of central importance in the events subject to this Review. It is the thread that links the four deaths. Each of the young people who died was performing or purporting to perform guard duty when they died.
- 4.69 The Commanding Officer of the Training Regiment has his own Regimental HQ at Deepcut in which a Second-in-Command of the Regiment (a Major), the Adjutant (a Captain) and the Regimental Sergeant-Major (of Warrant Officer Class 1 rank) are the principal personalities. The Commanding Officer would report up the regional chain of command to the Commander 2 Brigade for matters of discipline of senior staff, or recommendations for Court Martial, and was accountable to 2 Brigade for implementation of orders relating to security and guard duty.⁵⁵ The Regimental Sergeant-Major is the senior soldier in the Regiment and head of the Sergeants' Mess. He sets the tone for all NCOs and soldiers in the Regiment.⁵⁶

⁵² A fourth Squadron of the Regiment was subsequently created to accommodate the trainee chefs ('110' Squadron) but in 1995 they were all part of 'B' Squadron.

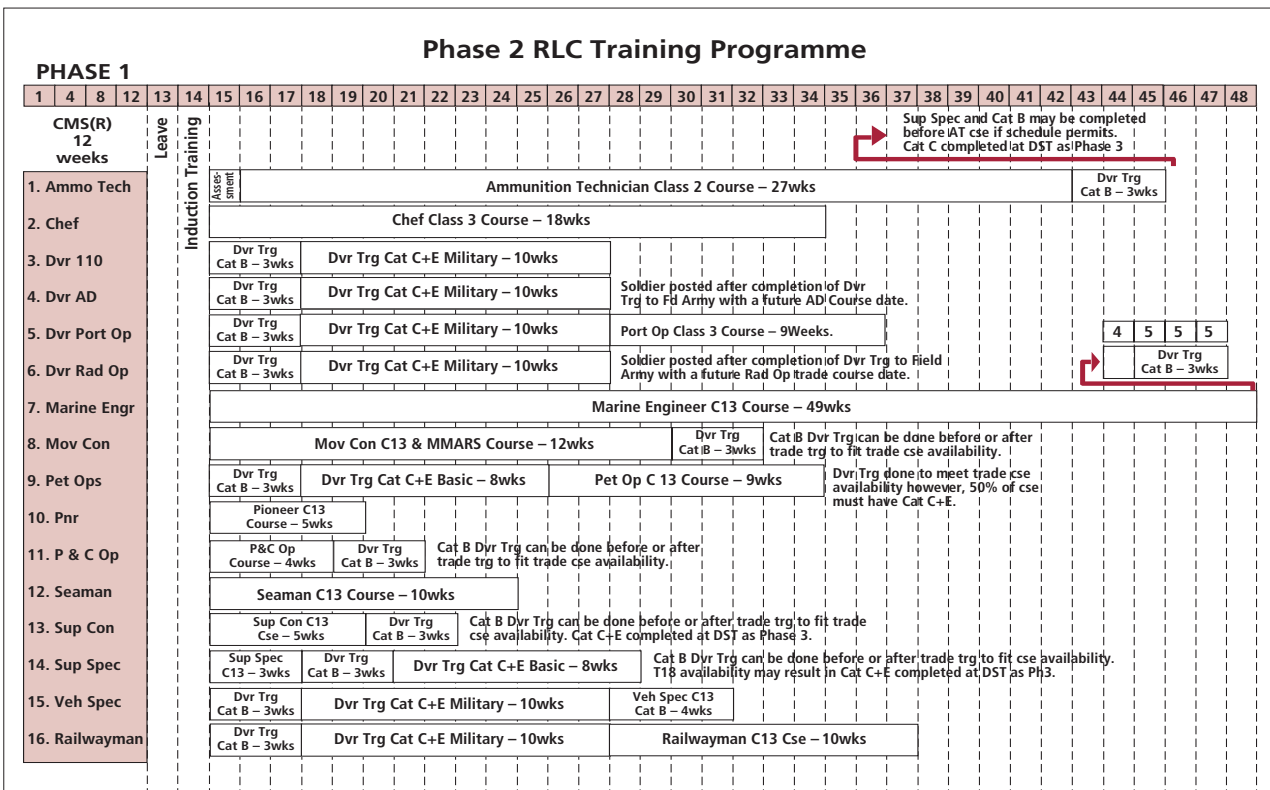
⁵³ The Squadrons were renamed as an implementation of the Evans Report, 14th December 1995, 'A Review of the Phase 2 Training System within Deepcut', recommendation 34(b), Appendix A11.010. For the rationale behind the renaming, see the transcript of this Review's interview with Brigadier Evans, Appendix A4/4.024 F – G.

⁵⁴ For a similar description of the functions of the three Squadrons in 1995, see Appendix A11.001, paragraph 2. In conversation with this Review, Brigadier Dalby-Welsh describes the function of the depot as being to "*hold the sick, lame, lazy*", see Appendix A4/2.031 F.

⁵⁵ See paragraph 4.64 above.

⁵⁶ See Appendix A4/1.028 F – G, where Brigadier Brown explains the influence of the Regimental Sergeant-Major. See also paragraph 6.131 below.

Figure 4.4: Trades and training periods for Phase 2 trainees at Deepcut today



- 4.70 Commanding the Training Regiment at Deepcut from 1995 to 2002 was a challenging command post for a number of reasons. The Regiment was neither a field army unit, available for deployment on operations, nor was it providing trade training itself as a stage in a soldier's career development. Instead, it was rather a holding centre for people waiting for something to happen elsewhere, be it getting on, getting well or getting out. The RLC Training Regiment received its Phase 1 trainees from nearby ATR Pirbright, in accordance with the 1993 reforms noted above. Phase 1 at ATR Pirbright was a very intensive ten-week period of tasks, targets and transition. There was much to learn in a short period. The day was structured and tiring. There was little free time for recreational activity. Everyone was focused on the next test and the hope of passing out without being back-squadded⁵⁷ for injury, inability or disciplinary reasons. For some, the Phase 1 training may have led to the realisation that the Army was not for them, or that they could not reach the levels of fitness and discipline demanded of them in their new career. This Review has not focused on ATR Pirbright and whatever individual problems and incidents may have arisen there from time to time. The available evidence suggests that each of the four young people this Review is primarily concerned with responded well to the challenge of Phase 1 training. It may have been exhausting and demanding, but it was never boring. None of the families of the four soldiers who subsequently died at Deepcut have expressed concerns to this Review about ATR Pirbright and it appears to have been a positive experience for each of their children.
- 4.71 By contrast, arrival at Deepcut represented a very significant change of pace. Progress through Deepcut was unpredictable as to length. Figure 4.4 shows the 16 trades and approximate training periods for Phase 2 trainees at Deepcut today. Almost every week new trainees arrive from ATR Pirbright assigned to one of these trades. The Training Regiment has to ensure that trainees are booked into the relevant training school, have the necessary driving licence⁵⁸ or other preliminary skills to undertake their chosen trade, pursue any secondary training needed to complete the trade training and pass on. Loading onto courses can be frustrated by the numbers arriving through ATR Pirbright being different from those anticipated, either because of delays or back-squadding, or as a result of trainees opting to change their chosen trade. The loading of trainees on to courses is very tight with very little room for spare capacity.⁵⁹ If a trainee misses or fails a course in trade training, it may be some time before a space is found for another chance to pass the course successfully. The Review understands that even today, with computer programming of this logistical challenge, problems can regularly arise that take time and human resources to address. The inference is that these were even more challenging tasks in 1995 when resources, both technical and human, were in shorter supply.
- 4.72 The result was that trainees could be at Deepcut for days, weeks or even months without pursuing the trade training they were intended to do. This is the phenomenon of Soldiers Awaiting Trade Training or SATT, a term that will appear from time to time in this Report. What was supposed to happen was that 'continuation training' was provided by the Regiment in the meantime: refresher weapons training, field craft and so on, whilst trainees were encouraged to keep fit by regular physical training and runs. However, the ability of the Training Regiment to deliver effective and stimulating continuation training depended on the number of regimental staff available to deliver it and the financial resources to provide it. The data available to this Review suggests that throughout the period 1995 to 2002 the number of staff available to the Regiment was substantially

⁵⁷ Put back in the programme for re-training and, as a consequence, not completing Phase 1 simultaneously as the recruits they had commenced training with.

⁵⁸ See Appendix A4/1.005 A – F for an explanation of the separate issue of obtaining B licences.

⁵⁹ See Appendix A4/3.037 A – C, where Brigadier Elderton explained how the capacity issue could arise depending on which trade the trainee was destined for or wished to pursue.

below what was required to deliver an efficient and effective regime for Phase 2 trainees. Particular attention is given to the concerns of Commanding Officers and others about staffing numbers in Chapter 9.

- 4.73 This is not a new conclusion. It is well known to all informed students of the events at Deepcut. Each time the Army has reviewed these events, or the training estate generally, senior officers have reached the same conclusion.⁶⁰ The question is whether the shortage of staff contributed to the circumstances in which the deaths occurred and, if so, was such a contribution foreseen or should it have been? Before reaching any conclusions on this issue it will be necessary to examine the circumstances of the individual deaths, so far as they can be ascertained. However, this Chapter can give a general picture of the scale of the difficulties faced and the likely consequences for the regime as a whole.
- 4.74 Estimates of the numbers of trainees passing through B Squadron in Deepcut in 1995 or later, are imprecise. The first documentary reports to the ATRA Management Board date from 1997 and vary in the details supplied. For the last seven years, the Regiment has processed an average of 1,400 trainees per year. There have been times in the past when the numbers were higher. Supply is based on advance estimates of the needs of the field army, and the ability of the Recruit Selection Centres (RSCs) to meet the numbers needed while adhering to the requisite standards. From the available data, and the information supplied to the Review by successive Commanding Officers, it seems that B Squadron consisted of some 500 to 800 trainees at any one moment in the training year, suggesting that the two Troops were formally responsible for some 250 to 400 trainees each. Numbers appear to have increased from 1995 through to 2001, although there were peaks and troughs in between. Whatever the precise numbers, it has been made plain to this Review that the Troops commanded in B Squadron were not really Troops in the sense of the normal staff ratio and degree of supervision and control expected in the field army.⁶¹ Instead of the ratio of one Corporal per 12 soldiers, as found in the field army, it seems likely that in B Squadron there were times when the ratio would be 1:100, and rarely less than 1:80. At night, when married staff returned to their quarters, the ratio could be stretched to over 1:200.⁶²
- 4.75 Of course, the nature of the Training Regiment is very different from a Phase 1 establishment, like ATR Pirbright, or a formed unit of the field army. At times, trainees would be away attending driver courses at Leconfield or elsewhere rather than remaining at the Barracks. In a sense, this feature exacerbated the problems at Deepcut, in that there was little opportunity for Corporals or Sergeants to get to know the trainees and relate to their interests, problems and aspirations. In common with other cap-badges from 1993, staff at Deepcut no longer trained recruits at Phase 1 and, therefore, missed out on the opportunity to get to know them in this initial process. Deepcut staff relied on reports from the ATR Pirbright staff as to who the trainees were and whether they had problems or outstanding talents.⁶³ Unlike some other Phase 2 training establishments, this knowledge deficit was not made good in Phase 2 because trainees did not receive much of their trade training there, and were instead dispersed to other training sites around the country.

⁶⁰ The formal milestones in this process were the Evans Report of December 1995 (see Appendix 11 to this Report), the Haes Report of February 2001 (see Appendix 13 to this Report), the Deputy Adjutant General's final report of December 2002 (see Appendix 15 to this Report) and the Directorate of Operational Capability's report of an Appraisal of Initial Training of December 2002.

⁶¹ This was, *inter alia*, stressed to the Review in meeting with Major Gascoigne, see paragraph 6.6 below.

⁶² See Appendix A15.012 paragraph 26, where the Deputy Adjutant General's Final Report refers to overnight supervisory ratios of 1:200 or more.

⁶³ See Appendix A4/4.002 A – B, where Brigadier Evans indicated to this Review that the contact between ATR Pirbright and Deepcut was fairly limited and mostly concerned the allocation of trades.

- 4.76 Trainees were accommodated in small dormitory-style rooms in accommodation blocks at the Barracks. Figure 1.1 is a plan of Deepcut showing significant buildings and places of interest. The male accommodation consists of eight beds to a room. Each bed has a cupboard for personal storage and kit. Privacy and security were problems. Washrooms were communal. The premises had been built in the 1960s and are in need of modernisation and updating. The plumbing regularly broke down. Sometimes the toilets became blocked or dysfunctional toilet. There was a room for a block senior or NCO but there have long been problems supplying personnel for this post at night, so in 1995, at least, the trainees were unsupervised. Rooms were assigned according to trade and training programme. At times in the past an accommodation block had been reserved for the under-18s but this is currently considered counterproductive. Left alone, young soldiers could misbehave and had no role models to emulate. Mixing them with mature soldiers was found to provide a sensible example. In the opinion of the Review, assigning supervisory staff to residence overnight in a young persons' block, as is done at AFC Harrogate, may be the most appropriate third way.
- 4.77 The female accommodation is similar in style, although there are fewer beds to the room and in 1995 to 1999 it seems that there were often two to four women in a room. Again, there was a room assigned for a female junior NCO or block senior (a Private soldier judged to be sufficiently mature to exercise some kind of positive influence) but there was a particular shortage of female NCOs and female commissioned officers at Deepcut. Access to the female accommodation was via an entry phone and buzzer system. There is now a video camera ensuring surveillance is maintained at the entrance to the block but this was not in place until after the death of James Collinson.⁶⁴ The female accommodation is out of bounds to males, and vice versa, by virtue of standing orders, which it is an offence to breach. Permanent staff accommodation is meant to be out of bounds to trainees, and vice versa, save on supervisory and security duties, but both rules seems to have been regularly broken throughout the seven years with which this Review is primarily concerned.
- 4.78 The question of sexual fraternisation between training staff and female trainees is very much an issue in this Review. The material seen by this Review strongly suggests that it was a consistent and persistent feature of Deepcut throughout the period of the events in question. Whether it was, in addition, a circumstance that contributed to these deaths is a matter that will have to be considered in due course.

Sexual behaviour policy

- 4.79 The law and policy with respect to sexual activities in the Army was itself a little confusing. Sexual activity between a man and a woman was not prohibited if the parties were over 16 and consenting. However, a pastoral responsibility of "*in loco parentis*" owed by the Commanding Officer towards minors involved some responsibility to ensure that they were not sexually exploited, were not staying overnight in premises where their whereabouts were not known, and to take other reasonable measures to promote their health and welfare with respect to sexual activity.
- 4.80 There is some tension between the Army policies relating to sexual relations. In October 1993, the Adjutant General issued a paper on Discipline and Standards in Military Life that he expected all Commanding Officers to bring to the attention of people under their command.⁶⁵ The paper reflected on the gap between the traditionally strict moral code of acceptable behaviour in the military and the increasing tolerance of civil society generally.

⁶⁴ See the Deputy Adjutant General's interim report, 11th October 2002, paragraph 7d. The role such surveillance could have played is considered in Chapters 6, 7 and 8.

⁶⁵ The Discipline and Standards paper D/AG/4/5/1 dated 21st October 1993.

Paragraph 31 referred to certain liaisons damaging morale but, surprisingly, there was no express condemnation of sexual relations between NCOs and trainees. The next paragraph was concerned with the damaging effects of adultery, then, in paragraph 33 the paper stated (with emphasis added by the Review):

“33. Other Sexual Relationships. The Army is based on a clearly defined hierarchical structure, with distinctions between the different ranks that are well understood and accepted, as is the particular division between officers and non-commissioned ranks. Sexual relationships which undermine this well-ordered structure cannot be tolerated. While there would be no objection to a consensual liaison between a junior non-commissioned officer and a private of opposite sexes, the same would not be true of a similar liaison between an officer and a non-commissioned rank. Such relationships diminish the authority and standing of the superior in the eyes of his subordinates resulting in a loss of credibility and trust. While marriage between an officer and a non-commissioned rank is not prohibited, such relationships will inevitably cause difficulties, as the couple will not be permitted to serve in the same unit, and are therefore to be discouraged.”

- 4.81 A Phase 2 trainee is a Private soldier. On the face of it, a Corporal, or possibly even a Sergeant, might consider that they could legitimately invite social and sexual relations with Phase 2 trainees of the opposite sex (irrespective of age as they will all be over 16) without breaching Army policy. At the very least they may consider it is a grey area depending on the exercise of discretion.
- 4.82 None of the Commanding Officers of the Training Regiment at Deepcut interviewed by this Review indicated that they tolerated sexual relationships between NCOs and Phase 2 trainees, anywhere, or, indeed, between trainees in military accommodation. But what they did about it, and how far active steps were taken to suppress or deter it may be a matter of greater doubt. Until Lieutenant Colonel Laden’s tour of duty as Commanding Officer of the Training Regiment, from June 2001 to September 2003, there is no consistent surviving record that NCOs were being regularly punished for fraternisation with trainees. However, from mid-June 2001 there was a steady stream of occasions when NCOs were brought before the Commanding Officer in connection with relations with trainees.⁶⁶ Even then, the sanction appears mostly to have been a fine and ‘sacking’, i.e. removal from their post in the Training Regiment, rather than loss of rank or military career, and it is debatable how much of a deterrent this was, given the regularity of the offence. It is unlikely that Lieutenant Colonel Laden had the misfortune to preside over a deterioration of standards in this respect. Indeed, the evidence that is available today suggests that this was not so.
- 4.83 It is noteworthy too that the earliest Code of Practice for Instructors seen by the Review, which forms part of AITO’s Employment Charter, dated 10th September 1996, makes no mention of the issue of instructor-trainee relationships. The first version of the ATRA Code of Practice for Instructors, issued in 1998, appears to have introduced this topic for the first time:

“Personal Relationships in Training. The relationship between an instructor and a trainee is inevitably a close one. Some trainees, particularly young recruits, can develop a sense of awe and hero worship which goes beyond professional respect and admiration. Instructors must recognise

⁶⁶ This analysis is based on the records of disciplinary interviews in the Commanding Officer’s interview book between 1995 and 2002. Precise comparisons are difficult as the books prior to Lieutenant Colonel Laden’s tour do not identify the nature of the offences in any detail. The interview books of the Officer Commanding B Squadron in 1995 have not been retained.

this and not allow their egos to be inflated which might lead to an unhealthy abuse of their authority or the trainee taking advantage of the situation. At all times a professional distance must be rigorously maintained. Failure to do so can lead to unacceptable personal relationships, accusations of favouritism or even allegations of misconduct.”⁶⁷

- 4.84 The Review is unsure how the unacceptability of such relationships was expressed in practice, although Commanding Officers have informed the Review that they briefed staff that such relationships were, indeed, unacceptable.⁶⁸
- 4.85 In the opinion of this Review, unless unacceptable conduct is defined in clear and unambiguous terms as a serious breach of duty, then the message given in oral briefings may be undermined by day-to-day practice. If the conduct is not regarded as particularly serious, then resources will not be devoted to preventing it, investigating it or pursuing the most appropriate sanctions by way of punishment. This Review has seen no evidence that an NCO has ever been subject to Court Martial for such conduct.⁶⁹
- 4.86 Persistent unwanted approaches by an NCO, or anybody else, could fall within the policy on sexual harassment. The Conduct and Behaviour section to the current ATRA Handbook, states:

“Harassment. Harassment can be defined as unwanted behaviour by one individual, whether intentional or not, that creates feelings of anxiety, humiliation, awkwardness, distress or discomfort in another. It can have devastating consequences for the individual concerned. Some typical examples of harassment are:

- a. Verbal or physical threats or abuse, including derogatory or stereotypical statements or remarks.*
- b. Innuendo, mockery, lewd or sexist/racist jokes or remarks.*
- c. Personal comments about a person’s physical appearance or character which cause embarrassment or distress.*
- d. Leering, rude gestures, touching, grabbing, patting or other unnecessary bodily contact such as brushing up against others.*
- e. Unwarranted, intrusive or persistent questioning about a person’s marital status, personal life, sexual interests or orientation, or similar questions about a person’s racial or ethnic origin, including their culture or religion.”⁷⁰*

- 4.87 However, sexual liaisons with training staff may well not be unwanted. They can be perceived as flattering or considered to give the trainee an edge with comrades. They may generate expectation of mutual favours and create discontent amongst those not favoured.

⁶⁷ The Review is aware that the ‘G1 – Personnel’ section of the ATRA Handbook contains a more detailed instruction entitled ‘Relationships between permanent staff and recruits’, version dated January 2004.

⁶⁸ See Appendix A4/9.032 A – D as an example.

⁶⁹ At a meeting, early in the Review, with ATRA, the Chief of Staff (ATRA) gave the Review the benefit of his opinion that a Court Martial would be an appropriate sanction for an ATRA NCO. This view was reiterated by Brigadier Advisory at the Adjutant General’s Headquarters, see Appendix A4/15.002 D – E.

⁷⁰ ‘G1 – Personnel’ section of the ATRA Handbook, ‘Conduct and Behaviour’, version dated October 2003, paragraph 7.

- 4.88 By contrast, homosexual relationships within the Army were forbidden at this time, although not generally for consenting adults in civil society.⁷¹ There was no ambiguity about what was unacceptable or the consequences of transgression. The Adjutant General's 1993 'Discipline and Standards' paper stated:

*"Homosexuality, male or female, is incompatible with military service because of the close physical conditions in which soldiers often have to live and work. Homosexual behaviour can cause offence, polarise relationships, induce violence, and as a consequence morale and unit effectiveness suffer. Anyone who admits to, displays the orientation of, or indulges in homosexuality will be required to resign or be discharged. Homosexual activity which is illegal under civil law or which has aggravating disciplinary features may also lead to prosecution."*⁷²

- 4.89 The above discussion is primarily concerned with sexual acts between trainees and permanent staff. There is also the question of acts between trainees and those of equal rank and status. The position at Deepcut and Leconfield was that the accommodation of the opposite sex was out of bounds by reason of a standing order. Trainees caught in the wrong accommodation would, therefore, face a disciplinary charge and financial penalty for breach of that Orders. There appears to have been persistent breaches of this Order in the period under review in this Report. Sexual relations off the camp between trainees were not the subject of sanction.
- 4.90 Leaving aside the special position of minors, there are some difficult issues of private life and public sanction that have to be addressed if a trainee is spending many months in a holding centre before progressing their military career. People who are assigned married quarters will be able to lead their private and sexual lives as they see fit. Single officers are able to sign in guests for overnight stays. There is some evidence in the guardroom daily occurrence logs from Deepcut that the guard deterred members of the permanent staff living in the assigned accommodation from bringing in partners overnight.
- 4.91 There is evident good sense in maintaining a ban on entry to the other gender's accommodation given the risk of unwanted sexual molestation or sexual assault. There is some evidence that women trainees were concerned about these risks. This leaves couples either the somewhat degrading practice of having sexual relations in the Garrison grounds, of which there has been substantial evidence,⁷³ or insisting that they opt for hotel accommodation off base, which may be both expensive and discriminatory compared with the position of some members of the permanent staff.
- 4.92 Certainly when the Review team visited Deepcut, an issue that appeared in private conversation with some trainees was the lack of privacy afforded to trainees generally by the nature of the accommodation.

Alcohol policy

- 4.93 The Adjutant General's paper on Discipline and Standards in Military Life⁷⁴ also noted both the dangers of alcohol and its regular use in the Army as a means of bonding and relaxing.

⁷¹ It was only following the case of *Smith and Grady v United Kingdom* [2000] 29 EHRR 493 that the United Kingdom removed such policies. Civilian criminal law has seen changes in the age of consent and only recently has it been equalised for heterosexual and homosexual behaviour.

⁷² *Supra*, footnote 65, paragraph 30.

⁷³ See for example Appendix A4/9.032 E – G.

⁷⁴ *Supra*, footnote 65.

- 4.94 At Deepcut, the NAAFI was the centre of most social activity, where alcohol was sold more cheaply than elsewhere and the profits from the sale would benefit facilities for the Privates. Although drunkenness on duty was a serious disciplinary offence, it is apparent that excessive drinking was the source of significant disciplinary problems at the Barracks, many of which were captured in the guardroom daily occurrence logs seen by this Review. Alcohol abuse is likely to occur when there are few other diversions, occupational or recreational.
- 4.95 One informant, who was a training Sergeant at ATR Pirbright but knew Deepcut well in 2001, told this Review:⁷⁵
- "Deepcut was run by the recruits. It was out of control. No control at all. After working hours it was just like Glasgow or London on a Saturday night. This was every night. For example at the disco at the NAAFI mid-week. Recruits were completely drunk. Both sexes. Staff would be needed to stop fights. Recruits have careers mapped out at Phase 1 to get them to the field army. They intentionally fail at Leconfield to carry on at Deepcut. Little work done. There was a party atmosphere."*
- 4.96 When asked about violence or fraternisation by staff, the same informant noted:
- "Pressure on instructors tremendous. Working hours. Bullying at Deepcut was from recruits to recruits. Don't know of bullying by staff. Violence by staff would be in the context of breaking up fights or defending themselves from violence. Fraternisation between recruit and recruit was rife. Men deprived of sex then chance to meet young women. Party atmosphere and alcohol. Sex would be everywhere would get the chance. No fraternisation by staff I was aware of."*
- 4.97 This information is cited because it links the themes so far discussed in this Chapter: lack of purpose for trainees whilst on SATT, shortage of staff and supervisory personnel, sexual licence and alcohol. Whether this was an accurate picture of life at Deepcut from 1995 to 2002, it would be difficult to say, but it is a description supported by individual accounts through this period and the general evidence derived from the guardroom daily occurrence logs.⁷⁶
- 4.98 Denial of alcohol to minors was a clear policy of the 1993 Single Entry Implementation Plan. Service of alcohol to such people is, of course, against the law, as well as Army policy. It seems that whilst they can enter the NAAFI, if minors buy a drink, or have one bought for them, there is a risk that they will be recognised by the staff, who have been briefed to watch out for them, or will be caught in a spot check of their ID.⁷⁷ This does not address alcohol that is brought into the base and consumed at parties in empty accommodation blocks or, indeed, under-18s going off to pubs and nightclubs in Camberley and beyond. There is a clear limit to what can be expected by way of enforcement of this policy.
- 4.99 For this Review, the practicalities of enforcement raise the issue of whether Single Entry, combining those above and below the age of 18 in one unit, was itself practicable or desirable. If moderate consumption of alcohol does, indeed, serve to bind the unit together, as suggested in the Adjutant General's paper, it would seem unfortunate to devise a training regime that excludes some members. If there is a duty of care to give

⁷⁵ The information was recorded in a telephone call received from the Sergeant in response to the Review's call for information. See paragraphs 1.41 and 6.130 above.

⁷⁶ The account given by Major BA to the RMP about such events in 1999 is noted at paragraph 8.21ff below.

⁷⁷ Major Gascoigne explained the procedures for this in meeting with the Review.

special attention to the welfare of minors in the Army, it would seem unwise to expose them to the temptations of adult pleasures and recreations with their comrades with whom they work, train, and rest.

Bullying and other harassment

4.100 The Army has long been aware of the risks to recruitment, training and retention posed by bullying and harassment. The topic has also been of concern to Members of Parliament from at least 1982.

4.101 In 1988, a paper produced on behalf of the Adjutant General, titled 'Bullying and Initiation Ceremonies in the Army',⁷⁸ informed Commanding Officers of measures adopted by the Army Board to reduce the risk of such behaviour. It noted that where such bullying occurred:

*"The fact that such behaviour appears in some cases to have gone unnoticed is due in part to a fall off in 'off duty' supervision and reduced communication and contact between officers, WOs, NCO and their soldiers."*⁷⁹

4.102 The summary of measures to be adopted make familiar reading in the light of what has followed:

- additional manpower to the ITO;⁸⁰
- increase in WRVS services catering for single soldier;⁸¹
- improved training and selection of instructors;⁸²
- improve recruit selection to weed out unsuitable soldiers;⁸³ and
- improved medical information on recruit selection;⁸⁴

4.103 To deter such conduct the following measures were to be implemented forthwith:

- banning of initiation ceremonies;
- the handling of alcohol abuse; and
- the need for closer after hours supervision and the need for formal inspection of accommodation.⁸⁵

4.104 It was envisaged that young officers and soldiers in Barracks provided necessary supervision and contact during off duty hours. Finally, all allegations of bullying and initiation ceremonies were to be reported, referred to the RMP for advice and, where substantiated, *"dealt with firmly."*⁸⁶

⁷⁸ Reproduced as Appendix A7 to this Report.

⁷⁹ See Appendix A7.001 paragraph 2.

⁸⁰ See Appendix A7.002 paragraphs 4 – 6.

⁸¹ *Ibid*, paragraphs 7 – 8.

⁸² See Appendix A7.003 paragraphs 10 – 13.

⁸³ See Appendix A7.003 – 004 paragraphs 14 – 15.

⁸⁴ See Appendix A7.004 paragraph 16.

⁸⁵ *Ibid*, paragraph 17c.

⁸⁶ *Ibid*, paragraph 18c.

4.105 There were reaffirmations of this policy in letters and memos sent down the chain of command from time to time. Such circulars appear to have been the genesis of what became the ATRA Code of Practice for Instructors, of which, as noted, the earliest published version seen by the Review is 1998. It is worth citing the following paragraphs from that statement of policy in 1998:

"2. ... For so long as they remain within the ATRA, both civilian and military instructors are to be in possession of a personal copy to this Code and they will be expected to match the ethos and standards set out within it.

"7. **Fairness.** Whilst the instructor will remember that he is training people for war – harsh, unforgiving; literally a fight to the death – the instructors must never physically strike a trainee, must never take unfair advantage of the instructor's position of authority over the trainee and must never lose compassion for the weakness of the trainee relative to him/herself.

...

"17. **Equality in Training.** All trainees of whatever rank, gender, religion or ethnic origin must be accorded fair and equal treatment. To do otherwise goes against team-building. No discrimination, harassment, intimidation or humiliation of any kind will be tolerated anywhere in the ATRA.

...

"19. **Respect in Training.** It is important that a relationship based on mutual respect exists between instructor and trainee. This will come naturally to the good instructors who will continually seek to develop the trainee's self-respect with constructive criticism and forceful encouragement. Nothing is achieved by physical humiliation or the use of violent, filthy or abusive language, apart from the instructor losing the respect of his or her trainees.

"20. **Discipline in Training.** An instructor must be entirely clear as to his disciplinary powers as published in the orders and regulations of his Training Centre. Unofficial disciplinary procedures can be interpreted as bullying or as an abuse of authority and, for these reasons, all disciplinary action must be clearly recorded and open for inspection.

"21. **Personal Relationships in Training.** The relationship between an instructor and a trainee is inevitably a close one. Some trainees, particular young recruits, can develop a sense of awe and hero worship which goes beyond professional respect and admiration. Instructors must recognise this and not allow their egos to be inflated which might lead to an unhealthy abuse of their authority or the trainee taking advantage of the situation. At all times a professional distance must be rigorously maintained. Failure to do so can lead to unacceptable personal relationships, accusations of favouritism or even allegations of misconduct.

...

*"24. **Welfare in Training.** An instructor is responsible for the general welfare of his trainees, particularly the younger ones who are away from home for the first time. Organisations such as the Army Welfare Service and the Council of Voluntary Welfare Work may be able to provide extra help and facilities at first hand."⁸⁷*

- 4.106 In conversation with Commanding Officers and the staff of the Adjutant General's HQ, it has been stressed to this Review that the Army has a policy of zero tolerance of bullying and initiation ceremonies.⁸⁸ It is not the case that the British Army condones or even uses bullying as a matter of policy or a means of natural selection of those who cannot take the stress of combat and an interdependent disciplined life. DG ATR and Commanding Officers responsible for delivering ATRA's values stress the philosophy is *"train in, not select out."*⁸⁹ This Review has seen no evidence that Commanding Officers at Deepcut, or elsewhere, turn a blind eye to bullying by recruits or NCOs, and, in the period under review, tolerated or condoned it. Indeed, the narrative of events in Part 2 of this Report will disclose cases of prompt action by Commanding Officers once information has come to their attention which suggests potential abuse.⁹⁰
- 4.107 The difficulties in the deterrence of bullying and harassment seem to be rather with respect to the following questions:
- What is regarded as bullying and what is considered an acceptable sanction?
 - How does the Commanding Officer come to know of allegations of harassment and bullying?
 - How are such cases investigated?
 - What evidence is there that they are dealt with firmly up the chain of command and, thus, have the deterrent effect intended?
- 4.108 Although the Army is a disciplined organisation, it seems reasonably clear that the issue of circulars, instructions, handbooks and the like is not sufficient to deter abusive practices. Much depends on the determination of the individual Commanding Officer to actively monitor and report on allegations of abuse, and to ensure that there are sufficient resources in place to deter it by one means or another. It will depend on the culture of reporting and disclosure in the Regiment, and the determination of all other people holding positions of responsibility within it, to do all reasonably possible within their powers to deter such conduct.
- 4.109 There has been a problem in the past as to how far NCOs are able to administer sanctions for petty irregularities: lateness on parade, untidiness, poor performance in training and the like. The present policy of recent vintage enables instructors to administer sanctions under the Army General and Administrative Instruction (AGAI) procedures with a record kept of the measure and the reasons, without having to refer the trainee up the chain of command for formal sanction. Historically, the alternative to the use of the sledgehammer of formal sanction to crack a fairly innocuous nut, was informal punishment by the NCO. As the ATRA Code of Practice for Instructors in 1998 noted, however, irregular sanctions

⁸⁷ Annex A to Serial 1 ('ATRA Employment Charter') of the ATRA Handbook, July 1998.

⁸⁸ See for example Appendix A4/15.035 D – F.

⁸⁹ *Ibid*, F – G.

⁹⁰ For Lieutenant Colonel Josling see the measures he took against Regimental Sergeant-Major Z (see paragraph 6.142ff below) and the investigation into Sergeant L (see Appendix A4/9.038 E – F and A4/9.044 A – B) and for Lieutenant Colonel Govan the speedy removal of Sergeant BB (see Appendix A4/5.025 F to 030 E).

may well result in claims of bullying and harassment. Yet informal sanctions seem, throughout the period of interest to this Review, to have been the lubricant that enabled the engine of the training machine to run smoothly. The difficulty is what constitutes a permissible informal sanction and what does not.

- 4.110 A small example of the problem occurred during the Review's visit to ATR Basingbourn, which, as explained earlier, provides Phase 1 training for particularly young soldiers. The Commanding Officer's briefing to this Review indicated that in the event of poor performance on parade the instructor had authority to direct the recruit to undertake ten press-ups, with a minimum of half an hour before a similar award could be given again. When the same question was directed to others, instructors and recruits alike, different answers were given: 20 press-ups, 50 press-ups and repeats.⁹¹ The ATRA Code does not appear to define the limits of the permissible, and if there is some definition elsewhere it did not appear to have been known to recruits, instructors and commanders alike.
- 4.111 With this brief outline of some of the background issues behind the new policy of Single Entry into the Army and the progression from recruit to trainee, this Report now turns to the specific circumstances of the first death under Review in Part 2.

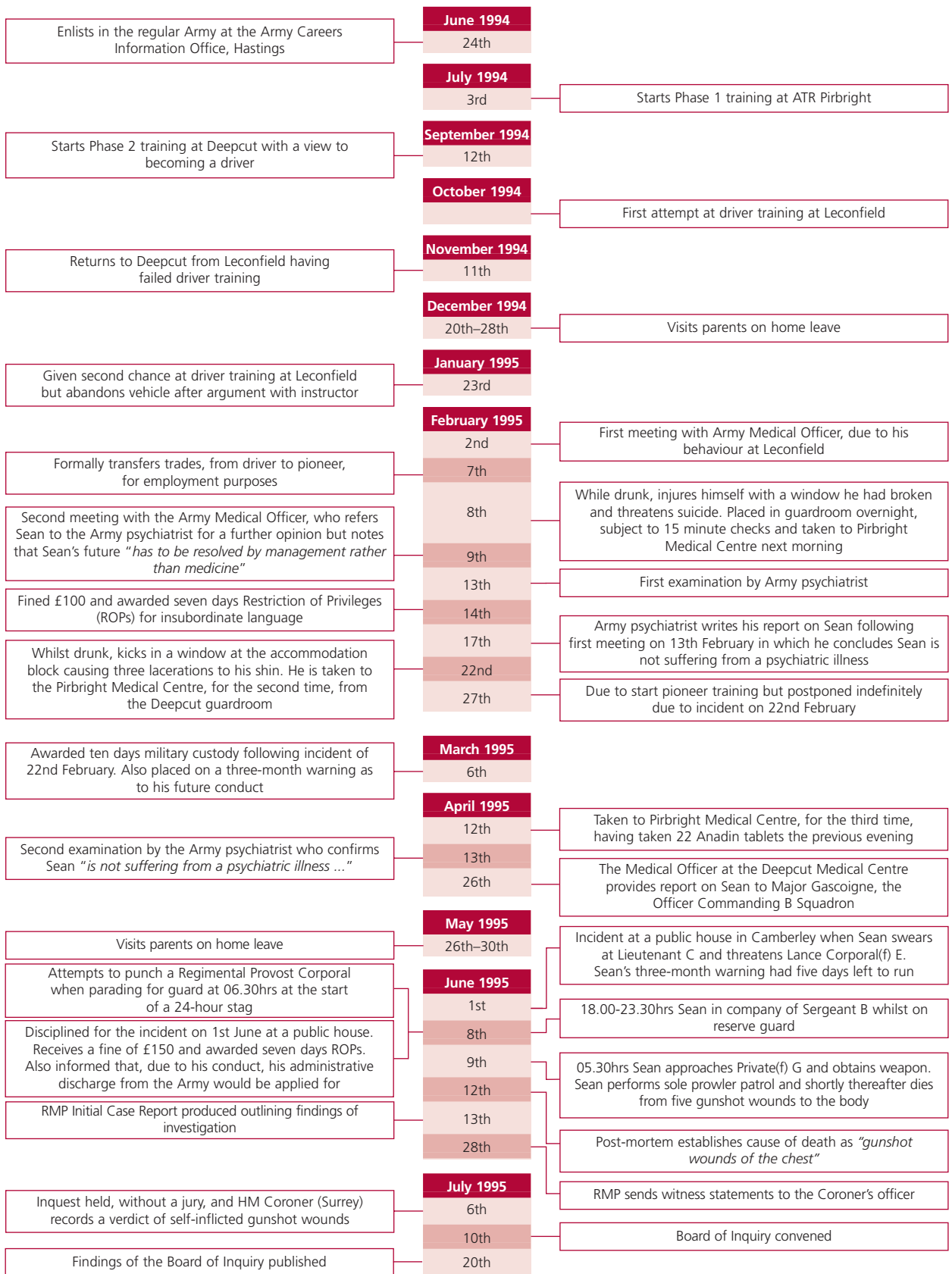
⁹¹ Intriguingly, none of the recruits expressed any concern about the level of press-ups awarded.

Part 2

5 The Death of Sean Benton

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Figure 5.1 Timeline – Sean Benton



Enlistment, recruitment and Phase 1 training

- 5.1 On 24th June 1994, Sean Harry Benton enlisted for open engagement service in the regular Army at the Army Careers Information Office, Hastings. He was 19 years, eight months old. He was to join the Royal Logistic Corps (RLC) in the trade of a driver, but first had to report at the Army Training Regiment (ATR) Pirbright, to undergo his Phase 1 training in the Common Military Syllabus (CMS). His attestation paper explained that, as he was over 18 years old, his enlistment was for a period of 22 years' service terminating in June 2016, but with the right to be transferred to the Army Reserves by giving 12 months' notice after two years' service, reckoned from three months after attestation. This effectively meant that Sean was committed to military service until September 1997, unless he failed to qualify for Phase 2, or trade, training or there were grounds for his discharge for medical, compassionate or disciplinary reasons.
- 5.2 Sean's enlistment in June 1994 was the culmination of a number of months' processing of his suitability for service following his original application made in January 1994. His application was supported by references from two social workers who had known Sean since 1991, in which they explained he had had adolescent difficulties with his family and, since leaving home, had to receive help with accommodation and benefits. One of the referees described him as a *"very sound young man of even temperament fairly quiet with a good sense of humour."*¹ He was also described as honest, reliable and hardworking, with a good ability to mix with others. Both referees thought he would make an excellent soldier. Sean had thought hard about a military career. He was single and unemployed with few academic qualifications recorded. There is very little in the paperwork in his Army personnel file to suggest the events that were to follow and his death inside the year.
- 5.3 In his application form, Sean had declared a previous conviction for criminal damage in March 1993. He stated that he had received a conditional discharge for 12 months, although he also mentioned a fine of £335. This may be a sum by way of compensation, as by June 1994 the Army was treating this conviction as spent, as it would have been if he had been conditionally discharged. In their subsequent re-investigation, Surrey Police were to provide the further details that the damage was to a shop window. In his medical questionnaire, Sean had identified no serious medical condition raising an issue as to his suitability for Army service. He accurately recorded that he had been in contact with Child Guidance Services and provided the name and address of his GP. He answered 'No' to the question as to whether he had suffered any self-injury or poisoning.
- 5.4 Following Sean's death, his GP was subsequently to write to the Coroner's officer about the circumstances of an overdose of paracetamol that Sean had taken when aged 16. This incident was followed up by visits to a psychiatrist, who did not find any deep-seated psychiatric problems. Sean was last seen by his GP in November 1993 and gave no appearance of a young man with any psychiatric problems. There is no evidence in Sean's medical records that this apparent occasion of self-harm was known to the Army before Sean died, but presumably enquiries with Social Services or the GP before enlistment could have revealed these matters. With the benefit of hindsight, it appears that the paracetamol overdose, leaving home and the assistance from Social Services and Child Guidance Services were all part of a combination of adolescent difficulties Sean faced aged 16 in, or about, 1991. It is worth noting, however, that Sean's background was not markedly different to that of many other Army recruits.

¹ 28th January 1994.

- 5.5 Sean reported to ATR Pirbright on 3rd July 1994 for ten weeks of Phase 1 training. He had his initial medical screening on 7th July and progressed through the various stages of his intense military training thereafter. At ATR Pirbright, Sean was subject to regular reporting by the supervising Non-Commissioned Officers (NCOs) in his unit. The person who was best able to monitor his performance was his Section Commander who wrote reports on Sean at weeks two, six and ten. Her comments would have been sent to the Troop Sergeant, then to the Troop Commander, who held the rank of Lieutenant, and then on to the Squadron Commander, with the rank of Major. Phase 1 training is designed to enhance physical fitness, instil discipline and develop basic military skills such as drill, field craft, weapon handling and the ability to implement orders. Throughout her reports, Sean's Section Commander was of the opinion that Sean would not make an effective soldier and she did not believe that he would be able to pass his Phase 1 training. At week ten, her conclusions were:

"Sean Benton has struggled in everything and scraped through to reach week 10. With his attitude and lack of determination and the ability to do well, he should not in my opinion pass out with this troop ... If pursuing the army as a career [he] will struggle due to his attitude to discipline."

- 5.6 Sean's Section Commander has subsequently explained that Sean had discipline problems and a short attention span, and had demonstrated unusual behaviour, such as breaking ranks and walking off when being marched to the Mess. Her views were shared by others responsible for Sean at ATR Pirbright. At week six, his Troop Commander was writing:

"His personal administration and self discipline are non existent. At the present time he is doing the bare minimum to survive and is miraculously scraping through tests."

- 5.7 However, Sean clearly made a concerted effort in the final weeks of his training and passed all the critical tests, to the surprise of some. Nevertheless, his Troop Commander at the time concluded in his final report:

"Benton is a liability and will need to be watched constantly."

When subsequently interviewed by Surrey Police in November 2002, Sean's Troop Commander maintained his opinion that Sean was not fit to move on, describing him as a temperamental individual who was not up to military standards. He confirmed Sean's Section Commander's example of unusual behaviour that he described as a "*tantrum*",² meaning shouting and stamping his feet and, indeed, storming off.

- 5.8 At the time, however, the Squadron Commander disagreed with the Troop Commander's assessment of Sean as a "*liability*" and noted Sean's good performance in the final tests of Phase 1. In his report of 9th September 1994, he detected "*a glimmer of hope for Benton as a soldier. Only time will tell.*" Thus it was that Sean arrived at Deepcut Barracks on 12th September 1994 to start his Phase 2, or trade, training.

² 21st November 2002.

The major events in Sean Benton's career at Deepcut

- 5.9 At Deepcut, Sean was assigned to 'A' Troop under a Troop Commander, Lieutenant(f) A, and a Troop Sergeant, Sergeant B. 'B' Troop was commanded by Lieutenant C and the Troop Sergeant was Sergeant D. Both Troops were part of 'B' Squadron of which Major Gascoigne (still serving in the Army) was the Officer Commanding, with a Captain as his Second-in-Command. Sergeant B has informed this Review that he does not recall that Sean was ever a member of his Troop, although he recalls encountering him on a number of occasions. Lieutenant C, by contrast, has said that Sergeant B spent much time with Sean trying to assist him to meet the requisite standards expected of trainees and that Sean was moved to Lieutenant C's Troop from that of Sergeant B. It seems that, as a result of the problems he was to confront at Deepcut, and the three-month warning he ultimately received,³ Sean switched Troops from A to B Troop, at which time Lieutenant C became his Troop Commander.⁴ As noted above and in Chapter 4, both Troops were part of B Squadron which was, in turn, part of the Training Regiment and Depot at Deepcut (the Training Regiment). Throughout Sean's career in the Army, the Commanding Officer of the Training Regiment was Lieutenant Colonel (now Colonel) Josling.
- 5.10 The idea of the Phase 2, or trade, training programme was that Sean would acquire his driving licence, then progress through to receive specialist driver training at the Army driving school at Leconfield, before joining a unit of the RLC, the field army. The period of time that this process could take depended on a number of factors: when the trainee could be loaded onto the specialist training courses; whether the trainee failed the course and needed to retake; any disciplinary or medical problems that would hold the trainee back; and when a final posting could be found and implemented. For a driver, there was no inherent reason why this process could not be completed in three months or so, as the actual trade training was not particularly lengthy. In the meantime, whilst not actually attending a training course, Sean would be located at Deepcut Barracks, supervised by his Troop Commander and NCOs, whilst awaiting trade training (a status known as Soldier Awaiting Trade Training (SATT)). In the absence of any activities that the NCOs could arrange as 'continuation training' or education at Deepcut, the lot of a soldier on SATT could be a very dull one, being subject to regular parades, being assigned to petty chores, such as picking up litter, and being eligible for guarding and security duties at the Barracks whilst waiting for the next trade course or posting to the field army.
- 5.11 In October 1994, Sean started his driver training at Leconfield but failed to achieve the necessary pass. He returned to Deepcut on 11th November 1994 and then had to wait for a vacancy for a second chance. Over the Christmas period, between 20th and 28th December, he had a period of home leave to visit his parents. His parents recall that Sean seemed to have lost some of his enthusiasm for military life by this time.⁵ On 23rd January 1995, Sean was given a second chance to undertake driver training at Leconfield, but this ended abruptly when he had an argument with his civilian instructor, resulting in him leaving the vehicle some distance from the Barracks. This was subsequently described as a tantrum and seems to bear similarities to the episode recorded at Pirbright.⁶ Sean's parents and his NCOs were aware that his quick temper and emotive reaction could cause problems for him in military life.⁷ Sean was promptly 'Returned to Unit' (RTU'd) at Deepcut and his military future reconsidered.

³ See paragraph 5.19 below.

⁴ The Surrey Police report to the Coroner noted that Sean moved Troop. It would appear that this is based on the statement of Lieutenant C. He attended Sean's funeral, indicating that, at the time of Sean's death, Lieutenant C was his Troop Commander in B Troop.

⁵ Interview with Devon and Cornwall Police.

⁶ Surrey Police interviewed the civilian driving instructor during their re-investigation, who recalled: "[Sean] didn't swear or raise his voice, he just stopped and walked off. The barracks were a good mile from where he stopped."

⁷ For the views of the parents, the Review notes comments made to Devon and Cornwall police.

- 5.12 With two failures at becoming a driver, the only available trade for Sean was as a pioneer, the soldiers who perform construction work for the Army. This trade was considered less prestigious than being a driver, and was one of the least intellectually demanding roles in the RLC, in particular, and the British Army in general.⁸ Although, following discussions with the Senior Selection Personnel Officer and his Commanders at the end of January, Sean had agreed to retrain as a pioneer, he was clearly unhappy at not being able to continue as a driver. For the next few months there was some ambivalence as to whether he wanted to remain in the Army as a pioneer, given that that was the only career on offer to him at that stage. Furthermore, Sean was now facing separation from friends he had met in the RLC during the training process who were, themselves, moving on to their field army units having completed their trade training whilst he was left behind, causing, as will be seen below, what was to be described in his medical reports as an “*abnormal emotional reaction*.”⁹ This was on top of a number of emotional outbursts at Pirbright and Deepcut that had been noted by training staff by then.¹⁰
- 5.13 There is further evidence that Sean was becoming emotionally unstable, prone to crying and abuse of alcohol. On 2nd February 1995, he was seen by the Army Medical Officer because of his behaviour at Leconfield. The case notes report the findings that there was no psychiatric disturbance but that Sean was emotionally labile with a quick fuse. Sean expressed his unhappiness at the pending transfer to become a pioneer and his separation from a friend. The Army records show he was formally transferred to the pioneer trade, for employment purposes, on 7th February 1995.
- 5.14 On 8th February 1995, while drunk, Sean injured himself with a door window he had broken and the unit recorded that he had threatened suicide. Sean was treated for his injuries at the Pirbright Medical Centre. The case notes record that he had broken a door window and walked through the broken glass causing a small laceration to the right side of his neck. Sean had been placed in the guardroom overnight, was subject to 15-minute checks and taken to the Medical Centre in the morning.¹¹ He was seen by the Army Medical Officer, for the second time, who referred him to the Army psychiatrist for a further opinion. The Army Medical Officer’s position seems to have been fairly summarised in an outpatient note of 9th February 1995:

⁸ See, for example, information given to this Review by Brigadier Brown, Appendix A4/1.019 E.

⁹ Notes by the Army Medical Officer dated 9th February 1995.

¹⁰ Sergeant B has told Surrey Police and the Review (in correspondence) that he first became aware of who Sean was when he found him crying and upset. Indeed, in his statement to the RMP on 9th June 1995 at 10.30hrs, Sergeant B stated: “*In late 94 I was instructing B Sqn recruits in drill when Pte Sean Benton of B Sqn began crying and in my opinion became hysterical. I told Cpl [F] of my troop to carry on the instruction. I took Sean with me to my office and tried to find out why he had been crying. Sean told me that a good friend of his, whose name I do not recall, had gone to ASMT [Army School of Mechanical Transport] Leconfield and he was missing him. He said there was no other reason. Between then and this date I became aware of incidents concerning Sean Benton ie, becoming drunk and attempting to jump through windows, I believe this happened about three times. Due to this I tried to speak to Sean about his problems and if I could, advise him.*” Sergeant B has confirmed this account to the Review and Surrey Police and added that if he had been Sean’s Troop Sergeant he would have monitored him more closely and given him support and encouragement.

¹¹ See also paragraph 5.157 below. During their re-investigation, Surrey Police were to find a short statement given by Sergeant D dated 9th February 1995 describing his actions on being called to attend the incident as Guard Commander. In that statement he said: “*I was called ... as there was a disturbance at approx 2350hrs. On arrival I found a large glass window damaged in a violent way. It had been smashed in such a way as to make a hole large enough for a person to climb through ... I was told by a group of soldiers that Pte Benton had broken the glass. I went to Pte Benton’s room ... and found him lying on his bed crying with a large cut on his neck. He appeared to be drunk and smelt heavily of alcohol ... After a few minutes I persuaded Benton to come with me. When we reached the room door he struck out as if to try and hit me, I restrained him and told him to calm down. This he did until he reached the outside door where he tried to attack a group of 6 or 7 soldiers who were stood nearby, they did not provoke him ... All through the route from the block to the guardroom he talked about rather dying than being a pioneer in the infantry. He was continuously crying and clenching his fists.*” Surrey Police were to take statements from a number of trainees who knew or recall rumours that Sean broke windows. One trainee specifically stated that she witnessed him run head first into a door window, while another recalls notifying the Guard Commander, Sergeant D, after hearing Sean break a window. These specific accounts appear to be consistent with the incident described above of 8th February 1995. See also paragraphs 5.149, 5.157 and 5.183 below.

"... has exhibited abnormal emotional reaction ... I am told that he has been threatening suicide but he denies this to me. His behaviour is of a very immature and angry personality."

- 5.15 Two further pieces of information can be gleaned from this medical report. It suggests that a full picture of Sean's social and medical background was not known. First, the notes record that:

*"there is nothing noteworthy in his previous home life."*¹²

Secondly, it was noted that:

"I have impressed on his Squadron officers that his future has to be resolved by management rather than medicine."

- 5.16 There is no doubt that the staff of B Squadron considered Sean emotionally unstable.¹³ In a report of 9th February 1995, in support of the psychiatric referral, made on behalf of the Officer Commanding B Squadron, it was stated:

"... would wish to discharge soldier as temporary unsuitable. He is considered by all staff to be unstable."

It may be that "temporary" is a misprint for "temperamentally". Significantly, as well as referring to the threat of suicide at the time of the 8th February 1995 incident, the report noted:

"... have had reports from troop staff he "plays" with his weapon whilst on guard, pointing it at people."

- 5.17 Sean was seen by the Army psychiatrist on 13th February 1995, who wrote his report on 17th February. The short report concluded that Sean was not suffering from a psychiatric illness and that, while there were questions about his temperament, it was recommended that "he should have the opportunity to demonstrate whether he can cope with the disappointment and make the transition to another trade." There is no indication from the case files that the Army psychiatrist had spoken to Sean's civilian GP or was aware of Sean's juvenile attempt at self-harm in 1991.
- 5.18 In the meantime, Sean's behaviour was giving continuing cause for concern. On 14th February 1995 he was fined £100 and awarded seven days Restriction of Privileges (ROPs) by his Officer Commanding, Major Gascoigne, for insubordinate language. From the account of Sergeant B, the Troop Sergeant of A Troop, it appears that this was an occasion when Sean called him an "arsehole" in public, undermining his authority.¹⁴ Lieutenant C has informed the Review that he understood part of the reason why Sean was transferred to his Troop was his falling out with staff in A Troop. This is inconsistent with Sergeant B's recollection.

¹² See paragraph 5.4 above. However, the notes do record an "unresolved argument" with his parents over the Christmas period.

¹³ There is some evidence to suggest that the Squadron kept an 'at risk' or 'welfare' register or list and that Sean was on it. No records of the register exist and the Review has been unable to ascertain accurately its origin, how trainees came to be on it, its specific purpose or how regularly permanent staff at Deepcut met to discuss it. See paragraph 7.13.

¹⁴ Correspondence with the Review and in interviews with Surrey Police. As noted, Sergeant B believes that Sean was in Lieutenant C's Troop at the time.

- 5.19 On 22nd February 1995, Sean was brought to the Pirbright Medical Centre for the second time from the guardroom at Deepcut. The case notes report that Sean had been drinking and was under the influence of alcohol on examination. Whilst drunk, he had kicked in a window at the accommodation block causing three lacerations to his shin, one of which was $\frac{3}{4}$ inch deep. This incident was to result in a further disciplinary appearance on 6th March 1995 when Sean admitted wilful damage, was awarded ten days military custody and placed on a three-month warning order as to his future conduct. Major Gascoigne, Sean's Officer Commanding, was to explain at the inquest into Sean's death that a three-month warning order must not, in itself, be seen as a punishment. The three-month warning order required Sean to sign a certificate, countersigned by his Commanding Officer, Lieutenant Colonel Josling, acknowledging that Sean would be under assessment and that if his efficiency and conduct did not improve, or he committed further breaches of discipline, his discharge from the Army would be applied for.¹⁵
- 5.20 One consequence of this disciplinary appearance was that Sean's pioneer training, that had been due to start on 27th February 1995 at Ouston, was indefinitely postponed. Thus a soldier who had borderline prospects of making a success of a military career, and had been emotionally unstable at his failure to make progress, was held back as a SATT for a substantial further period. Given the Army Medical Officer's earlier remarks that Sean's future was to be resolved by "*management rather than medicine*,"¹⁶ and the clear view, also noted above, of the Squadron on 9th February 1995, it is difficult to see from the written records why a further opportunity was thought appropriate for Sean to demonstrate how he could deal with disappointment. However, Major Gascoigne has explained to the Review why this was the case, as will be seen later in this Chapter.¹⁷
- 5.21 On 12th April 1995, a further opportunity to review Sean's future in the Army was provided when he was brought to the Pirbright Medical Centre, for the third time, having taken 22 Anadin tablets the previous evening. He was then taken to the accident and emergency department at Frimley Park Hospital and, thereafter, admitted to Cambridge Military Hospital, Aldershot for 24 hours. Sean was seen on 13th April by the Army Psychiatrist, for the second time, and his notes record Sean's unhappiness at his situation since their last meeting. Sean was not looking forward to pioneer training, but was increasingly fed up with not being allowed to get on with it and was feeling jealous that others were able to progress as drivers. He was worried about his financial position, felt tense and "*pissed off*". He had suicidal thoughts at the time but did not want to die; he took the tablets to see what would happen. The Army psychiatrist's report of this consultation reveals that he encouraged Sean to stick at the pioneer trade as there was the possibility that he could retrain as a driver later, but that report concludes:

*"he is not suffering from a psychiatric illness but his personality is immature and I am not sure whether he will be able 'to make it' in the Army."*¹⁸

- 5.22 The Medical Officer in charge of soldiers at the Deepcut Medical Centre, reported on these matters to Major Gascoigne on 26th April 1995. The next entry in Sean's medical file is the report of his death from gunshot wounds on 9th June. At the inquest into Sean's death, Major Gascoigne told the Coroner that Sean was re-interviewed when he came out of

¹⁵ The Troop Commander of B Troop, Lieutenant C, informed Surrey Police that he had to write weekly reports on Sean whilst he was on the three-month warning order but these do not appear to have been retained.

¹⁶ 9th February 1995.

¹⁷ See further below paragraph 5.174 ff.

¹⁸ 13th April 1995.

Cambridge Military Hospital and it was put to him that maybe the Army was not for him but Sean was adamant that he wanted to stay, “so we allowed him to stay and have a crack at the Pioneer course.”

Discharge from the Army

- 5.23 It is the statements made to the Royal Military Police (RMP) and the Army Board of Inquiry (BOI) following Sean’s death that are the most contemporaneous material presently available as to Sean’s conduct between 13th April and 9th June 1995. The Officer Commanding’s interview book from 1995 was not found by Surrey Police in 2002 and appears to have been routinely disposed of, in accordance with the Army’s document retention policy.¹⁹ Sergeant B has pointed out to the Review that he could only have had little contact with Sean in the months leading up to Sean’s death as he recollects that he was away on a course for five weeks before 7th April, and from 24th April to 5th May 1995. Reference to his personnel files confirms that he was on a course for the latter dates but not the former.
- 5.24 Between 26th May and 30th May 1995, Sean was awarded home leave to his family in Hastings. Sean’s father, Harry Benton, told the Coroner at the inquest that Sean was very down, wanted more time off and was not looking forward to going back to the Barracks. Sean told his parents that he was due to attend pioneer training at Catterick on 26th June.²⁰
- 5.25 Shortly after his return to Deepcut, there was an incident on 1st June at a public house in Camberley. Sean was present with some other trainees. He swore at an officer whilst under the influence of alcohol. He also threatened a female junior NCO, who had confirmed to him that he was on guard duty over the coming weekend. The officer was Lieutenant C, the Troop Commander of B Troop. He was in the pub with members of his Troop staff, including Sergeant D, his Troop Sergeant, when they became aware that trainees had entered the pub and so thought it was appropriate to leave. The junior NCO was Lance Corporal(f) E, who was to feature prominently in subsequent enquiries about events at Deepcut.²¹ Sean was disciplined for these matters on 8th June 1995, when he was fined £150 and awarded seven days ROPs,²² although the charges could have been referred to his Commanding Officer, Lieutenant Colonel Josling, for more substantial punishment. Having dealt summarily with these charges, Sean was marched back in to see Major Gascoigne who informed him that, given he was on a three-month warning order, he would be applying for Sean’s administrative discharge from the Army on the grounds of his conduct. Sean’s three-month warning order had, at the time of the incident on 1st June, only another five days to run.
- 5.26 There is no doubt that Sean was guilty of the misconduct for which he was disciplined. As will be seen later in this Chapter, Sean was to ultimately write a letter to his parents in the hours before his death in which he stated:

“... I got drunk on the 2nd of this month (Thursday) down a pub called the Staff and I said “fuck off”, quite a few time to Lt [C] and then I said to Corporal [(f) E] If you put me on guard again on a weekend I’ll shoot ya.”²³

¹⁹ The Officer Commanding’s interview book records all formal interviews, including those of a disciplinary nature, usually with a brief description of the outcome. The Commanding Officer also has a similar interview book.

²⁰ Pioneer training at that time included elements of infantry training conducted at Catterick.

²¹ See paragraph 5.146ff below.

²² See Report of the Board of Inquiry, Appendix 9 at A9.005, paragraph 10.

²³ See Appendix A8.001 for the transcribed version of the full letter.

- 5.27 It should be noted that the “*Thursday*” is 1st June rather than 2nd, so there is no discrepancy as to the date of this incident. Lieutenant C and Lance Corporal(f) E both gave statements to Surrey Police in 2002 about the incident; however, any details of the charge against Sean and supporting evidence in the discipline file have now been lost. It is likely that the job of preparing the charges for the Officer Commanding would have fallen to the Squadron Sergeant-Major of B Squadron. There is further evidence that Sean was not behaving sensibly around this time. At the BOI convened after Sean’s death, a Regimental Provost Corporal gave evidence that he was inspecting the guard at 06.30hrs on 8th June at the start of the 24-hour stag (guard duty shift). He noted that Sean had dirty boots and when he challenged him on this Sean swung a punch at him that did not connect. Sean was removed from the guard parade and placed in the guardroom and ‘warned for orders’.²⁴ He was detained there until released to prepare for orders for the earlier offence from 1st June.
- 5.28 Sean’s letter to his parents also mentions his frustration at not being able to get home leave. His father told the Coroner at the inquest that the lack of weekend visits home and frequent guard duties were matters of concern to Sean during the weeks before his death. Major Gascoigne confirmed in his statement to the RMP in 1995 that the obligation to perform guard duty would be a reason to prevent trainees going home at a weekend. The guardroom rosters for 1995 are no longer available, so the frequency with which guard duties were assigned cannot now be accurately gauged, but the surrounding evidence of problems at Deepcut at the time suggests that guard duties were frequent. The issues of guard duty and home leave, and their effect on Sean, are discussed later in this Chapter.²⁵

The events of 8th-9th June 1995

- 5.29 It is clear from the incident with the Regimental Provost Corporal that Sean had previously been rostered for duty to form part of the guard for 8th June, prior to his appearance before Major Gascoigne for the 1st June offences. It was established at the inquest that a decision was taken at some level within the Squadron that Sean was not to be assigned a weapon on 8th June, as there was concern as to his state of mind and likely reaction to the news that Major Gascoigne would be applying for his discharge from the Army. It is less clear who took the decision, although subsequent investigations by Surrey Police suggest that it was the Second-in-Command of B Squadron. He probably took this decision in consultation with Squadron staff and certainly it was communicated to the Guard Commander that night, who was Sergeant B. As noted, Sergeant B was a member of permanent staff, the Troop Sergeant of A Troop attached to B Squadron. Some reference has already been made to the fact that he had previous knowledge and experience of Sean although, with Sean’s move to B Troop, was not his Troop Sergeant in June 1995. The Second-in-Command of the guard that night was Corporal F, a training instructor in A Troop.²⁶ It is perhaps surprising that Sean was not removed from the guard roster altogether following the incident earlier that morning with the Regimental Provost Corporal but the fact remains that he was not. He was, however, on the reserve list of guards.²⁷

²⁴ ‘Warned for orders’ means that a soldier is given warning that he is to be charged with an offence and that he will be dealt with summarily for an orders process. He would be named in unit orders and would be required to report for an ‘orderly room’ in due course where his case would be formally dealt with.

²⁵ See paragraphs 5.150 ff, 5.188 and 5.195.

²⁶ In the same way that trainees were assigned guard duty, permanent staff would also undertake such duties in addition to their daytime duties.

²⁷ See Report of the Board of Inquiry, Appendix A9.005, paragraph 13.

- 5.30 In 1995, Sergeant B made a statement to the RMP in the hours after Sean's death and was called to give evidence at the inquest as to these matters. In his statement to the RMP, dated 10.30hrs on 9th June, Sergeant B said:

"On Thu 8 Jun 95 I was told that Sean Benton had been discharged from the Army. As I was Guard Commander between 18.30hrs and 07.00hrs Fri 9 Jun 95, I told Sean he was to accompany me on various security checks until I decided. Due to Sean Benton being discharged that day I did not want him to go to the bar and get drunk so it was my intention to keep him with me until the bar had closed. During the course of the evening I talked to Sean Benton about what his intentions were and tried to tell him that there were things to look forward to. At no time did he say anything which would make me think that he would bring harm to himself. About 23.30hrs I stood Sean Benton down and I returned to the Guardroom."

- 5.31 At the inquest, Major Gascoigne answered a question put by the family as to whether measures were taken in the light of Sean's previous self-harm attempts. He replied:

*"We were slightly concerned about that but the psychiatrist report had quite clearly said that he was not suffering from a psychiatric illness ... [we] ... tried to put in some measures to make sure he didn't have access to drink."*²⁸

- 5.32 Sergeant B explained to the inquest that, as a reserve guard, Sean would normally expect to be able to return to the accommodation block and be on stand-by in case his services were required. However, in order to keep him from drinking, it was decided that after Sean paraded for duty, he would be tasked with assisting Sergeant B in his rounds. The evidence at the inquest confirmed that it seemed that Sean was with Sergeant B continuously from 18.30hrs to around 23.30hrs on 8th June, when he was stood down as the NAAFI was closed.²⁹
- 5.33 The original investigation into Sean's death, conducted by the RMP, obtained no information as to his actions and whereabouts from 23.30hrs on 8th June to 05.30hrs the following morning. There was, accordingly, no evidence adduced at the inquest as to this period of time. The evidence in 1995 indicated that Sergeant B returned to the guardroom at 23.30hrs and remained there until about 04.00hrs when he went to sleep at the quarters at the back of the guardroom, leaving Corporal F, the Second-in-Command of the guard, in charge. Considerably more information has been obtained about this period from the Surrey Police re-investigation in 2002.
- 5.34 In 1995, the RMP took witness statements from two female Phase 2 soldiers who were performing armed guard duty together on the night of 8th and morning of 9th June 1995: Private(f) G and Private(f) H. Their witness statements were taken between 12.00hrs and 13.00hrs on 9th June – that is some seven hours after the incidents they are describing. Private(f) G gave evidence at Sean's inquest. Although both women were re-interviewed by Surrey Police in 2002, nothing emerged from the later re-investigation so as to throw any doubt on their accounts as originally given. Both Privates had been issued with an SA80 rifle and a magazine, to be held separately (i.e. not attached to the weapon), containing the standard issue of ten live rounds of ammunition for guard duty.

²⁸ In 2002, a number of former trainees interviewed by Surrey Police noted that Sean did drink a lot and, indeed, ultimately Sean himself admits that this was a cause of some of his disciplinary problems in his letter to his parents (Appendix A8.001). A good friend of Sean's, Private I, was under the impression that, at one point, Sean was on a drink ban, which may be a reference to attempts to keep him away from the NAAFI.

²⁹ In fact, it appears that Sean may still have gone to the NAAFI at some point that evening, see paragraph 5.165.

- 5.35 Between 05.00hrs and 07.00hrs on the morning of Friday 9th June 1995, both women were on armed guard duty at gate Alpha Eight, A8, (as marked on the map at Figure 1.1). This is a gate that controls vehicle access to and from the Deepcut Barracks from the Pirbright Barracks, located some one and a half miles away and is therefore sometimes referred to as the Pirbright Gate. The perimeter fence at the gate continues north, encompassing the site of an old disused tennis court that was attached to the Princess Royal Barracks Officers' Mess within the perimeter of the Deepcut main site. This Officers' Mess was primarily used by visiting officers attending courses at the School of Logistics.³⁰
- 5.36 Both female Privates describe being approached by Sean, dressed in his combat fatigues, at 05.30hrs. Both knew that he was on guard duty in the same roster as them. Private(f) H said she knew that he had been employed that night to run errands for Sergeant B. Having asked Private(f) H for her name, Sean turned to Private(f) G and told her that Sergeant B wanted her and that she was to go to the guardroom. He indicated that he had been sent to relieve her from guard duty. Private(f) G, therefore, handed over her weapon, the unattached magazine containing ten live rounds and the 'rules of engagement' card. The normal safety drills do not appear to have been carried out.³¹ Private(f) G then ran back along the Brunswick Road to the guardroom to report as Sean had informed her she was to do. When she got there, she found Corporal F, the Second-in-Command of the guard that night, in charge. He told her she was not wanted and to return to her post and tell Sean to come to the guardroom. Private(f) G returned to the guard post and was given a lift by someone in a vehicle for part of the way. When she got back, Private(f) H told her what had happened in her absence.
- 5.37 Private(f) H's own statement indicates that shortly after taking possession of the rifle and ammunition, and after a brief conversation, Sean said he was going off on a prowler patrol. A prowler patrol is part of the routine for armed guarding, although there were separate standing orders for prowler and static guards. This Review understands that it was Army policy that armed prowler patrols should normally be deployed in pairs.³² Sean went off in the direction of the car park by the Officers' Mess and pursued a course parallel to the perimeter fence. Corporal F then radioed Private(f) H and she explained to him that Sean had gone off on prowler patrol. Shortly thereafter, she saw Private(f) G return in a vehicle and as the vehicle approached she heard what sounded like a single gunshot. She told Private(f) G what she had heard and radioed to Corporal F to inform him. A few minutes later, both Privates(f) G and H saw the duty vehicle drive to the car park by the Officers' Mess. Shortly afterwards both heard two rounds fired in quick succession from somewhere within the camp not too far away. After that Corporal F appeared at the post and asked for assistance.
- 5.38 As noted, Corporal F was a member of the permanent training staff in B Squadron. He made a statement to the RMP at about 12.45hrs on 9th June 1995. He was well aware of Sean and his problems, having disciplined him in the past. He confirms that Sean was not to be assigned use of a weapon on 8th June and explained that when a female member of the guard became sick at about midnight on 8th June a replacement was available in the form of Sean, but that Sergeant B had indicated that Sean was not to have a weapon.
- 5.39 Corporal F's account then picks up the narrative of events from shortly after 05.30hrs when Private(f) G entered the guardroom and was told by him to return to her post. He also confirms the radio conversation with Private(f) H in which she informed him that Sean had gone on prowler patrol. Shortly after that conversation concluded, he was radioed back by Private(f) H and told that she had heard "*gunshots from the area of the Officers'*

³⁰ This is not the same Officers' Mess that features in Geoff Gray's and James Collinson's deaths, known as the 'RLC HQ Officers' Mess', which was used by the officers permanently assigned to Deepcut.

³¹ It is unclear whether the weapon was 'cleared' before being handed over, but, assuming the 1995 statements are more reliable, it would appear it was not. Given that the magazine was not attached to the weapon prior to coming into Sean's possession, this does not appear to be an issue of importance. In 2002, Private(f) G added that, having started to make her way to the guardroom, she returned with the magazine of rounds to hand to Sean.

³² Annex E to Section 5 of the United Kingdom Land Forces Anti-Terrorist Security Measures extant in 1995. See paragraph 11.15 ff below.

Mess.” Corporal F then explains that his next action was to wake Sergeant B and brief him. Corporal F then armed himself with an SA80 rifle from the weapons rack “*plus what I thought was 10 rounds (I subsequently know it was 9 rounds)*” and a radio. He then went with the duty driver, Private(f) J, in the duty vehicle to the Officers’ Mess near the A8 gate.

- 5.40 They drove to the car park at the rear of the Officers’ Mess. For ease of explanation, the Review has commissioned some recently taken photographs of the area showing the scene (see Figures 5.2 and 5.3). The location of the events that followed is also noted on Figure 1.1. The light was quite good. Private(f) J was able to spot Sean “*sitting with his back against the camp perimeter fence (where the two fences join)*.” Although Corporal F could not see a weapon with Sean at that stage, he got out of the vehicle, moved cautiously towards him and said “*Benton put the fucking weapon down.*” Corporal F then heard what sounded like three rounds of automatic fire come from where Sean was sitting. Corporal F was 60 metres away at that stage and approaching slowly. He saw Sean “*almost half stand onto his feet and then seemed to crouch and roll over to his right.*” He then reached Sean and saw blood and tried to staunch the bleeding. Corporal F directed Private(f) J to make Sean’s weapon safe, after which she placed it on the ground next to his own weapon, and to get in the vehicle and fetch first aid equipment. Corporal F then radioed for medical assistance. Private(f) J returned with a Lance Corporal and a first aid box and they attempted to administer first aid.³³ Sean appeared to die shortly before an ambulance arrived. When attention was diverted from first aid, Private(f) J handed Corporal F three pieces of paper she picked up close to the fence where Sean had been sitting.³⁴ They were folded over. On one was written ‘Sergeant [B]’,³⁵ on another ‘Mum and Dad’ and Corporal F could not recall seeing what was written on the third. They were immediately handed to the Second-in-Command of the Squadron, who attended the scene after the ambulance had arrived.

Figure 5.2: A photograph of the view from the car park at the rear of the Princess Royal Barracks Officers’ Mess looking towards the perimeter fence and disused tennis court near where Sean Benton died



³³ See paragraph 5.76.

³⁴ The contents of these letters are reproduced in Appendix A8.001 – 3.

³⁵ Name anonymised by the Review, but he is the same Sergeant B referred to in this Chapter.

Figure 5.3: A photograph of the view from the corner of the disused tennis court near where Sean Benton died looking towards the car park and Princess Royal Barracks Officers' Mess



- 5.41 In the light of the re-investigations by Surrey Police in 2002, it is necessary to briefly set out what Private(f) J had to say about these matters at the time. Her original statement to the RMP is dated 11.15hrs on 9th June 1995. She knew Sean and had spoken to him around 22.30hrs on 8th June when he was doing his security rounds with Sergeant B. Sean had explained to her the reason for his discharge and was quiet and polite – she described that as out of character. There is no significant divergence of her recollection of Private(f) G entering the guardroom and the radio contact with Private(f) H. She drove Corporal F in the car to the Officers' Mess car park. Her recollection at the time was that Corporal F got out of the car and went to the left around the perimeter of the tennis court. Private(f) J described what she saw:

"I could see that Benton had hold of an SA80 rifle but I cannot recall the exact position of the weapon. I believe it was held somewhere in between his legs. He appeared to look up in front of him and almost immediately I heard a short burst of gunfire. Private Benton's body lurched back and he rolled over to his left and he fell face down on the ground. As he fell I saw the weapon fall to the ground."

- 5.42 Private(f) J adds that she approached Sean from the opposite side of the tennis court to Corporal F. She first kicked the weapon away from Sean's body and after attempting to apply pressure to staunch the wounds cleared the weapon: *"I picked up the weapon Pte Benton had fired and cleared it. In that I mean I removed the magazine, cocked the working parts to the rear and a live round ejected from the chamber ... and I placed the weapon and magazine next to [Corporal F's weapon]."* The safety catch was off but she cannot recall whether the weapon was switched to automatic or single fire. She adds to Corporal F's account that Sean was extremely unhappy the previous night but had not spoken of suicide. She did not read any writing on the sheets of paper she handed to Corporal F and recalls that the Guard Commanders usually sleep in the guardroom building when they are on

periods of rest, but because the guardroom was being refurbished at that time the guard slept in one of the accommodation blocks.³⁶ Private(f) J ends her statement:

"I do not know Pte Benton's movements between 23.00hrs last night and about 05.40hrs this morning when I witnessed him shoot himself."

The 1995 investigation

- 5.43 The protocols for the investigation of a major incident on Army property have been discussed in Chapter 3. The Regimental staff alerted the RMP and civilian police. Two uniformed Surrey Police officers were probably first on the scene along with the ambulance crew. An RMP Special Investigations Branch (SIB) Sergeant, also trained as a Scenes of Crime Officer (SOCO), arrived shortly after at about 06.30hrs from Aldershot. He recovered one SA80 rifle and a magazine with four live rounds of ammunition in it. He found four spent cases of 5.56mm ammunition and later found two more making a total of six. It would appear that all ten rounds issued to Private(f) G had been accounted for, and that six rounds had been fired. Subsequent examination of Sean's body showed there were five bullet wounds in it. The RMP SIB Sergeant also took seven photographs of the scene that have been retained to this day. An armourer attended the scene at about 08.05hrs and found the weapon set to automatic fire. At around 12.30hrs he inspected the weapon and found it to be in full working condition.
- 5.44 The Coroner's officer gave evidence at the inquest and said he arrived at 06.50hrs, when both the RMP and uniformed civilian police were present. He added the detail that six one pound coins were found by Sean's left hand,³⁷ and that the third letter he was handed was addressed to a 'Pte [K]'.³⁸ A routine post-mortem was conducted on 12th June 1995 and the post-mortem report of the same day established the cause of death as *"gunshot wounds of the chest"*. One of the five wounds had signs of being fired in close proximity to the body. The Coroner's officer informed the Coroner in a statement that *"from inquiries I have made into this death and the SIB have made into this death it is quite apparent that no other person is involved."* Surrey Police have retained a copy of the original post-mortem report where the Coroner's officer has endorsed a similar conclusion indicating that that was the conclusion of the civilian police as well.³⁹ No other scientific investigations were conducted on any weapons or clothing or the scene.
- 5.45 On 13 June 1995, the RMP provided a short Initial Case Report⁴⁰ summarising their investigation and the contents of the three notes left by Sean. The statements they had gathered were passed to HM Coroner for Surrey, Michael Burgess, for use at the inquest that he held, without a jury, on 6th July 1995. He recorded a verdict that Sean took his own life. Sean's father was amongst those who gave evidence at the Inquest and was represented by a solicitor. Major Gascoigne was the most senior Army officer giving evidence. The basic narrative of events set out above was established.

³⁶ The Review has seen other statements from former trainees that confirm the guardroom was being refurbished at that time.

³⁷ In 2002, Surrey Police spoke to a number of former trainees who recalled that Sean enjoyed playing on the fruit machines in the NAAFI and this may be an explanation for the pound coins. Indeed, Private Q, who shared a room with Sean, and another trainee, recalled in his statement to Surrey Police that in the week before he died Sean hit the jackpot on the fruit machine in the NAAFI, apparently winning £100.

³⁸ Name anonymised by the Review, but he is the same Private K referred to later in this Chapter.

³⁹ The note records: *"Police are quite happy that no other person is involved in this death. Notes were left, he has psychiatric problems and has taken an overdose in the past."*

⁴⁰ The RMP SIB produced an Initial Case Report outlining their immediate actions but no Final Report, as they did not consider they were conducting an investigation but assisting the civil police or the Coroner for the purposes of the inquest. In both Cheryl James's and Sean's cases, there is a further letter to the Coroner from the RMP providing the witness statements and other material sought. See paragraphs 5.91 and 6.67 below.

The Army Board of Inquiry

- 5.46 Following the inquest, an Army BOI was held on 10th July 1995 in accordance with the provisions of s.135(4) of the Army Act 1955.⁴¹ The Board was briefed to examine the circumstances leading to Sean's death and the adequacy of procedures for guards and the issuing of ammunition within the Training Regiment. The Board heard evidence from a number of people, including Private(f) G from whom it established that, after being stood down by Sergeant B, Sean had gone to accommodation block 11, where members of the guard were resting in between their two hour stags.⁴² At 01.00hrs Sean had inquired about which duty Private(f) G was performing and promised to wake her.
- 5.47 The records of the BOI reveal that Major Gascoigne was managing a Squadron of some 500 trainees with only four Corporals, three Sergeants and a Sergeant Major. Some anecdotal evidence of guard frequency can be deduced from the fact that Private(f) H said she had done about ten guards in five months, while Private(f) G had done four guards in four months. There were no specific standing orders for the A8 gate and no standing orders preventing a soldier on guard from handing a weapon to another soldier,⁴³ although the rules were that soldiers were responsible for their own weapon and ammunition. It does not appear to have been uncommon for soldiers to relieve another guard without the attendance of an NCO. Private(f) H had swapped her guard duties with another on 7th June.⁴⁴ The BOI made a number of recommendations in this respect,⁴⁵ that the Commander of the Garrison, Brigadier Evans (since retired), agreed with and directed that the Commanding Officer, Lieutenant Colonel Josling, should implement by 28th August 1995.

Subsequent enquiries by the family

- 5.48 On 25th July 1995, Sean's father wrote a letter to the Ministry of Defence (MOD) asking for assistance on some issues of concern. Amongst them was whether there was a civilian police report into Sean's death, as the family had been told it was a joint military and civilian investigation but they had heard nothing from the civilian police. After the family were shown an edited copy of the report of the BOI, and after they had heard about the death of Cheryl James in November 1995, more enquiries followed on 26th March 1996. One of the numerous points made related to the post-mortem report. That one point was that, if only one of the wounds showed evidence of being fired at close distance, how could Sean have shot himself by reversing the rifle on his body? The family also expressed the opinion that more rigorous adherence to standing orders and procedures could have prevented Sean's death. These matters were also raised by their MP who corresponded with the MOD and received a response.
- 5.49 There matters rested and doubtless would have rested but for the events of 2002 and the response to the death of James Collinson and the decision by Surrey Police in July 2002 to re-investigate Sean's death.

⁴¹ The Records of Proceedings of the Board of Inquiry are reproduced in Appendix 9 to this Report.

⁴² 'Stag' appears to have been a term used to describe a specific two-hour guard duty, as well as the longer period (usually 12 or 24 hours) that would include both two-hour guard duties and rest periods.

⁴³ See Appendix A9.007, paragraph 25 b.

⁴⁴ The Review is aware of some anecdotal evidence to suggest that guard duties could be swapped informally.

⁴⁵ See Appendix A9.008, paragraph 28.

The Surrey Police re-investigation in 2002

- 5.50 As discussed in Chapter 1, there is no doubt that Surrey Police have conducted a very thorough re-investigation of Sean's death. They have interviewed a great number of witnesses, both members of the training staff and those who were Phase 2 trainees in 1995, and have attempted to pursue all reasonably available avenues of enquiry that could inform how, and possibly why or in what circumstances, Sean met his death. Considerably more detail about the narrative of events described above has been obtained and some new questions have emerged.
- 5.51 This Review will not attempt to summarise all the evidence obtained by the Surrey Police re-investigation. It may be, if there is a fresh inquest or disclosure to legal advisers to decide whether there should be an application for a fresh inquest, as discussed in Chapter 2, that in due course Mr and Mrs Benton will be afforded disclosure of the material obtained to review it for themselves. It is, however, considered appropriate to briefly outline the new features uncovered by the re-investigation that support or contradict previous assessments of how Sean came to meet his death or may provide relevant information as to why he did. In particular, there are three issues that the Review will consider arising from the new material:
- (i) Is there any evidence that has now emerged that undermines the verdict of suicide?
 - (ii) Is there any evidence that the original investigation into Sean's death covered up evidence?
 - (iii) If the verdict of suicide is not undermined, is there any evidence that Sean was driven to self-harm by bullying or harassment from those in authority, or by other trainees?

(i) Evidence to undermine the verdict of the original inquest?

- 5.52 The issues that arise in respect of the first question are essentially two-fold: first, reported concern of the inconsistency of the injuries received by Sean with the conclusion of suicide; and, secondly, the implications of some of the answers given in 2002 by Private(f) J. These will be addressed in turn.

(a) The nature of Sean Benton's injuries

- 5.53 Any popular account of the deaths at Deepcut notes that a verdict of suicide does not appear to sit easily with the existence of five bullet wounds in Sean's body. Further, although this Review has not seen the scientific investigations conducted by Mr Frank Swann in 2002, initially for the BBC Scotland 'Frontline Scotland' programme and then on behalf of some of the families, there has been reporting of the fact that the pattern of the bullet wounds in Sean's body, and in particular the space between the bullet holes, is inconsistent with a sequence of shots inflicted at close range. Put simply, the suggestion is that if Sean had turned an SA80 rifle on himself and fired on automatic, the bullet holes from an arm's length away would be closer together. Clearly, if there is scientific evidence to exclude the possibility of self-administered injuries, then there must be something wrong with the otherwise clear and consistent witness testimony to the contrary.

- 5.54 The section of this Report that follows seeks to summarise the conclusions of independent experts, consulted by Surrey Police, that address these and related issues. There is no doubt that the task of expert re-evaluation is rendered considerably more difficult by the passing of time and the absence of scientific tests conducted at the time of death. Amongst the tests not performed in the original investigation in 1995 were the following:
- (i) no fingerprint testing on the rifle that Sean took from Private(f) G that was found by his body or, indeed, of the letters also found;
 - (ii) no swabbing of Sean's hands for gunshot residues;
 - (iii) no scaled plans of the blood staining on the fence or the ground from which information as to the mechanics of infliction might have been obtained;
 - (iv) no testing of Corporal F's weapon or Private(f) G's, or the spent cartridges, to see whether the spent rounds were fired from either weapon; and
 - (v) no testing of Sean's clothing against the wounds on his body to see whether there was a match and whether further information could be obtained.

The importance of conducting some or all of the above, even in a case where the conclusion of self-harm may look strong at the outset, is underlined by the new disclosures from Private(f) J, discussed later, and the fact that, in Sean's case, there was at least a candidate alternative weapon that could have been used to inflict force.⁴⁶

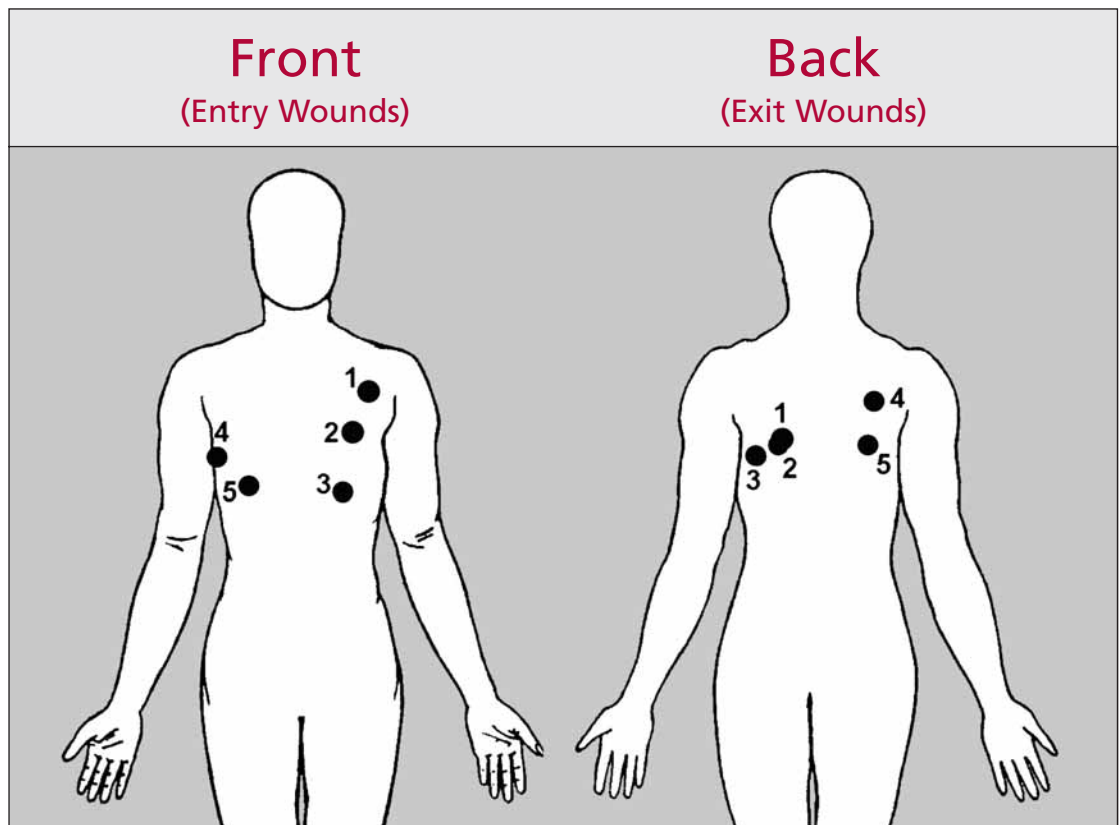
- 5.55 Despite these problems, the 2002 re-investigation did unearth one chance find from which valuable scientific data has been retrieved. It seems that Sean's blood-stained combat jacket, although condemned for destruction as a possible biological hazard, was retained and washed by the mortuary technicians who were connected with the case. On delivery to the experts consulted by Surrey Police in 2002, despite the intervention of some seven years and the washing process, chemical data was retrieved from around the bullet holes that provides some further information relevant to the mode of death.
- 5.56 The standard Army rifle introduced since 1985, and used by the guards in each of the four deaths at Deepcut, is the SA80 weapon. This rifle is 785 mm in length with a barrel length of 518 mm. The rifle is fitted with a flash suppressor at the muzzle to prevent a flash of light being emitted when the weapon is fired. The trigger and guard is located underneath the barrel, approximately in the middle of the weapon, thereby enabling an arm of a man or woman to reach it if the weapon is reversed and the barrel pointing close to or in contact with body. The SA80 fires 610 to 775 rounds per minute when in automatic mode or continuous fire. Bullets will continue to come out of the barrel whilst a finger is depressing the trigger and ammunition remains in the magazine. Any substantial depression of the trigger on automatic is likely to result in the discharge of more than one round.⁴⁷ In answer to one question raised by this death, therefore, it is plainly perfectly possible for self-inflicted harm to generate a substantial number of bullet wounds, particularly if the first wounds are not on a particularly vulnerable part of the body and death is not instantaneous.
- 5.57 Surrey Police obtained the opinions of two experts on the nature of Sean's injuries – one attached to the Forensic Science Service (FSS) in the United Kingdom and the other the Forensic Institute of the German Federal Crime Bureau or Bundeskriminalamt,

⁴⁶ An RMP Corporal, when interviewed in 2002, recalls seeing three rifles on the ground at the scene. No one else supports this recollection that may be a trick of the memory. The fact that there was more than one weapon when investigators arrived is, however, clear.

⁴⁷ Indeed, the Review has been informed that it would require considerable skill to discharge only a single round when the weapon is set to automatic fire. See also paragraph 5.85 below.

Kriminaltechnisches Institut (BKA). The FSS conclusion was that the wounds to Sean's body could have been inflicted in two bursts. As Figure 5.4 approximately illustrates, there were three wounds on the left of the chest, numbered 1, 2, and 3 by the pathologist and two wounds on the outer right of the chest, numbered 4 and 5 by the pathologist.⁴⁸ All the wounds have a trajectory from the front to the back of the body – none enter or leave from the side. Examination of Sean's jacket showed evidence of damage characteristic of close contact discharge.

Figure 5.4: The approximate entry and exit wounds to Sean Benton's body



5.58 The BKA conducted more extensive tests and their scientific report has been revealed to the Review. The surprising discovery was that copper deposits, consistent with the chemical constituents of the standard ammunition in use at Deepcut, were found around each of the bullet holes in Sean's jacket. Two of the holes had deposits consistent with discharge from the flash suppressor fitted to the end of the barrel of the SA80. Evaluating all the available material and models available to them, a convincing case was advanced by the BKA to the following effect:

- (i) Wounds 5 and 4 were inflicted first, followed by wounds 3, 2 and 1. Wound 2 would have been fatal within a short period of time. The wounds were ascending the body and there could well have been a missed shot in either sequence accounting for the sixth cartridge.
- (ii) From the residues on the clothing, it can be calculated that the distances at which the shots were fired from the body range less than 10 cm for wound 4, less than 5 cm for wounds 3, 2 and 1 and in direct contact for wound 5. Such distance is also supported by the damage to clothing.

⁴⁸ The numbering of the wounds is arbitrary and is not an indication of the sequence in which the shots were fired.

- (iii) The gaps between the wounds of between 7 and 10 cm could be achieved with a weapon held at such close distance to the body, bearing in mind the victim's body may change position during the course of the shots. A possible standing position for wounds 5 and 4 and a falling sequence from a kneeling position for wounds 3, 2 and 1 were obtained consistent with this evidence.
 - (iv) The blood staining to the fence captured in the photographs taken soon after the death suggests that the victim could have been standing with his back to the fence when wounds 5 and 4 were inflicted.
- 5.59 The purpose of the scientific evidence is to confirm or undermine the primary evidence of the death supplied by the witnesses, Privates(f) G, H, J and Corporal F, as discussed above. After 19 pages of detailed analysis, the conclusions of the three BKA experts was:

*"The chain of events [the witnesses suggest] appears plausible. All shots were fired from close range. No grounds were found which would contradict self-inflicted injury. The resulting pattern of evidence is totally consistent with shots fired in suicidal intent."*⁴⁹

- 5.60 In the opinion of this Review, that is a powerfully reasoned conclusion that satisfactorily addresses an issue of concern raised by Mr and Mrs Benton in 1995 and by media reporting since 2002. It provides no basis to undermine the evidence of Privates(f) G, H, J and Corporal F, indeed, in some ways, it materially supports their accounts. Of course such scientific material cannot, by itself, exclude the possibility of a third party taking possession of the weapon and firing it at close quarters in the sequences indicated. However, such a possibility would appear to be at odds with all the witness evidence and, in the end, a judgement has to be made on all the available evidence in the case, and not rest merely on the opinion of the scientists.

(b) Fresh information from Private(f) J

- 5.61 The second issue that arises in respect of the first question posed at paragraph 5.51 above concerns the evidence of Private (f)J. On 8th August and 19th September 2002, Surrey Police conducted extensive interviews with Private(f) J. As a result of these interviews, significant new points emerged about the circumstances surrounding Sean's death that may be summarised as follows:
- (i) Private(f) J ran back to the guardroom to ensure that Corporal F had a magazine of ammunition before they drove to where Sean was.
 - (ii) Private(f) J was encouraging Corporal F to insert the magazine in his weapon as they were driving to the scene.
 - (iii) Private(f) J saw Corporal F fit the magazine to the weapon.
 - (iv) Private(f) J and Corporal F walked towards Sean from different sides of the tennis court and both were shouting to him to put his weapon down.
 - (v) Sean had his weapon pointing in the general direction of Private(f) J. Private(f) J could see that Corporal F had, by this time, raised the butt of his weapon to his shoulder and was pointing it at Sean.

⁴⁹ 2nd June 2003.

(vi) Private(f) J then heard the sound of a fired round passing her right side. It was a whizzing sound she believed was fired from Sean's weapon but not an aimed shot.

(vii) When they reached Sean after the final shots were fired, Private(f) J was shouting at Corporal F: *"I was shouting at him [Corporal F] saying he should have shot him [Benton] or took an aim and shot. He [Corporal F] had the gun why didn't he [Corporal F] shoot him [Benton]?"*⁵⁰

5.62 The interviews with Private(f) J give, in some detail, a description of how Sean disliked Lieutenant C, his Troop Commander for the two months prior to his death, and how unpopular Lieutenant C was in the Training Regiment. She described what she and Corporal F were thinking when they were on the way to the scene, after Private(f) H had reported that Sean had gone on a prowler patrol and that she had heard a gunshot:

*"We didn't know whether Benton had just accidentally [fired] or what. But we all knew he'd spoken to [Sergeant B] on how much he hated [Lieutenant C] and how much of a tosser he was, and he was. He just basically bullied him. Full stop."*⁵¹

5.63 Two observations flow from this extract. First, Private(f) J was telling Surrey Police that she knew Sean talked to Sergeant B about how much he disliked Lieutenant C. If this is correct, it implies that Sean had, by the time of his death, achieved a level of trust and confidence in Sergeant B. Secondly, she refers to Lieutenant C bullying Sean. It is known that Lieutenant C had to report weekly on Sean to the Officer Commanding during the period of Sean's three-month warning order, although the contents of the reports have not been preserved. It may be that Sean knew that Lieutenant C held the key to his prospect of being able to continue as a soldier and that was a factor in any hostility between them, and, in particular, the outburst on 1st June in the public house in Camberley. Amongst the many allegations seen by this Review in the Duty of Care Schedules and supporting Surrey Police material, there is no allegation that Lieutenant C assaulted or verbally abused or otherwise harassed Sean.⁵² 'Bullying' may, therefore, be in the eye of the beholder, and it would appear that even a member of the permanent staff may equate bullying with the repeated application of disciplinary sanctions. Whether those sanctions were legitimate or disproportionate depends on an assessment of whether the person subject to them had done anything to merit censure and sanction.

5.64 The second observation from the extract quoted above from Private(f) J's interviews with Surrey Police is that it shows how angry she was that Corporal F had not fired at Sean when she shouted at him to do so, after she believed Sean had fired his weapon towards her.

5.65 On 23rd June 2003, following her recorded interviews, a witness statement was taken from Private(f) J. She noted Sean's behaviour earlier in the evening in the following terms:

"I was aware by the general conversation that Sergeant [B] was worried about Benton but at that stage I did not know why. Sean was very emotional and upset. I overheard Benton in the land rover saying, "how am I going to tell my mum?" or words similar. The conversation continued and Sean said that he wanted to complete a guard duty or 'stag on'. Sergeant [B] wouldn't let him but again at this stage I did not know why."

⁵⁰ 8th August 2002.

⁵¹ *Ibid.*

⁵² One informant alleges that Sean got more "grief" from Lieutenant C than Sergeant B, see paragraph 5.149.

- 5.66 She noted that Sergeant B had explained that Sean was to be kept on reserve as a 'runner', rather than removed from the list altogether, so an eye could be kept on him, even though he was sent to the guard accommodation for much of the time.⁵³ There is some confusion as to where Sergeant B was actually sleeping in the early hours of 9th June, because, as noted, the guardroom was being redecorated. A recital of the different recollections and possibilities does not assist in the clarification of any of the issues relevant to this Review.
- 5.67 When the news of the shot heard by Private(f) H reached the guardroom, Private(f) J's account in her 2003 statement was as follows:

"My thoughts at the time were that knowing Benton had obtained a rifle and being that he had previously, openly, stated that he hated Lieutenant [C] (one of the Officers' Messes being adjacent to Alpha Eight gate) I believed that Sean was perhaps trying to do something stupid and possibly scare Lieutenant [C]. It was clear that many people in the camp disliked Lieutenant [C] and realising this initially made Corporal [F] and me laugh."

- 5.68 Thereafter she continued:

"I said with an urgency for Corporal [F] to get a rifle ... I got into the land rover and then asked Corporal [F] whether he had collected any rounds [ammunition]. I ran back to the guardroom and grabbed a rifle magazine from beneath the front counter. I did not count the number of rounds, merely confirmed that the magazine did contain rounds. I immediately returned to the land rover and 'threw' the magazine onto Corporal [F]'s lap. I particularly remember due to my increasing concern for the situation, starting off in fourth gear. Again, due to the influence of the television programme⁵⁴ which also mentioned about travelling different routes to avoid routine; I had that thought in my mind when I began the journey to Alpha Eight gate and therefore took a route behind the Officers' Mess rather than go directly to the gate along Brunswick road. During this journey I was telling Corporal [F] to load the rifle. Initially [Corporal F] said 'no' but I continued insisting and I saw [Corporal F] fit the magazine to the rifle. I do not believe that [Corporal F] 'cocked' the weapon."

- 5.69 On descending from the vehicle her description of events is as follows:

"Both Corporal [F] and I were shouting for Sean to put the weapon down. I believe that Corporal [F] was moving towards Sean from his direction as I was from mine. At this stage I saw no wounds to Sean's body. Sean at this time had the weapon he was holding pointing in my general direction. Sean was holding the weapon with the butt of the rifle resting on the ground. The muzzle was pointing upwards and slightly forward of Sean's body. I saw that Corporal [F] had brought 'his' weapon into his shoulder pointing at Sean and again shouted for Sean to drop 'his' weapon. I then heard the sound of a fired round passing by my right side. It's a difficult sound to describe but it was a 'whizzing' sound. I honestly

⁵³ There is some suggestion that this may have been done to ensure that Sean did not visit the NAAFI.

⁵⁴ Private(f) J previously mentioned in her witness statement that she had recently seen a television programme on the IRA and the Army in Northern Ireland.

believe that this round was fired from Sean's weapon and I further believe that it wasn't an aimed shot. Sean's rifle was in the same position as previously described, i.e. muzzle pointing upwards. Almost immediately Sean turned the rifle muzzle towards his body lifting the butt of the rifle upwards which resulted in the rifle butt facing me. I do not believe that Sean changed his grip on the rifle. I heard the sound of an automatic burst of gunfire. I also remember seeing the flashes and smoke from the rifle muzzle. Sean's body 'lifted' slightly before falling to the ground."

By contrast with her previous interviews, there is no reference in the witness statement to Private(f) J urging Corporal F to fire at Sean or remonstrating with him for not having done so.

- 5.70 Corporal F was interviewed at length by Surrey Police on 24th October 2002, 12th December 2002 and 16th July 2003.⁵⁵ In his first interview, Corporal F recollected the events of the evening of 8th June and of the morning of 9th June 1995. He described his initial thoughts on being informed by Private(f) H of gunfire being heard:

"My first thoughts and I still remember that now quite clearly are what are the intentions of Private Benton to take over that position and also take a weapon and again I remember quite clearly but my one of my thoughts was the Officers' Mess was close by and one of the platoon officers which I assumed was accommodated within that mess and again I think that my recollection that they probably didn't see eye to eye from the degree of he was an officer and Private Benton was a problem child so thoughts were going through my mind was he going to commit harm to someone else ... I wouldn't say [Lieutenant C] was particular popular amongst the recruits no ... his role was obviously to discipline yes but I don't think he had had necessary the best approach towards recruits I don't think and obviously he's doing his job as a capacity of one of the commanders. It's just a general feeling you get like people are liked or disliked."

- 5.71 Corporal F further described his reason for taking a weapon and ammunition as he and Private(f) J left to find Sean:

"My concern was I don't know what was going through Private Benton's mind in relation to causing harm to himself or causing harm to someone else on the camp. All I would have been thinking was obviously we had a duty of care and safety for other people, he's now in charge of a weapon he shouldn't be in charge of a weapon and that's why I took a weapon and ammunition and made the weapon ready in case the situation or the circumstances developed."

- 5.72 On arriving at the scene, Corporal F stated that, in addition to his own safety and that of Lieutenant C's, or anyone else on the camp, he was particularly concerned for the safety of Private(f) J, who was unarmed. As they arrived at the scene, Corporal F and Private(f) J spotted Sean with his back to the perimeter security fence, which itself tracks two sides of a disused tennis court with a narrow track between those sides of the court and the fence. Sean was near the corner of the perimeter fence, his body facing west down the longer side of the court but his head turned to face diagonally across the court to where the vehicle had stopped in the car park (see Figure 5.3). Corporal F recalls that he did not see Sean holding a weapon:

⁵⁵ Corporal F voluntarily attended these interviews and did not take up the offer of having a solicitor present.

"I then issued a challenge to Private Benton if you want to call it such although I couldn't see a weapon it was an understanding that he had a weapon with him and I'm basically telling him to put the weapon down where we can physically see it so obviously we can then like take a stage further, get him away from the weapon and then obviously find out what exactly [was] going on."

- 5.73 Corporal F believes that when he was approaching Sean, his own weapon would have been in what is referred to as the 'rest position', i.e. with the butt of the weapon in his shoulder and the muzzle pointing to the ground, rather than in the 'aimed position', where the muzzle is raised and aim taken through the sights. When it was put to him that he may have had the weapon in the aimed position, Corporal F replied:

"It wasn't the first instinct to treat him as an ultimate threat obviously the main priority and concerns was to see what he was going to do."

- 5.74 When he was asked directly whether any rounds were discharged from his weapon, Corporal F replied:

"I know I didn't fire the weapon, I know the weapon was not trained on him in a professional manner i.e. me looking through the sights at him, there was no cause to fire a weapon because no rounds were fired at us, that was the first reaction if you like that would have taken an action with him firing at us."

- 5.75 In his first interview in 2002, Corporal F could not recall how he came to possess the ammunition, and, therefore, how there were only nine rounds on returning to the guardroom when he thought he had ten initially. He could not recall whether he grabbed a loaded magazine or whether he loaded a magazine himself. It should be noted here that Surrey Police have taken a statement from a former trainee who was on the same guard duty as Sean and who recalls being called into the guardroom in the early hours of the morning of 9th June 1995. He recalls seeing a male Corporal hurriedly load a magazine with rounds and, while doing so, drop some rounds on the floor. He cannot recall the Corporal being armed at this point but remembers a Land Rover speeding off shortly afterwards. Corporal F suggests that it is possible that there were only ever nine rounds in the magazine, or that whoever unloaded the weapon at the scene unloaded a live round and did not place it back in the magazine. Either way, it is noteworthy that Corporal F volunteered the fact that there were only nine rounds on his return to the guardroom in his statement to the RMP at 12.45hrs on 9th June 1995.

- 5.76 Corporal F cannot recall Private(f) J and himself approaching Sean by different routes as she describes. Private(f) J says she approached Sean from the right side of the tennis court and that Corporal F went to the left side of the court – a longer route. Corporal F is adamant he went right rather than left. Indeed, he argues that it is not logical to go left and that there were no tactical considerations because on telling Sean to put the weapon down, as they left the vehicle, they witnessed Sean's shooting. After that point, Sean was no longer a danger to anyone and the priority would have been to get to him as quickly as possible - it would not have made sense to go the long way round. Corporal F suggests that a possible explanation for the discrepancy in the accounts of parking and approaching Sean between himself and Private(f) J may be because Private(f) J left the scene and returned a short time later with first aid kits and a Lance Corporal and, therefore, may be confusing two separate events.⁵⁶

⁵⁶ The Lance Corporal gave a statement to the RMP in 1995 in which he described Private(f) J entering the guardroom asking for medical boxes and then returning to the scene with her.

- 5.77 Corporal F has the recollection that on arriving at the scene, Sean was sitting with his legs either out straight or slightly bent. However, Corporal F accepts that, given the response he saw by Sean's body to the automatic fire, it could be more likely that Sean was kneeling rather than sitting, in order to achieve such a rotation of his body. While Private(f) J believes that Sean's body was positioned more to the centre of the alley way between the tennis court and the perimeter fence, Corporal F's recollection is that Sean was against the perimeter fence.
- 5.78 Corporal F does not recall seeing Sean's weapon until he approached his body after witnessing the shooting. When it was put to him that the reason why Private(f) J may have seen a weapon and he did not might be because he took a different route towards Sean, Corporal F insisted he did not take a different route. He has no recollection of Sean firing his weapon at Private(f) J and does not recall Private(f) J having encouraged him to shoot at Sean.
- 5.79 On 12th December 2003, Corporal F was re-interviewed by Surrey Police and he was given the opportunity to read the witness statement of Private(f) J dated 23rd June 2003. In so far as he was able to comment further on the inconsistencies between her and his own account, Corporal F confirmed a strong recollection that he made the weapon ready outside the guardroom. He pointed out the real difficulty in firing a single shot from the SA80 when it is on automatic mode.⁵⁷ Overall he concluded:

*"[Private(f) J]'s account might be truer than mine but I can only tell you from what I've seen and what my memory's ... telling me."*⁵⁸

- 5.80 Private(f) J was aware that the details of Sean shooting at her had not previously been mentioned to RMP or the BOI in 1995. She pointed out that she was in shock at the time her first statement was taken (11.15hrs on 9th June 1995) and that she is dyslexic, which means she has some difficulty in reading statements. She had not been pressured by anyone into making the present statement or suppressing information previously. On the other hand, her account of separate routes being taken towards Sean was recorded, if not explored further, by the RMP in her statement in June 1995.
- 5.81 Surrey Police sought to investigate whether Private(f) J had given a similar account to anyone else previously. Both her mother and father gave information that Private(f) J had given an account in 1995 of Sean firing at her on 9th June after she had been sent home for respite. Two other Privates gave Surrey Police an account that Private(f) J had said at the time that Sean had pointed the weapon at her, although no reference was made to him firing.
- 5.82 Clearly this new account raised some intriguing questions. If accurate, then Corporal F not merely had the means – a readied rifle – to fire at Sean but a legitimate occasion to do so to protect his colleague. He took a rifle because he feared Sean might be seeking to harm Lieutenant C. On one version given by his unarmed colleague, she had reprimanded him for not having fired when she asked him to, following what she thought was a shot fired at her. If Sean had fired a shot at Private(f) J, that would be an alternative explanation for the sixth round unaccounted for by his five wounds. Although Private(f) J was clear that Corporal F had not fired at Sean, indeed in her interview she was angry that he had not done so, if he had done so, that might provide another explanation for the anomaly in the

⁵⁷ The Review has subsequently had this point confirmed by weapons instructors when an SA80 was test-fired at AFC Harrogate in the course of the Review's visit there.

⁵⁸ 12th December 2002.

number of rounds he returned to stores at the end of the incident, if indeed he had ten rounds to begin with. It is also necessary to bear in mind that a number of the former trainees interviewed by Surrey Police in 2002 allege that Corporal F was someone who behaved oppressively towards Sean in the last few months of his life.⁵⁹

- 5.83 The emergence of this new account, seven years after Sean's death, underlies the importance of adhering to best practice procedures for a sudden death being treated as a potential homicide (i.e. 'think murder') unless evidence is obtained to exclude that possibility. If Corporal F's weapon had been forensically examined immediately after Sean's death, the possibility of recent discharge from that weapon could have been confirmed or eliminated. Equally, it may have been possible to discover at the time whether Corporal F was supplied with only nine rounds, as he volunteered in the hours after Sean's death. An audit of the ammunition could have revealed whether a round was in fact unaccounted for. Similarly, if a magazine had been loaded in the rush to get to Sean, as seemingly recollected by the trainee in the guardroom, this could have been recorded in detail at the time, confirming whether it was indeed Corporal F, and perhaps corroborated by others.

(c) Conclusions on the new evidence on how Sean Benton died

- 5.84 Some assessment is necessary as to whether this new material uncovered by Surrey Police's re-investigation in 2002 undermines the previous evidence given in 1995, or suggests a different cause of death to that recorded in the original inquest. This Review is conscious that, in the light of the principles discussed in Chapter 2, there may be a fresh inquest into Sean's death as the material now available shows a more complex picture than that presented at his original inquest. If there is a fresh inquest, any conclusion that inquest reaches is authoritative, whilst any conclusion expressed in this Review is not. However, in order to examine the circumstances surrounding Sean's death it is necessary to address the evidence as to how he died and conclude whether there is any reason to believe that his death was not self-inflicted. In the clear opinion of the Review there is not.
- 5.85 There is nothing in Private(f) J's account that undermines the broad narrative of events established by Privates(f) G and H, the two trainees on guard at gate A8. Sean had, therefore, obtained possession of a rifle and ammunition by a deliberate stratagem and had fired some shots before Corporal F and Private(f) J arrived at the scene. From the expert analysis of the BKA, those shots were most probably the non-fatal wounds 5 and 4 on the right side of his body (see Figure 5.4). Even if Sean had pointed his weapon at Private(f) J on her arrival at the scene, it is unlikely that he would have been able to force off a single warning shot when the weapon was on automatic. The Review has been informed that it would take considerable skill to achieve this. It may be that the sound of the bullet Private(f) J hears as a "*whoosh*" is the sound of the missed round heading into the open as Sean inflicted the fatal sequence of wounds 3, 2 and 1. Undoubtedly the whole incident, from approaching a man with a loaded weapon, whom they feared might shoot at Lieutenant C, to watching him turn the weapon on himself, must have been a very traumatic experience for a young woman of 19 years. There is ample room for confusing what she feared might be happening with what was actually happening.

⁵⁹ See Appendix 5, entries 9, 29, 37, 42, 48, 60 and 61 of the 1995 Duty of Care Schedule. See paragraph 5.137 ff below.

- 5.86 Private(f) J is vague about when she berated Corporal F for not shooting at Sean. It is missing from her final witness statement in June 2003, and in her interviews it seems to be something she raised with him when they reached Sean's body rather than while the events were unfolding. If Corporal F had no chance to fire before Sean inflicted the fatal sequence of wounds on himself, her concerns do not alter how Sean died. Finally, Private(f) J is the only source of this new information and she is adamant that Corporal F never did fire at Sean and, indeed, was angry with him afterwards for not doing so. Even if Sean did fire at her, her own account does not support a discharge of any rounds from Corporal F's rifle.
- 5.87 The only rationale for Corporal F firing a shot at Sean would have been to disable him from being a threat to Private(f) J and himself. This could only have occurred before Sean shot himself with the fatal sequence of shots (wounds 3, 2 and 1) and while Corporal F and Private(f) J were approaching him. The BKA evidence is very clear that all the bullets that entered Sean's body were fired at point blank range, within ten centimetres, and nothing in Private(f) J's account suggests or supports such a contact between Corporal F and Sean. Of course, if, contrary to the reasoning above, Sean had fired at Private(f) J, any subsequent lethal force used against him would have been legitimate to prevent injury or death to another.
- 5.88 This issue was of central importance to the Surrey Police re-investigation in 2002. It is difficult to see who else could have been interviewed and what further lines of enquiry would now be open to explore this matter further. There is no conflict between Private(f) J and Corporal F as to how Sean died that calls for a judicial adjudication, nor is there likely to be new material available to throw doubt on this feature of the evidence of both of them. It is this Review's opinion that the verdict of self-inflicted injuries at the original inquest will, therefore, not be displaced by this new material.

(ii) Evidence of a cover-up in the original investigation?

- 5.89 The second question posed at paragraph 5.51 above asks whether there is anything to suggest that the original investigation covered up evidence. As noted at paragraph 5.54 above, better retention of relevant exhibits and further testing at the time of Sean's death would have improved the ability to make positive comments on how Sean's injuries were inflicted. Current practice with respect to a sudden death occurring on Army property is to seal the scene immediately until the civilian police arrive and to not even make the weapon safe by disengaging the magazine and clearing the chamber. An example of such practice in action was brought to the Review's attention with respect to a recent death from gunshot wounds at Catterick.⁶⁰
- 5.90 However, it is appropriate to dispel any suggestion that the weaknesses in the original investigation were the result of any desire or intention to conceal evidence or due to a lack of concern for how Sean met his death. The Coroner's officer was on the scene within 50 minutes of the approximate time of the injuries to Sean; civilian police and the RMP were already in attendance. The Coroner's officer's conclusions have already been noted. There was manifestly no attempt by the Army to conceal this incident from the civilian authorities and evidence that was obtained, and retained by the RMP SOCO, has subsequently proved of value. If the investigations thereafter were very limited in nature and did not conform to best practice for a homicide investigation at the time, let alone the present best practice now laid down in the Association of Chief Police Officers (ACPO) Murder Investigation Manual, the context in which that investigation was initiated has to be taken into account, as already noted in Chapter 3.

⁶⁰ See Appendix A4/14.028 A – E, where Lieutenant Colonel Strutt gives this as an example.

- 5.91 The RMP's Initial Case Report, dated 13th June 1995, stated: *"It was requested by HM Coroner's office, Chertsey that SIB RMP record all relevant witness statements from the appropriate unit personnel concerning this incident which, when to hand will be forwarded direct to HM Coroner. Although no further report will be submitted by this unit appropriate addressees will be notified of the findings of the Coroner's Inquest which will be held in due course."* The witness statements were duly sent direct to HM Coroner under cover of a letter dated 28th June. The reality is that RMP undertook the taking of witness statements and evidence retrieval because the civilian police did not see Sean's death as suspicious or one of possible third party involvement. In short, they did not believe that a crime had been committed. If that was the stance taken at an early stage on 9th June 1995, then what the RMP were investigating thereafter was, by definition, a non-suspicious death or probable self-harm. There was no specific factor pointing in any other direction and such a conclusion had the concurrence of the Coroner's officer who, while not necessarily a trained detective, has the responsibility of co-ordinating or instigating lines of enquiry to assist at the inquest. If the early conclusion that the death was not suspicious was reached by the civilian police and that was why the RMP were tasked with investigating, then it might be argued that expensive forensic tests were not required to demonstrate something already accepted.
- 5.92 The question of primacy for the investigation continued to be an issue in the other deaths, but with the benefit of hindsight it can be said that the pattern established in Sean Benton's death, and followed in the deaths of Cheryl James and Geoff Gray, should not have occurred. Responsibility for the investigation in each case should have been retained by the civil police until a sufficiently thorough and objective investigation enabled a senior civilian police officer to reach a policy decision that excluded the hypothesis of homicide or third party involvement or responsibility.
- 5.93 However, it was not the decision of the RMP to exclude Surrey Police from the investigation. Indeed, the Army clearly thought at various times that, by investigating in support of the Coroner, it was acting on behalf of Surrey Police. Constitutionally, the Coroner's officer, although frequently a constable or former constable in a local police force, is the agent of the Coroner, rather than of the police force who pays and employs him or her.
- 5.94 Nor is there any evidence identified by Surrey Police or this Review that in 1995, or subsequently, evidence was deliberately mislaid or destroyed. Frustrating as the consequences have been of missing documentation and unretained exhibits, documents appear to have been disposed of in good faith in accordance with local practices. With the inquest taking place within a month of Sean's death, and the BOI shortly thereafter, this did, indeed, seem to be a case of speedy investigation and closure for all concerned. That, of course, is not how things have transpired.
- 5.95 As discussed in Chapter 3, a jointly agreed Protocol between the MOD and ACPO now exists for investigations of all deaths in land or premises owned, occupied or under control of the MOD in England and Wales.⁶¹ In the concluding Chapter of this Report, recommendations will be made on the need for the RMP to adopt available best practice, applied by the civilian police force, when they have primacy for investigation of potentially serious incidents or crimes by reason of occurrence abroad. In particular, the RMP will have to be sensitive to the challenge of protecting witnesses from harassment or victimisation when investigating serious misconduct in a close knit military unit. Whatever the shortcomings in their original investigation, scrutinised as it has been in subsequent years, there is no evidence to suggest, or other reason to believe, that the RMP covered up the wrongdoing of others.

⁶¹ See Appendix 16, Protocol of September 2005.

(iii) Evidence of bullying by NCOs and trainees?

5.96 The third question posed at paragraph 5.51 above asks whether there is any evidence that Sean was driven to self-harm by bullying or harassment. At the inquest into Sean's death on 6th July 1995, the Coroner asked a direct question of Major Gascoigne, the Officer Commanding B Squadron: was there any evidence at all of Sean being pressured or bullied, verbally or physically? The answer was as follows:

"No, he was not the sort of person who was going to be bullied, he was a physically strong boy and could keep up with the runs, he could handle things without any problem at all and there is no bullying going on in my squadron that I am aware of at the moment anyway."

5.97 The answer is a bold one as, despite Sean's physical strength, his emotional responses to disappointment at not advancing his military career, and his regular conflicts with authority, were hardly likely to endear him to comrades. The subsequent Surrey Police re-investigation has unearthed a body of material suggestive of oppressive practices by NCOs directed against some Phase 2 trainees at Deepcut, and Sean in particular.⁶² It has also brought to light material indicating that some fellow trainees had ganged up on Sean and subjected him to physical force.⁶³ The Review is in no doubt that the evidential picture in this respect has changed substantially since the inquest into Sean's death. Major Gascoigne may well have been unaware of evidence of bullying at the time,⁶⁴ indeed, it would appear few, if any, of the complaints that subsequently came to Surrey Police's attention were reported contemporaneously, but the evidence from Chapters 7 and 8 of this Report tends to show that a failure to report abuse of power is by no means conclusive that such abuse was not, in fact, happening.

5.98 The evaluation of the evidence of bullying in the material behind the Duty of Care Schedules causes particular difficulties to this Review. If there is clear, consistent and credible evidence that Sean was ill-treated and humiliated by others during his training and that this led to the decline in his conduct and morale, noted by others, over the period from February to June 1995, this is doubtless material to the circumstances in which he met his death. The Coroner's question to Major Gascoigne was relevant to the conduct of the inquest in 1995 and it is even more relevant in light of the more generous construction of the scope of inquiry of an inquest, as discussed in Chapter 2.

5.99 As noted in Chapter 1, some of the material in the Duty of Care Schedules is extremely vague in content, frequently consists of the recycling of hearsay and rumours, and may emanate from people who, themselves, have poor records with respect to discipline or honesty and may have their own motives for making allegations against others. None of the allegations relating to incidents in 1995 appear to have been the subject of contemporaneous formal complaint to Major Gascoigne, or others in authority at the time. Only a few of the allegations, unrelated to Sean, were the subject of RMP investigations at the time.⁶⁵ One trainee explained to Surrey Police that he did not complain of an assault as there was no point in complaining up the chain of command at the time.⁶⁶ Sean,

⁶² See Appendix 5, entries 10, 13, 14, 15, 18, 19, 22, 29, 34, 37, 48, 60, 63, 74 and 80. See also paragraph 7.7 below where the Evans Report of 1995 notes "... there is no indication of mistreatment within Training Regiment and Depot RLC."

⁶³ *Ibid*, entries 11, 50 and 69. See paragraph 5.156 ff below.

⁶⁴ As noted at paragraph 5.99 below, having met Major Gascoigne, the Review believes he would have acted on any such evidence.

⁶⁵ See Appendix A5, entries 71 (1996) and 77 (1994). For a detailed discussion of the incident behind entry 71, see paragraph 7.22 ff below.

⁶⁶ *Ibid*, entry 60.

however, was not assessed to be of shy or nervous disposition. A number of informants – trainees, NCOs and officers alike – have suggested that he was able to stand up for himself and answer back, and indeed the latter appears to have been the source of some of his problems.⁶⁷ Sean had frequent meetings with his superior officers, and the medical staff, in the period from January to June 1995 and if he believed he was being unjustly treated he had considerable opportunities to make this clear. Having interviewed him, the Review does not believe that Major Gascoigne would have ignored such matters if they had come to his attention.

- 5.100 Further, as the evidence of Private(f) J cited earlier illustrates,⁶⁸ ‘bullying’ is a subjective term with no clear distinction between legitimate sanctions available to an NCO to deal with unacceptable behaviour, and gratuitous violence or humiliating conduct. Soldiers today, and then, refer to being ‘beasted’ by an NCO, without intending any alarming connotations of degradation. As a sanction, it would appear that ‘beasting’ may involve a range of conduct: a restriction of privileges, where a person cannot leave the camp and has to report at designated times; show parades where a person has to parade on extra occasions at a specified and inconvenient time with kit in immaculate order; and a range of physical exercise, non-exhaustive examples of which may include running around the square, a number of press-ups and carrying kit above the head.⁶⁹
- 5.101 In short, it would seem that ‘beasting’ could take any form an NCO deemed appropriate. Whether these were permissible sanctions is a matter of some debate unresolved by any clear criteria laid down in Army regulations at the time. The Review notes that where there is uncertainty, and much is left to the initiative of the NCO, there is a risk that the limits of legitimate sanction may merge into excessive physical tasks, or oppressive repetition of, or humiliating details attached to, modest physical sanction.

(a) Sergeant B

- 5.102 Nowhere are these concerns more central than in forming an assessment of Sergeant B, the Troop Sergeant of B Troop, who has been at the centre of persistent allegations in the media and elsewhere since the BBC Panorama programme ‘Bullied to death?’ broadcast in December 2002. As noted earlier in this Chapter, Sergeant B was directly concerned for the welfare of Sean in the final hours before his death. However, a significant proportion of the entries in the 1995 Duty of Care Schedule concern Sergeant B. That material, much of which is contradictory, has been seen by this Review and suggests that Sergeant B is a complex character.
- 5.103 Sergeant B joined the Army as a Junior Leader in the infantry and had tours of duty abroad before being assigned to recruiting duty. From there, he transferred to the RLC and trained as a Military Training Instructor (MTI). Corporal F attended the same MTI course as Sergeant B and both men moved to Deepcut at around the same time. During his tour at Deepcut, Sergeant B was highly praised by his superior officers for his particular compassionate concern for young trainees and his interest in them. Indeed, after he left Deepcut, Sergeant B had a career in Army Welfare Services (AWS) for which he was seen to be particularly suited. He has an unblemished disciplinary record.

⁶⁷ Major Gascoigne has told this Review that he did not believe that Sean was the sort of individual who would put up with bullying. See paragraph 5.174 below. See also paragraphs 5.125 and 5.128 for the opinions of Sean’s colleagues.

⁶⁸ See paragraph 5.62 above.

⁶⁹ See paragraphs 5.116, 5.137-138, 5.142 and 5.160 below. See also Appendix A4/12.007 F - G for the examples given to this Review by former Squadron Sergeant-Major at Deepcut, Graham Milne.

(b) Evidence of Sergeant B's compassionate behaviour

5.104 In the mass of evidence collected by Surrey Police, there are numerous references by members of permanent staff and former trainees to Sergeant B's paternal attitude towards the young soldiers.⁷⁰ There is evidence that he took time out to tell them about his military career and experiences and that he was responsible for trips offsite to broaden the trainees' own experiences. Thus, Private(f) J, whose views on Lieutenant C and his treatment of Sean were highly critical, mentions Sergeant B's concern for Sean both in general and, in particular, on the night of 8th June 1995 when Sean accompanied him on his rounds and they spoke about Sean's future after the Army. Indeed, one trainee recalls how, in the hours after Sean's death, Sergeant B was showing particular concern towards him:

*"Sergeant [B] came over and told me that he was changing me around. I told him that I was OK but he insisted and I was sent back to the guardroom. This came about because he was aware that my brother had taken his own life. I believe he had been informed by Pirbright but he had spoken to me personally. During my time at Deepcut I had to apply for further compassionate leave for other family matters and Sergeant [B] would have approved this application."*⁷¹

5.105 Private(f) J is not the only NCO to have identified a seemingly compassionate streak in Sergeant B. A fellow Sergeant, Sergeant L, gives the following description of Sergeant B:

*"... he was a high-energy type of person. He was not someone who would simply melt into the background. He was a larger than life character who made a success of everything he had done in the Army. He had the best military intentions and would take control of any given situation. I recall that he had a close relationship with the WRVS [Women's Royal Voluntary Service] and was someone who showed an interest in the welfare of the recruits."*⁷²

Another NCO highlighted Sergeant B's particular ability to relate to trainees:

*"[Sergeant B] tried to raise the standard of recruits ... He would spend time with the recruits out of hours. He would know where they came from, their families circumstances. He was streetwise, he would read the same magazine as the recruits and listen to the same music. He had a better understanding of the young recruits than me ... He could reach them on their level."*⁷³

5.106 It is clear that the vast majority of the permanent staff at Deepcut respected Sergeant B as a soldier. The following are further general comments about him from his superior officers: "he was a particular strength throughout my tour" (Major M);⁷⁴ "he was held in very high regard by all" (Major N);⁷⁵ "an extremely capable NCO, [I] respected his opinion" (Major Gascoigne);⁷⁶ and "he was a very experienced Sergeant that I trusted" (Lieutenant(f) A).⁷⁷

⁷⁰ See also paragraphs 7.24-25 and 9.55 below.

⁷¹ 13th March 2003.

⁷² 16th December 2002.

⁷³ 22nd January 2003.

⁷⁴ 5th June 2003.

⁷⁵ 7th February 2003.

⁷⁶ 9th October 2002.

⁷⁷ 15th November 2002.

(c) Sergeant B's 'twin brother'

5.107 A number of former trainees, in their evidence to Surrey Police during their re-investigation, describe in some detail how Sergeant B had two sides to his personality. A female Phase 2 trainee at Deepcut in 1996 gave the following portrait:

*"Sergeant [B], was a troop Sergeant, who I would describe as hard but professional, in fact his style of training helped me to get where I am today. Sergeant [B] gave the impression, and spoke of having two sides to his nature, one the 'soft side', the Mr Nice Guy, and the other Mr Nasty, which would blow up, if you mucked up during your training."*⁷⁸

5.108 The description of Sergeant B as *"hard but professional"* is reflected in a number of other statements: *"firm but fair"* (Private P)⁷⁹ and *"hard but fair."*⁸⁰ However, by far the most consistent characteristic of Sergeant B to emerge from the 1995 material is his use of an imaginary 'twin brother' when disciplining trainees. This was acknowledged by him in his extensive interviews with Surrey Police and in correspondence with this Review. He explained that he deliberately cultivated it as a management tool to cope with the strains and stresses of his job as a continuation training instructor to those on SATT at Deepcut, with few resources, facilities or staff to assist in the task of managing large and unpredictable numbers of trainees, who were essentially waiting for something else to happen.⁸¹ A trainee who shared a room with Sean, Private Q, understood this approach:

*"I had a lot of respect for [Sergeant B] as a person and as an instructor. I was aware that [Sergeant B] had another side to him, his 'twin', but I took this as a training method. I knew he used this as an instructional aid."*⁸²

5.109 Lieutenant(f) A, who was Sergeant B's Troop Commander, was also aware of the 'twin brother':

*"I was aware of his use of his imaginary 'brother'. I think he called him 'Jerry Can' but as far as I was concerned it was not an issue and was his way of management. I would describe him as a soldier's soldier."*⁸³

As will be seen in the next Chapter, it would appear to be a feature of Lieutenant(f) A's management style that she deferred to Sergeant B's discretion with little supervision or scrutiny of his actions.⁸⁴

5.110 This use of his 'twin brother' clearly endeared Sergeant B to some of the trainees, who saw him as an inspiration, one even citing him as one of the reasons for staying on in the Army. It is interesting to note that there is a suggestion that those who remained at Deepcut for longer than normal, for instance as a result of long-term injuries causing them to be

⁷⁸ 31st December 2002.

⁷⁹ See Appendix 5, entry 37.

⁸⁰ 12th February 2003.

⁸¹ See paragraph 5.119 below.

⁸² 24th April 2003.

⁸³ 15th November 2002. Lieutenant(f) A would appear to be mistaken in the name assigned to Sergeant B's 'twin brother'. See paragraphs 5.115, 5.126, 5.133 and 5.144 below.

⁸⁴ See paragraph 6.171 ff below.

medically downgraded, may have had the opportunity to become better acquainted with Sergeant B and were able to adjust their views on the use of his 'twin brother' which, as will be seen later, was clearly intimidating to some.⁸⁵

- 5.111 Life during SATT at Deepcut in 1995 was tedious and one of Sergeant B's tasks, as one of the Troop Sergeants, was to try to keep trainees occupied, as well as disciplined. Private(f) R gave a picture, echoed by others, of what life entailed:

*"I remember a Sergeant named [B]. He used to run the parades. Jobs would be allocated and volunteers would be asked for. Generally the type of jobs given were cleaning duties, cleaning the Sergeants' mess or sweeping the camp. There was very little actual military training, most of the time it ended up being a run. We used to try to stretch the jobs out for as long as we could just for something to do to kill the time. People used to skive off down to the NAAFI or back to their rooms. This was easy because most of the time we were unsupervised."*⁸⁶

- 5.112 The management tool adopted by Sergeant B of attributing his verbally aggressive side to his 'twin brother' was perhaps his way of trying to control the large number of transient trainees, in the face of few stimulating tasks and limited support. Some former trainees, when interviewed by Surrey Police during their re-investigation, took a benign view of Sergeant B's behaviour and the motivation behind it, and made the following observations:

*"I found him all right, he was a typical army sergeant and was only doing his job. He may have been over excessive sometimes but I now appreciate the job he had to do. If you played ball with him he was OK. He had to maintain the standards set in Pirbright. I do not believe he picked on individuals, he just picked up people who needed to have been picked up. In fact I was often pulled up..."*⁸⁷

*"He expected high standards, which he maintained, which was his way of preparing you for your unit when you got posted."*⁸⁸

- 5.113 The more persistent view of those who gave statements to Surrey Police in 2002 was less generous. A female Private, who was at Deepcut in 1995 with Cheryl James, described how Sergeant B's approach appeared to her:

*"I clearly remember a Sergeant [B] who used to more or less run the camp. He was extremely strict and seemed mad. He used to say he was going to get his brother then turn around shouting and spitting at us. It was his threat of 'shall I go and get my brother?' He used to creep through the grass whilst you were on guard duty and spring out on you. I remember once he was on top of a building watching us. If he was on duty you had to be a few metres apart from each other on guard so you did not talk. You had to remain alert if he was guard commander."*⁸⁹

⁸⁵ It appears to the Review, that some of the more informative material obtained by Surrey Police during their re-investigations was from former trainees who worked in the Quartermaster stores or offices as a result of a long-term injury. Indeed, Major Gascoigne was to note at the BOI held in response to the death of Cheryl James that: *"Much of our information comes from trainees working in the Staff Quartermaster Sergeant Stores."*

⁸⁶ See Appendix 5, entry 19 of the 1995 Duty of Care Schedule; 22nd January 2003. The Review has seen other evidence, from trainees and NCOs, to suggest that trainees would attempt to hide in the camp in order to avoid being given tasks.

⁸⁷ *Ibid*, entry 53; 21st January 2003.

⁸⁸ 20th December 2002.

⁸⁹ See Appendix 5, entry 35 of the 1995 Duty of Care Schedule; 20th September 2002.

- 5.114 There is evidence that would seem to suggest that Sergeant B did display some eccentric behaviour. In addition to the description of him creeping through the grass, cited above, there are references to him watching trainees from the roofs of buildings and hiding in bushes, seemingly done to keep trainees on their toes.⁹⁰ Similarly, several trainees recall seeing Sergeant B – a Sunderland supporter – burn Newcastle football shirts belonging to other trainees, although it is not clear on how many occasions this occurred.⁹¹ However, the consensus on this issue seems to be that this was done in good humour. One trainee whose own shirt was burned is noted by Surrey Police as describing it as “*just fun*”.⁹² Another trainee recalls that, despite his fanatical support for Sunderland, Sergeant B did not make fun of him for owning a Newcastle shirt, as he was aware of and sympathetic to that particular trainee’s personal circumstances.
- 5.115 There are suggestions that Sergeant B was friendly and helpful if he liked you, but could be oppressive and aggressive if he did not. Those who met his ‘twin brother’, or saw others incur his wrath, never forgot it. To this day, when members of the Review team had an opportunity to speak with staff now serving at Deepcut, who had themselves been trained at Deepcut in 1995, Sergeant B’s ‘twin brother’, and a water container filled with sand dubbed ‘Private Jerry Can’, were immediately remembered. The apparently contradictory character of Sergeant B is captured in a Surrey Police officer’s report summarising an interview with a trainee:

*“He said that he would describe [Sergeant B] as a very, very intimidating person but on other occasions could be kind and helpful ... However, [he] went on to explain that when [Sergeant B] turned, he got really nasty and became the most evil person one could ever imagine.”*⁹³

Another trainee recalls Sergeant B’s changeable mood: “*When he was in a good mood he was a nice bloke to be around but if his mood changed anything could happen.*”⁹⁴

(d) Abuse of authority?

- 5.116 There is a substantial body of material collected by Surrey Police from former Phase 2 trainees that suggests that on occasions Sergeant B, through the use of his ‘twin brother’ personality, and other NCOs generally, exceeded the legitimate bounds of disciplinary command and sanction. This Review has been able to analyse that evidence, which is essentially the material behind the 1995 Duty of Care Schedule. Female trainees who gave statements were particularly critical of Sergeant B and his methods. For example, Private(f) R recalled:

“When his ‘twin’ brother came out people would be picked up for the slightest thing. I tried my best to stand in the back ranks and to keep my head down and not to get noticed. However I recall him shouting in my face for no apparent reason. The parades could go on for hours and I remember some people passing out when it was hot. He used to get the whole parade running up and down. Sending us back to the blocks and get changed into shorts or whatever he wanted. Running back to the parade then sending us back to do something else. In my opinion he used

⁹⁰ See Appendix 5, entries 24, 25, 26 and 35 (see paragraph 5.113 above). See also paragraph 6.122 below. The Review is also aware of other evidence that supports these accounts.

⁹¹ *Ibid*, entries 16, 17, 21 and 76. The Review is also aware of other evidence that supports these accounts.

⁹² Another trainee was under no doubt that the incidents were ‘set up’.

⁹³ See Appendix 5, entry 76 of the 1995 Duty of Care Schedule; 5th March 2003.

⁹⁴ 6th January 2003.

*to go over board and what he did was totally unnecessary. The Friday afternoon parade was one of his favourites. Sometimes you could guess what type of mood he was in before the parade started. If he was in a bad mood that parade would be extended, knowing that people needed to catch trains to get home for the weekend. I think he did it purely to mess people around. Again if people did not come up to standard I often witnessed recruits having to take their belts and berets off and being marched down to the guardroom for a beating. As previously stated I took my father's advice to keep quiet. There were a number of people [Sergeant B] used to regularly pick on. He would bring them out of ranks and make them do things like press up and sit ups, especially if it was muddy."*⁹⁵

- 5.117 In his interviews with Surrey Police, Sergeant B denied that it was in his power to order trainees to do press-ups, as that was a matter for the Physical Training Instructors (PTIs) alone. Indeed, in correspondence with the Review, Sergeant B has stated that he *"cannot remember any guidance being given regarding disciplining trainees apart from any organised physical activity must be conducted by appropriately trained Physical Training personnel."* From other information available to this Review, it is apparent that some NCOs were able to discipline trainees informally, including by use of press-ups, not supervised by PTIs. Former Squadron Sergeant-Major Milne (since retired), who was the senior Warrant Officer in B Squadron during Sergeant B's time, had the following exchange with the Review in a meeting:

"Qn: But for example, one issue which I can't quite get to the bottom of is, can any of the Sergeants or yourself award as a punishment extra press-ups for example?

Ans: Yes, it would probably happen.

Qn: And what's the limit to that – 1,000 press-ups might be oppressive.

*Ans: I think that's over the top. I don't suppose it would happen on parade – they would probably get marched away to the jail, the guardroom, and the Provo staff would work it out."*⁹⁶

- 5.118 The Regimental Sergeant-Major of the Training Regiment at this time has also been interviewed by the Review and expressed the opinion that press-ups of an indeterminate number could be awarded by a Sergeant in the exercise of his discretion.⁹⁷ Other NCOs who served at this time, and subsequently, have similarly stressed there was a broad discretion for imposition of sanctions for minor infractions.
- 5.119 Sergeant B has explained to the Review, in correspondence, that his 'twin brother' was a conscious tool he turned on and off, so he could be both a caring instructor and apply necessary discipline. He states the *"chain of command were aware of the use of this 'tool' and not on any occasion was I notified not to use the 'tool' in fact to the contrary often I was told by people senior to myself to use my twin brother as a 'tool' to management."* It has already been noted that Lieutenant(f) A, the Troop Commander of A Troop, knew about this device and did not counsel against it. Sergeant B has told the Review that he

⁹⁵ See Appendix 5, entry 19 of the 1995 Duty of Care Schedule; 22nd January 2003.

⁹⁶ Appendix A4/12.004 D – F.

⁹⁷ Appendix A4/17.007 A – 008 C.

adopted the tool partly as a response to the very high numbers he had to supervise, with the ratio of Troop Sergeant to trainees often exceeding 1:300. He believed his *"natural unassuming style of leadership would be ineffective mainly to the ratio of trainee soldiers and other factors such not having a command structure of NCOs within the troop and also the transient constant change of personnel within the Troop, trainees were arriving and leaving on a daily basis."*

- 5.120 However, a number of trainees give accounts of being hit by Sergeant B or seeing him hit other trainees, at times reducing them to tears.⁹⁸ It is asserted by a number of these trainees that they had not done anything to provoke such assaults. Others recall Sergeant B firing objects at trainees using a catapult, although there is some inconsistency as to what was being fired, and whether this was done by way of practical joke or not.⁹⁹ Another trainee recalls Sergeant B coming into his room late at night to assault a fellow trainee, then leaving and returning to ask whether anyone had seen his brother.
- 5.121 A further alleged incident, recalled by a female trainee, is worthy of note, as it would seem to suggest that Sergeant B was substituting his own punishments rather than taking matters through the formal disciplinary channels:

*"I had a fight once with a female who I can't recall her name. I punched her, [Sergeant B] got to hear about it, he came looking for me, found me in the warehouse, questioned me about the fight I had had and gave me two opportunities: 1) his punishment or 2) take it further which might have ended in a Court Martial. I said I will take your punishment and with that he punched me full force in the right arm. He said 'I don't want to hear any more' and walked away."*¹⁰⁰

(e) Sergeant B and Sean Benton

- 5.122 The use of press-ups as a sanction is clearly recalled by a number of the trainees, as well as the fact that one of those it was used as a sanction against was Sean. A female trainee recalls:

*"[Benton] was always messing about and often drank too much. He used to get singled out at on parade by the likes of [Corporal F] and [Sergeant B] and was given the 'shit' jobs to do and was given press-ups. I felt that Benton was given a hard time."*¹⁰¹

- 5.123 Even if press-ups might have been an acceptable disciplinary tool, there is evidence that inappropriate variations were adopted. A female trainee at Deepcut in 1995, gave her recollection of a specific occasion, also recalled by another female trainee, as follows:

"The only incident I can recall with any certainty is on one occasion he was made to stand out in front of the parade by a Sergeant [B] and do press-ups on top of a female Lance Corporal as punishment, I can't

⁹⁸ See Appendix 5, entries 11, 28 and 58.

⁹⁹ *Ibid*, entries 17, 36 and, 49.

¹⁰⁰ *Ibid*, entry 61; 12th December 2002.

¹⁰¹ *Ibid*, entry 42; 15th October 2002.

*remember what he had done. I remember thinking that it was out of order and humiliating for Benton. That is the first and only time I have seen anybody being made to do this whilst I have been in the Army.”*¹⁰²

The other female trainee who corroborates this incident, recalls another occasion when Sergeant B and Sergeant D, the Troop Sergeant for A Troop, made Sean do press-ups while having his face held in a puddle.

- 5.124 ‘Humiliation’ is a recurring term in some of the statements from former trainees when recollecting the treatment of Sean by Sergeant B and other NCOs. Much like ‘bullying’, it is an emotive term and one that is open to interpretation. It would appear Sean may well have been the subject of verbal abuse¹⁰³ and that some trainees felt that he was being ‘singled out’ or ‘picked on’.¹⁰⁴
- 5.125 However, as previously noted,¹⁰⁵ there is evidence to suggest that Sean was not afraid to voice his opinions or stand up for himself. One trainee, who felt that Sean was singled out to an extent, felt that Sean took punishments in good heart and gave NCOs an equally hard time. He recalled how Sean would often make ‘a wise crack’ on parade that would cause other trainees to laugh, but frustrate NCOs who could not control him and who may have felt that he was undermining their authority. Over time this particular trainee was surprised that Sean continued with this type of behaviour when it was clearly bringing unnecessary attention on himself, but noted that that was the type of person Sean was.¹⁰⁶ Other trainees recall that Sean always had ‘a grin’ on his face when parading, and that this would cause him problems, and that Sean always gave the NCOs a lot of ‘back chat’.¹⁰⁷ Private K, one of Sean’s closest friends and to whom he wrote a note before he died, recalls that Sean acted “*as the class clown, he liked to make people laugh, and it is possible he got up some person’s noses.*”¹⁰⁸ A female NCO recalls her impression of Sean:

*“I wouldn’t describe Private Benton, as a trouble maker, but he played to a crowd if others were around him. If on parade, and an NCO made a comment Private Benton would make a remark back, he had a cheeky streak in him. But I had no problems with him.”*¹⁰⁹

- 5.126 There are strong and consistent recollections by former trainees of disciplinary use of a heavy jerry can, normally used to contain water. It is suggested that this was personified by Sergeant B as ‘Private Jerry Can’. Two trainees, one of whom, Private S, was having to do the same, recall Sean being made by Sergeant B to get on his knees and ask Private Jerry Can for forgiveness.¹¹⁰
- 5.127 While some trainees recall only verbal abuse, the material relating to Sergeant B’s treatment of Sean does extend beyond humiliating press-ups and repeated drilling and petty duties. Private(f) T, a female friend of Sean’s, describes Sean being kicked and physically humiliated by Sergeant B:

“They had done the call roll ... called Sean out to front and [Sergeant B] said about you are going to be discharged, you are waiting for disciplinary action, he says so what are you you are a piece of shit and Sean just

¹⁰² *Ibid*, entry 20; 21st August 2002.

¹⁰³ *Ibid*, entries 14, 18, 19, 22, 29 and 63.

¹⁰⁴ *Ibid*, entries 10, 18, 34 42 and 74. The Review is aware of other evidence that supports this proposition.

¹⁰⁵ See paragraph 5.99 above.

¹⁰⁶ See Appendix 5, entry 48. See also paragraph 5.156 below.

¹⁰⁷ *Ibid*, entries 19 and 46.

¹⁰⁸ 15th November 2002.

¹⁰⁹ 1st May 2003. The Review is aware of other evidence consistent with this portrait of Sean, in particular the evidence of Lance Corporal(f) E.

¹¹⁰ See Appendix 5, entry 11 in the 1995 Duty of Care Schedule.

*laughed and he said don't who do you think you are laughing at or swearing he was swearing at him. He got him down on the floor and started kicked him ... I just remember like him being on the floor I think it was either like press he was supposed to have been doing something and he just sort of rolled him over and just started laying into him ... It was just kicking him with his boots ... [Sean] just laughed it off ... [Sean] says he has got it in for me why, I said I don't know, I really don't know Sean and he said, I reckon its because I'm, I'm being discharged he says, I think I'm going to be discharged. I think its because I'm going to be discharged and I said don't be silly you won't be discharged and I said you'll probably just get a slap on the wrist or whatever and he says no, no I'm not and he says that's why he has got it in for me, he says because I shouldn't be here should I ..."*¹¹¹

- 5.128 It was not only the female trainees who thought Sergeant B was bullying Sean. Private U, whose friends included Sean and Private S, described the following in a statement to Surrey Police:

*"I have seen Sergeant [B] for a unknown reason, punch Sean in the chest and other areas on the body, whilst on parade and just when passing Sean. These punches were not in fun and I am sure they hurt Sean. At first Sean took the abuse and laughed it off but as time went on it got to him almost every other day. As did the constant guard duty that he was put on by these two. Looking back I now think that Sergeant [B] and Corporal [F] went out to break him, but Sean's reaction was to 'fight back harder' and answer back more. When told his kit was in a poor state and it hadn't been ironed, Sean would answer back it had. This reply would cause him additional problems and punishments. Sean's attitude was defiant and he was adamant that 'he wasn't going to be broken' and forced to do something he didn't want to do. Most male and female soldiers were in fear of NCOs but [Sergeant B] and [Corporal F] were the worst. Both had favourites and Sean wasn't one of their boys."*¹¹²

- 5.129 One former trainee¹¹³ says he saw Sergeant B head-butt Sean on one occasion and felt that he was picking on him. Such allegations are contrasted by the recollections of Private P, who considered himself to be a friend of Sean's, who has good words to say about Sergeant B's treatment of Sean:

*"Sergeant [B] who I knew as [B] was fine towards Sean. I thought that [B] was a good bloke he was firm but fair. He would have a laugh and joke with the lads. He would sometimes play around and punch some of the bigger lads. I never saw him hit anyone small ... A few week's before Sean's death [B] asked me to look out for Sean to make sure nobody picked on him."*¹¹⁴

- 5.130 None of the NCOs interviewed suggest that physical assault was a legitimate sanction at this time, although, as will be the seen in Chapter 8, the position may have been more ambiguous in as late as 1998. Sergeant B vigorously denies all the allegations of assault. He argues cogently (along with others accused of such assaults) that if, as alleged, they had happened on parade more people (trainees and others) would be aware of them and

¹¹¹ 12th September 2003.

¹¹² See Appendix 5, entry 60; 16th January 2003, but see footnote 114.

¹¹³ *Ibid*, entry 10, but see footnote 114.

¹¹⁴ *Ibid*, entry 37; 15th January 2003. It is to be noted that this and the two previous references were from statements made after the BBC Panorama programme broadcast in December 2002 that named Sergeant B as a bully.

could have complained at the time or support these allegations now. He identifies that the one occasion when Sean was formally punished at his instigation was when Sean called him an 'arsehole' in front of other trainees when he tried to offer words of encouragement to him on finding him upset.¹¹⁵ This may have been the punishment recorded against Sean for the 14th February 1995 for insubordinate language, and, if so, this was referred to by Sean in his last letters, as will be seen later in this Chapter. Sergeant B has also pointed out that the publicity given to allegations in the media has been extremely distressing to him and his family and has resulted in him and them being subject to undeserved harassment and abuse.

- 5.131 As noted, a number of other trainees thought that while Sergeant B was 'hard', he was also fair, and specifically noted that they never witnessed physical violence by him on parade or elsewhere. The totality of the allegations of criminal conduct against Sergeant B was sent by Surrey Police to the Crown Prosecution Service who concluded that there was insufficient material to mount a prosecution.
- 5.132 This Review is not a court and it has not conducted a trial. It is clear, from the totality of material seen, that Sergeant B is vulnerable to being demonised by lurid accounts in the media that influence others. Further allegations against him from females appear in the next Chapter and have been similarly vigorously denied and have been damaging to him. He has suggested that he may have been mistaken for other NCOs and may have remained uppermost in the recollections of former trainees because he was the induction Sergeant they first met on arrival at Deepcut and he was attempting to grasp the problems he faced in an unusual manner, by use of his 'twin brother'. Similarly, it may be that the conduct of other NCOs is crowded out from the memories of trainees by Sergeant B's eccentric behaviour. Some of the reported claims made against him may well be false or inaccurate or, indeed, malicious. However, in selecting the references above the Review has sought to identify direct observations not based on hearsay, from people who have no apparent or known grievance against the Army in general or against particular NCOs.
- 5.133 The adverse accounts given by the trainees receive some support from other members of the training staff at Deepcut at that time. Putting aside for present purposes the controversial figure of Lance Corporal(f) E, who was to be removed from Deepcut in late 1995, there are others who expressed their concerns to Surrey Police. Sergeant V, who was a Sergeant in the stores at the time, stated:

"Sergeant [B] was a very experienced soldier. Everyone used to go to him because of his experience, he was the main man when it came to the recruits. Some of his techniques I disagreed with for example he definitely had two personalities however he was a good soldier and a good instructor. Sometimes it was like talking to two different people. He invented his twin brother who when he became him was a complete lunatic and madman. The recruits could not reason with him they could not do anything right when he was as his brother. We all thought when he went into his brother we did not want to be part of that and that included instructors. I had 14 years experience of training and I thought it was totally wrong. It was as if he had no control over it. Specifically I have seen him hit recruits in the chest with his fist although he never drew the arm back. Recruits have gone down winded. He did not hit them once they went onto the floor. He reduced recruits to tears. He

¹¹⁵ See paragraph 5.18 above.

made them carry a jerry can around as punishment ... I think that he had some mental problems especially when he was his brother although he had a lot of stress with the recruits.”¹¹⁶

- 5.134 Corporal(f) W was an experienced soldier and NCO assigned to Deepcut for six months from September 1995 and was, therefore, only present after Sean’s death. She has a recollection of Sergeant B:

“I have been asked to comment on a Sergeant [B] who I noted as a very professional soldier, who attempted to maintain discipline at all times and expected it from his NCO’s around him. That was until I witnessed a female soldier out on a run, where she was falling behind and showing lack of effort. This caused Sergeant [B] to lose control which resulted in him throwing a ‘tirade’ of abuse at the female. His face was purple with rage, which was inches away from the female’s and she was leaning backwards to escape the verbal assault. This action caused to me to stop for a few seconds I thought that he might take further action against the female. What I witnessed caused me concern and changed my impression on the man from that day. He knew I was present and watching him, but having made a comment about the incident he was still in a rage but calming down and walking away. This outburst ‘stunned me’ and shocked me and I couldn’t believe what I was witnessing. Because what I had seen caused me to comment about it back in the Squadron only to be told ‘You have now met his twin brother’.”¹¹⁷

- 5.135 The Regimental Provost Corporal whom Sean tried to hit on the morning of the 8th June 1995 as he paraded for guard had this to say:

“A person that caused extra friction, and had two sides to him, was Sergeant [B], who was a strange man. He would be nice one minute, the next he could be wild with rage, which he referred to as his brother. He is the Jekyll & Hyde person. I was not aware of any incidents or assaults carried out on any phase two soldiers by him or Corporal [F], otherwise I would have said something.”¹¹⁸

(f) Other NCOs and Sean Benton

- 5.136 There are a number of other accounts of physical assault of Sean whilst on parade that have come to light during Surrey Police’s re-investigation. While it is difficult to neatly separate allegations where more than one NCO was apparently present, even if not physically contributing to a punishment, it would be invidious not to draw attention to allegations of bullying against Sean in which NCOs other than Sergeant B are also, or exclusively, involved.

- 5.137 Corporal F, whose role in the events leading up to Sean’s death has been noted, is an NCO who is mentioned by former trainees, often in conjunction with Sergeant B. The Regimental Provost Corporal, referred to above, recalls how he noticed the effect on the trainees of these two NCOs:

¹¹⁶ See Appendix 5, entry 73; 18th March 2003. The Review is aware that some trainees have made complaints of sexual fraternisation against Sergeant V, see paragraphs 6.128 and 6.162 below. Others have pointed out that he should have voiced his concerns at the time and it should be noted that this statement was made after December 2002 when the BBC Panorama programme that named Sergeant B as an alleged bully was broadcast. However, the Review has seen no evidence of a particular animus against Sergeant B.

¹¹⁷ See Appendix 5, entry 52; 16th December 2002.

¹¹⁸ *Ibid*, entry 23; 31st January 2003.

*"I noticed that when certain NCOs were on duty, most of the Phase two soldiers appeared to be beasted a great deal, in fact they were "fucked about", with what appeared to be extra show-parades, room inspections and kit inspections. The main persons causing this extra trouble were, Sergeant [B], Corporal [F] and a few others ... All these beatings, were done to keep the soldiers away from the NAAFI and drink ..."*¹¹⁹

- 5.138 We have already seen, in relation to Sean, that denying him the opportunity to go to the NAAFI was a consideration in the hours immediately before his death. However, a number of former trainees suggested to Surrey Police that Corporal F and Sergeant B worked in partnership and handed out punishments arbitrarily:

*"Corporal [F] was just an out and out bully and an extension of [Sergeant B], in fact his right arm man for punishments."*¹²⁰ (Private U)

*"[Corporal F] like [Sergeant B] was prone to giving unnecessary punishments. I recall an incident when I returned to my accommodation block to find all the beds had been turned over and the rooms trashed. Although [Sergeant B] and [Corporal F] were not there it was clear that they or someone else from the training team were responsible."*¹²¹ (female Private)

*"If you got caught for doing anything you shouldn't Sergeant [B] or Corporal [F] had you beasted til you dropped. If they didn't do it they got the PTIs to do it for them ... whilst being beasted when they got tired watching you, they handed over the supervision to another NCOs again til you dropped. Blokes would hide in various places in the camp to get out of 'tasks' but the NCOs would come looking for you, this resulted in more beasting and so it went on."*¹²² (Private K)

- 5.139 It would seem that Corporal F may have been a significantly different personality to Sergeant B. Private S, a friend of Sean's, recalled: *"Corporal [F] was very quiet in his actions but he was hammering people on the drill square and he would also speak to people on the QT making sure no one else knew what was said."*¹²³
- 5.140 Private U, who was friends with Private S and Sean, alleges that he was physically assaulted by Corporal F. Similarly, some evidence suggests that Corporal F was witnessed physically assaulting Sean. For instance, the evidence of Private(f) X to Surrey Police stated:

"I shall never forget seeing my first parade which would have been round about the end of March and on the first week in April [1995]. About 150 soldiers, looking back, too many standing outside of the road, pathway near the cookhouse where I witnessed a male soldier who I later found out was Private Sean Benton, being bullied, shouted at by Sergeant [B], what was being said I can't recall. Because Private Benton didn't reply, or say the correct words, Corporal [F] punched Private Benton in the stomach, Sean fell to the ground as his legs gave way, in fact I heard the air come out of Sean. As Sean lay doubled up, one hand holding his stomach, the other

¹¹⁹ *Ibid*

¹²⁰ 16th January 2003.

¹²¹ See Appendix 5, entry 42; 15th October 2002.

¹²² *Ibid*, entry 34; 14th December 2002.

¹²³ *Ibid*, entry 11; 11th September 2002.

hand, left hand was held over his head as if he was protecting his head, from a expected blow. [Corporal F] then commenced kicking Sean in the back, kidney area, two or three time at the same time Corporal [F] was shouting at Sean to get up. Sean got up, I could see he was holding back tears, his face was bright red. He rejoined the paraded soldiers. I had just arrived at Deepcut ... I never witnessed any other assaults." ¹²⁴

- 5.141 Another female Private recalls Sean being given the choice by Sergeant B of whether he would like a dead arm or a dead leg and that this was carried out on parade.¹²⁵ Another female informant may be referring to this or a similar incident, in which another member of staff may have assaulted Sean, when she describes the following:

"Sergeant [B] would pick Benton out of the parade and humiliate him in front of us. I can recall one incident when Sergeant [B] got Benton out in front of us and made him lay down on the ground, I can remember Benton saying 'no sarge, no sarge'. He was then punched in the leg giving him dead leg. I cannot remember whether it was Sergeant [B] or an RP [Regimental Provost] that punched him. Other incidents would take place on the parade ground when Benton would be picked by Sergeant [B], Benton would be picked on if another member of the parades kit was not up to scratch, or he would get the soldier with the problem out as well as Benton and bang their heads together." ¹²⁶

- 5.142 Another former trainee¹²⁷ never saw Sergeant B hit anyone but believes Sean was subject to 'beastings', by which he means being made to do fast time marching and other forms of punishment three or four times a week. Another informant to Surrey Police recalls an assault on Sean by an unidentified NCO:

"Something about Benton's dress had upset one of the inspecting NCOs, who slapped Benton across the face, with the palm of his hand. Benton made no reply or gave any reaction, he just stood in line and took it. This incident took place in 1995." ¹²⁸

- 5.143 A trainee¹²⁹ recalls Sean telling him that he had received beatings at the hand of NCOs and seeing an unidentified Sergeant having Sean up against a wall by his throat. A female trainee, who responded to the BBC Panorama programme had a recollection of seeing Sean punched in the stomach by an unnamed NCO when he was made to stand aside from the parade:

"I have memory of one specific incident involving Benton. It was during a parade where Benton was wearing civilian clothing. I cannot remember the date of this parade or the time of the day it occurred. However, Benton for some reason was removed from the parade ground and was made to stand alone, at attention in front of the parade. I do recall that the location was the footpath outside the offices. One of the training team, a male punched him in the stomach. Benton was supposed to take the punch and not fall but he doubled up and fell to the ground. I cannot

¹²⁴ *Ibid*, entry 29; 30th January 2003. It should be noted that this statement was made after the BBC Panorama programme naming Sergeant B, and alleging that Sean was bullied, was broadcast in December 2002.

¹²⁵ *Ibid*, entry 13

¹²⁶ *Ibid*, entry 18; 20th September 2002.

¹²⁷ *Ibid*, entry 66.

¹²⁸ *Ibid*, entry 65; 10th February 2003.

¹²⁹ *Ibid*, entry 43.

recall how many times he was punched, it may have been more than one punch. Again I am presuming the male punching him was an NCO. I cannot now describe him and he was not someone from the general staff I recognised. I do not know why Benton was punched, I personally think it was more to intimidate than a punishment for doing something wrong. I recall that Corporal [O] was present when this happened.”¹³⁰

- 5.144 Corporal O is another NCO at Deepcut whose name is mentioned in statements in relation to the treatment of Sean. Private P, who considered himself to be a good friend of Sean’s, and who, as noted earlier, did not have concerns regarding Sergeant B’s treatment of Sean, recalls an incident when Sean was punished by Corporal F and Corporal O:

“As time went on at Deepcut, I got to know Sean Benton better and began to look out for him. He always seemed to be picked on by [Corporal F] and [Corporal O] I can recall one incident where Sean was made to run from our block to the rugby posts and back with a jerry can that was full of sand and water. This can weighed a great deal. The jerry can I believe was called Private Jerry. Corporal [F] made Sean do this with the jerry can but I do not recall why. Others would also be made to run with the jerry can if the billets weren’t up to scratch for example. At some stage everybody would have to run with the jerry can the distance would be about 300 yards. Sean had to run with the jerry can on a number of occasions, because he was small built he couldn’t do it every time, he would be called a poof, prick, he would be pushed and kicked by [Corporal F] and [Corporal O] to make him carry on. As time went on Sean’s mood changed he started to not care about himself or his kit.”¹³¹

- 5.145 Private P also believed that Corporal F and Corporal O tried to turn trainees against Sean by handing out punishments to those who tried to help him. The incident described above and each of the other allegations were put to Corporal F during his interviews with Surrey Police and he emphatically denied that they ever occurred. Indeed, he effectively described the incidents as so preposterous that they were laughable given that they would have been performed in front of other trainees and members of staff. Corporal F further states that he did not see any trainees being bullied, either by members of staff or by other trainees. He recalled that Sean was a *“problem child he had a lot of issues and distresses on his mind.”*¹³² He also alluded to the point that friends of Sean may, quite rightly, have seen things differently from their point of view as they may only have seen the punishments Sean received, rather than the behaviour that led to them. He also expressed surprise that Corporal O has been mentioned in this context as he was *“a model soldier.”*¹³³ Corporal O has, similarly denied the allegations made against him. Corporal O has maintained these strong denials of misconduct in response to correspondence from this Review. Both Corporals will be the subject of further comment in the next Chapter.

(g) Lance Corporal(f) E

- 5.146 It is appropriate at this juncture to note the evidence of Lance Corporal(f) E. The evidence suggests that Lance Corporal(f) E, a female NCO, was seen by a number of trainees as being approachable and fair.¹³⁴ Lance Corporal(f) E has alleged that the NCOs mentioned above

¹³⁰ *Ibid*, entry 78; 12th September 2003. She also alleges she was the victim of harsh treatment from Sergeant B.

¹³¹ *Ibid*, entry 37; 15th January 2003.

¹³² 16th July 2003.

¹³³ *Ibid*.

¹³⁴ See Appendix 5, entries 34, 60 and 62 of the 1995. The Review is aware of other statements that support these impressions..

did bully and physically assault Sean. She states that she did voice concern at the time to Corporal F regarding Sean's treatment but was given short shrift by him. This is supported by some evidence seen by the Review.¹³⁵ Lance Corporal(f) E did not escalate her concerns regarding the treatment of Sean up the chain of command at that time nor did she first approach Surrey Police with them in 2002. The Review has met with Lance Corporal(f) E and is grateful for her assistance, but in light of the circumstances of her dismissal from the Army, noted below, as a basis for a grievance against some NCOs with whom she worked at the time and some inconsistencies that have emerged in the details of her accounts, is compelled to treat her recent accounts with very considerable caution.

- 5.147 As one of only a few female NCOs, living in the female block before moving to a permanent staff block, Lance Corporal(f) E was a confidante of some of the female trainees.¹³⁶ Lance Corporal(f) E states that over time, after she voiced her concerns regarding Sean and as she became aware, often in confidence, of the fraternisation between female trainees and NCOs, she was viewed suspiciously by the other (male) members of staff. This is supported by some of the evidence seen by this Review.¹³⁷ Ultimately, Lance Corporal(f) E left the Army after a Court Martial,¹³⁸ however she has always maintained her innocence and believes that she was set up so as to silence her. The Review has seen no supporting evidence to this effect.
- 5.148 Although Lance Corporal(f) E has indicated that she was reluctant to press charges against Sean for his threatening remarks to her in the public house on 1st June 1995, the Review concludes it is unrealistic to imagine that the Squadron could have ignored Sean's behaviour to a Lieutenant and a Squadron NCO in a public place when under the influence of alcohol.
- 5.149 Lieutenant C has already been noted as someone with whom Sean was in apparent conflict. One informant told Surrey Police that Sean got more 'grief' from Lieutenant C than from Sergeant B. Lieutenant C's qualities as a Troop Commander will be reviewed in the following Chapter, where allegations of sexual fraternisation are a theme. If Sean was receiving disciplinary measures from April to June 1995 when he was a member of Lieutenant C's Troop, it would appear that this was monitored and noted by Lieutenant C in his weekly reports, required as a result of Sean's three-month warning. Whether officious discipline can be equated with bullying during this last period is a matter of conjecture. No substantial allegations of abuse are made in respect of Sean's Troop Sergeant for this last period, Sergeant D. Indeed, Sergeant D has written to this Review reminding it that there is clear evidence that he positively helped Sean in his difficulties when he cut himself having broken a window on 8th February 1995.¹³⁹ As will be seen later in this Chapter, Sean was to remember this in his final hours.

¹³⁵ *Ibid*, entry 29

¹³⁶ *Ibid*, entries 28, 40 and 52.

¹³⁷ *Ibid*, entry 28.

¹³⁸ Lance Corporal(f) E was removed from Deepcut in late 1995 and subsequently faced Court Martial for false accounting offences in respect of food and accommodation from a period in 1995.

¹³⁹ See paragraph 5.14 above and, in particular, footnote 11. Other former trainees refer in their statements to rumours that NCOs were responsible for Sean's incidents with windows. The Review finds no basis for a conclusion that NCOs were responsible for assaulting Sean by throwing him into or through a window. There is consistent evidence to the effect that Sean twice injured himself by breaking a window after which he came to the attention of the supervisory staff who brought him to the Medical Centre (see paragraphs 5.14 and 5.19 above). Indeed, Sean mentions in his final letter to his parents that they may be able to claim insurance to cover the "*windows that I broke*." See Appendix A8.001. The rumours clearly illustrate the difficulty the Review has faced in assessing the evidence obtained by Surrey Police.

(h) Sean Benton, extra guard duty and home leave

5.150 The reference to Sean being on constant guard duty in Private U's statement, quoted earlier at paragraph 5.129, is reflected by others, including those who, unlike Private U, did not consider themselves close friends of Sean.¹⁴⁰ Private K, the friend to whom Sean left a note, stated in 2002: *"If I had to do the amount of guard duty that Benton did, it would have got me down, I'm sure. Looking back perhaps it was their way of keeping an eye on him."*¹⁴¹ A former female trainee thought there was nothing wrong with assigning extra guard duty as an informal punishment and explained:

*"Guard duties were done on a rota, everybody had to do it at some stage, also people who had 'mucked up' did extra guard duties, amongst other things. For example if you were late for parade, not on parade, you might get extra duties on guard. You might also get given 'dirty' jobs as we called them, cleaning gutters, things like that as punishment. The offences that could result in 'extra duties' tended to be for the more serious stuff that if the NCOs wanted could get you put on a charge. Instead unless you kept doing it, you got a punishment more suitable, if they put you on a charge it went on your records. It seemed to us a sensible way of doing it and fair."*¹⁴²

5.151 The practice of issuing additional guard duty was put to Corporal F in his interviews with Surrey Police:

*"As a Corporal at the barracks at Deepcut I haven't got the authority to put people on guard or take people off guard ... That's not my call... As far as I can remember it would be the Company Sergeant Major or it might be delegated from the Company Sergeant Major down to the two Sergeants but as a Corporal you don't do a guard roster, you don't decide who's on guard and who's not on guard. You haven't got the authority to take people off and put them on guard."*¹⁴³

5.152 In discussing matters of policy with senior Army officers, this Review understands that guard duty should be allocated fairly as a tedious, but necessary, military chore and should not be used as an informal punishment. The Review, however, is satisfied, from a variety of statements and sources of information,¹⁴⁴ that this was how some NCOs responsible for drawing up guard rosters were using it at Deepcut in 1995:

"... because certain NCOs etc had their 'favourites' other recruits conversely had the worst jobs and a larger amount of guard duties." (Lance Corporal Y)¹⁴⁵

*"You may get extra guard duties as a form of punishment. So extra guard duty may be one form of punishment, but clearly when you're on guard, you are then on duty. At that level, young soldiers may be given a couple of extra guards."*¹⁴⁶

¹⁴⁰ See Appendix 5, entries 10, 34, 61, 62 and 67. The Review is aware of other evidence that supports these impressions.

¹⁴¹ *Ibid.*, entry 34; 15th November 2002.

¹⁴² *Ibid.*, entry 40; 6th November 2002.

¹⁴³ 16th July 2003.

¹⁴⁴ See Appendix 5, entries 3, 7, 10, 32, 51 and 62. The Review is also aware of other statements that acknowledge that guard duty could be used as a punishment. Further light is thrown on this by the evidence of Lieutenant BI in the incidents in 1999 discussed in Chapter 8, see paragraph 8.33 in particular.

¹⁴⁵ *Ibid.*, entry 3; 16th January 2003.

¹⁴⁶ See Appendix A4/17.003 F – G, former Regimental Sergeant-Major Z in his interview with this Review.

*"Yes, you can get extra guard duties because it's in your free time, you know, usually on a weekend you can get it, or on a Friday if you are hoping to go out for a beer or something, for doing something wrong during the week. Two extra duties, you would do them on a Friday and a Sunday ... but if somebody had done something wrong, a Corporal or Sergeant without me saying so could put somebody on an extra duty - one duty or maybe two for being late for parade ... but I mean normally they come through me if it's a disciplinary, and if it was something that I thought to be futile and not worth worrying the Officer Commanding for or doing a charge report, then I would just say no, two extra duties. But if you are going to get extra duties you should go by the Officer Commanding. That's the official way ... You can do it because it's simple and you are saving a soldier going in front of the Officer Commanding then and possibly getting fined. So if it's a misdemeanour and the soldier knows he's done wrong, he's quite happy to accept an extra guard duty."*¹⁴⁷

- 5.153 This use of guard duty as an informal punishment could be used in respect of weekend guard duties that were uniquely oppressive in that they prevented trainees leaving the camp for home visits or other social purposes. Sean's father's evidence at the inquest was that this was one of Sean's grievances, as has already been noted at paragraph 5.28 above. Indeed, one female trainee who knew Sean fairly well recalls the following:

*"I recall one conversation when Sean moaned that he wanted to get home for just one weekend. It was clear that Sean was having his requests for weekend passes denied for no apparent reason. He was always placed on weekend guard duties and this was getting him down."*¹⁴⁸

- 5.154 Private(f) R gave the following statement to Surrey Police in 2003:

*"I remember that on every Friday and sometimes Monday we had an inspection in our work dress. I found these parades pretty intense. The reason being that if the turn out was not perfect you could not get the weekend off. The slightest amount of fluff on your uniform would mean the weekend on camp. Sometimes I just decided to stay on camp and not to get my hopes up about going home for the weekend."*¹⁴⁹

- 5.155 During their re-investigation, Surrey Police gathered a quantity of material from former trainees complaining that they had leave cancelled at the last moment after they had made arrangements with family and friends. A female trainee¹⁵⁰ described one occasion when she was due to appear as a bridesmaid at a wedding but Sergeant D cancelled her leave without apparent explanation. She stated that she saw him do the same thing to others. Another trainee complained of leave chits being torn up in front of others on parade.¹⁵¹ Sergeant D, in correspondence with this Review, has agreed that, on occasion, weekend leave did have to be cancelled at the last minute as a matter of military necessity.¹⁵² One Squadron NCO told Surrey Police that leave and weekend passes were given on the approval of Squadron Sergeants to assist in relieving the tedium, but that leave requests could be refused as a form of punishment if a trainee was guilty of a misdemeanour.¹⁵³

¹⁴⁷ See Appendix A4/12.008 C – G, former Squadron Sergeant-Major Milne in his interview with this Review.

¹⁴⁸ See Appendix 5, entry 14; 7th November 2002.

¹⁴⁹ *Ibid*, entry 19; 22nd January 2003.

¹⁵⁰ *Ibid*, entry 42.

¹⁵¹ *Ibid*, entry 10.

¹⁵² His answer is quoted in Chapter 6 at paragraph 6.117 in the context of similar complaints raised in the case of Cheryl James.

¹⁵³ See Appendix 5, entry 54.

Another NCO stated that Squadron commitments could override leave passes but that, in his experience, leave passes were never ripped up. Colonel Josling, in discussion with Mr and Mrs James and the Review in January 2006, stated that Sergeants and Junior NCOs did not have the authority to cancel leave or a weekend pass at the last moment, but conceded that trainees may not know that and might have felt unable to complain if this happened.¹⁵⁴ The issue of guard duty as an informal sanction, and particularly weekend guard duty that affected home leave, is a recurring theme and further evidence to support such use will be considered in Chapters 6 and 8.

(i) Bullying of Sean Benton by fellow trainees

- 5.156 Whatever the reasons, justified or otherwise, Sean may have been the recipient of more attention from NCOs, compared with some other trainees. Further, there is evidence to suggest that the frequency of his punishments did not endear him to his fellow trainees. Some trainees believed it was a disadvantage to their careers to be too closely connected to Sean, who was thought to have often brought things on his own head: *"Benton didn't have a group, as people would avoid him and it didn't do you any favours to be one of Benton's mates."*¹⁵⁵ Indeed, some trainees were of the opinion that it was better to be unknown when on parade and it may be that Sean's reputation and character encouraged NCOs to use him as an example to control the large Troops. There is also some suggestion that fellow trainees may have taken Sean's treatment by NCOs as an example for, or as condoning, their own treatment of him.
- 5.157 There is evidence that during his time at Deepcut Sean was assaulted by his fellow trainees on more than one occasion, although it is worth noting that Private Q, who shared a room with Sean and one other trainee for at least a month prior to Sean's death, has stated that he never witnessed any such assaults. Surrey Police have identified that the apparent self-harm incident with a door window on 8th February 1995¹⁵⁶ was prompted by an assault on Sean by fellow trainees who were, themselves, training to become pioneers and complained that his public unhappiness at joining their trade was insulting to them.¹⁵⁷ More significantly, there is information supporting the suggestion that a group of trainees did assault Sean in his accommodation while disguising their identity with the respirator masks that were standard part of the trainees' Nuclear Biological Warfare (NBC) kit, because they perceived Sean was letting down the unit.¹⁵⁸
- 5.158 Private S knew Sean fairly well and appears to have been someone in whom Sean confided. He told Surrey Police:

*"I also remember that Sean also told me about a further incident which involved Sean being attacked by a number of persons whilst he was asleep in his bed. He said that they were all wearing S10 respirators and the top half of their NBC suits in order that they would not be recognised. Sean believed that he was attacked because his kit was not up to scratch. He did not know who it was that attacked him."*¹⁵⁹

¹⁵⁴ See Appendix 4/8.021 A – D, where Colonel Josling told the meeting that the authority to cancel leave would rest with the Squadron Commander or the Squadron Sergeant-Major.

¹⁵⁵ See Appendix 5, entry 65; 10th February 2003. This is also supported by the evidence of Private P.

¹⁵⁶ See paragraph 5.14 above.

¹⁵⁷ Indeed, Sergeant D, in a statement dated 9th February 1995, noted that on being called to help Sean: *"All through the route from the block to the guardroom he talked about rather dying than being a Pioneer in the Infantry. He was continuously crying and clenching his fists."* See footnote 11 above.

¹⁵⁸ It would appear that Sean may not have been the only recipient of such treatment.

¹⁵⁹ See Appendix 5, entry 11; 4th December 2002.

5.159 Another trainee¹⁶⁰ described in his statement how late one night in February/March 1995 he heard shouting coming from where Sean was sleeping and then saw two figures, wearing respirator masks over their faces, run off. When he went into the room, Sean was lying on his bed cowering and asking to be left alone.

5.160 One trainee has admitted to Surrey Police that he was part of the group who assaulted Sean:

“During the training of Private Benton and us, that is the other soldiers at Deepcut, we were encouraged as a team to support each other, so if one of us mucked up we would all get a beating, which meant extra show parades, locker room inspections and drill-marching at the weekends. We as a collective group, tried to support and teach Private Benton, but he gave the impression of not being interested. This resulted in some of the lads including myself putting on a respirator, which is a gas mask, and visiting Sean in his block where we would slap him around and shake him about a bit. We never kicked him, or caused him any serious injury, it was just body punches with verbal warnings to get his act together basically. Looking back, I don’t think we even scared him, as he couldn’t be bothered to change his ways.”¹⁶¹

This informant denies being encouraged to take such action by an NCO. Others recall Corporal F encouraging a group of trainees to ‘sort out’ another poorly performing trainee so that life would be easier for them. He took this to mean use of force although this was not how he and his comrades responded.¹⁶²

5.161 The evidence of those allegedly closest to Sean is worthy of comment as, not unreasonably, one might assume they would have been privy to his own thoughts. Private K was remembered by Sean in the hours prior to his death and his comments on Sean are discussed later.¹⁶³ As noted, Private P gave an account of an instance when he believed Corporal F and Corporal O were trying to turn trainees against Sean, but, again, exempted Sergeant B from this. Indeed, he stated that he was asked by Sergeant B to look out for anyone who might be bullying Sean.¹⁶⁴ He also recollected that:

“Sean would often say that he couldn’t leave the army as he couldn’t go home with his tail between his legs and let his mum and dad down as he had done this in the past and wouldn’t do it again.”¹⁶⁵

¹⁶⁰ *Ibid*, entry 50.

¹⁶¹ *Ibid*, entry 69; 2nd June 2003. The Review is aware of evidence from another trainee who also admits to taking part in such attacks on Sean, but his account differs significantly.

¹⁶² *Ibid*, entry 65. The Review is aware of evidence of a similar nature from another trainee who believed such comments were made so trainees could deal with the problem in their own way, and not necessarily by force.

¹⁶³ See Appendix A8.003 for the transcribed version of Sean’s letter to Private K.

¹⁶⁴ See Appendix A5, entry 37. See paragraph 5.129 above. This informant may need to be treated with caution as he ended up serving a disciplinary sentence for fighting and was removed from the Army approximately six months after Sean’s death.

¹⁶⁵ *Ibid*, 15th January 2003.

- 5.162 Private Q, who shared a room with Sean, does not believe that Sean was bullied. Private I, who was described by NCOs as being a disciplinary nightmare particularly in relation to drink, and who was ultimately discharged from the Army, was recognised by others as being a good friend of Sean's.¹⁶⁶ He made the following statement to Surrey Police in 2002:

*"[Benton] used to like to drink but he could not hold that much and used to get drunk easily. Like myself Benton had a reputation but I found him to be a good laugh. He was a funny character and friendly. He was someone you could not really dislike. I thought Benton was very much like myself in many ways in respect that he loved the army but was not very good with discipline. His kit was not always up to standard and he was therefore scapegoated by the NCOs. On parade I remember him being shouted at and made to do press-ups in front of everyone. I think it was done in an attempt to humiliate him. It very much depended on what mood they were in before parade but Benton seemed to be picked on quite a bit more than most ... We used to talk about things happening in the camp and in my mind things did not seem to bother him. He used to laugh about being picked on during parade. He never told me that he was being bullied and I have no memory of him being assaulted. If he had been he certainly kept it to himself. I did not witness him being bullied or assaulted by anyone from the training team or from other recruits."*¹⁶⁷

Additional information as to the events preceding Sean Benton's death

- 5.163 From the re-investigation undertaken by Surrey Police, a more comprehensive picture of Sean's movements and mood on the night of 8th June and early morning of 9th June 1995 can now be gauged.
- 5.164 It seems that he spent some time in the accommodation block used for the guards throughout the night. Several soldiers recall seeing him writing for long periods and sometimes asking for assistance with spelling.¹⁶⁸ It seems quite likely that these texts were the letters found at the scene of his death next morning.¹⁶⁹
- 5.165 Private S recalls that Sean did manage to visit the NAAFI that night and have a drink, despite Sergeant B's intentions. It may be that the NAAFI was open a little later that night as a result of a visit by the darts player Bobby George with whom Private S says Sean had a game.
- 5.166 Sean is also recalled by Private(f) X as being outside the accommodation blocks in the early morning of 9th June, when she had returned to camp with her boyfriend. She states:

"The last time I saw Sean Benton was about - between 00.00hrs midnight and 03.00hrs on the 9th June 1995 ... As we stood outside the female block, arguing over wedding plans, Sean came up to us and asked for a

¹⁶⁶ In his meeting with this Review, Major Gascoigne described Private I as a "genuine liability". In Annex C to the Evans Report, which records 'Problem Cases' in B Squadron, Private I is described as having "amassed the worst disciplinary record in B Sqn history" (see Appendix A11.018). Private I also appears in Annex B to the Evans Report, which recorded incidents of self-harm in 1995. During Surrey Police's re-investigation, Private I described his reasons for self-harming, and in doing so provided a portrait of life on SATT: "I was becoming depressed because I never seemed to achieve anything from day to day. Each day was becoming pointless and I did not seem to be going anywhere."

¹⁶⁷ 15th January 2003.

¹⁶⁸ See Appendix 5, entries 12, 15, 16, 18, 22 and 74. The Review has also seen other confirmatory evidence.

¹⁶⁹ See Appendix 8.

*light for his cigarette, he had with him. He was in full uniform and I thought he was on duty doing stag guard duty. It was a warm night ... I had a cigarette with Sean who stood with us. What I recall the most was the way Sean spoke, he was calm but I got the impression he had something on his mind, he gave the impression he was happy. The conversation between Sean and me was disjointed as if both of us had been drinking but I wasn't pissed nor was he. It was odd it wasn't normal, he was very vague. Sean left us after about ten minutes, the time it takes to smoke a fag. Sean walked up the steps as if he was going towards the guardroom and that was the last time I saw him alive."*¹⁷⁰

- 5.167 Perhaps the most significant information as to Sean's state of mind that evening comes from his friend Private(f) T, who was also on guard duty that night. She confirms that Sean was distressed at the thought of being discharged from the Army and returning to civilian life, as making a success of a military career was important to him. She confirms that he was writing three letters, one of them to his family, and was asking for stamps to mail them.¹⁷¹ He was calm and did not mention self-harm. However, he pleaded with her to buy her stag off her for £10 and borrow her rifle, as he was not allowed to use a rifle that night and he wanted to perform another armed guard before discharge. Despite their friendship, she refused his request and had some concerns as to why he wanted to do this. She says she reported this to the other members of the guard and the Guard Commander but there is no other support for her having done so.¹⁷²
- 5.168 Surrey Police's re-investigation reveals two other incidents of Sean trying to take over someone else's guard duty. An NCO informed Surrey Police that a few days previously Sean had entered the guardroom and told a trainee on guard duty that he had come to relieve her but he was foiled in this attempt. There is some evidence that Sean had been denied access to a weapon whilst assigned to guard duty on days prior to 8th June, but the evidence is fragmentary. The other attempt by Sean is recalled by a female trainee¹⁷³ who says that at some time between 02.00 and 06.00hrs on the morning of 9th June, Sean offered to do her stag and she refused, as she had got up to do it, and was aware that he was not to handle a weapon. By her own account, she appears only to have told a fellow guard member of this attempt by Sean.
- 5.169 If these accounts are accurate, Sean made three attempts to take over a guard stag and a weapon from female soldiers on the night of 8th and morning of 9th June. Two refused him and were aware that he was not meant to be in possession of a weapon that night. One did not and was apparently unaware of the restriction.¹⁷⁴

¹⁷⁰ See Appendix 5, entry 29; 30th January 2003.

¹⁷¹ *Ibid*, entry 18 also recalled Sean asking for stamps.

¹⁷² The Surrey Police report to the Coroner noted that a witness claims to have heard Sean say that if he was put on guard he was going to kill himself. The Review is unaware of any further corroboration of this incident that, in any event, does not appear to be consistent with his attempts to perform guard duty noted in this and the following paragraph.

¹⁷³ See Appendix 5, entry 22.

¹⁷⁴ The Review has seen evidence from other trainees who confirm that if they had been in the same position as Private(f) G on gate A8 when Sean approached her on the morning of 9th June 1995 they would have handed their weapon over. At the time of Sean's death the standing orders at Deepcut merely stated that "...you are personally responsible for the safe custody and handling of the weapon and ammunition in your charge..." Paragraph 28(d) of the Report of the BOI convened after Sean's death included a recommendation that "Guards are clearly told that they are not to hand over their weapons or ammunition unless specifically ordered to do so by a member of the RP staff, Guard Commander or Guard 2/C." See Appendix A9.008. The standing orders were amended by the time of Cheryl James's death to specifically include an instruction that weapons should not be handed over.

- 5.170 Taken as a whole, the material that has come into existence as a result of Surrey Police's re-investigation paints a picture of a spiral of disappointment, poor behaviour and increasing sanctions imposed on Sean by his Troop and Squadron leaders from February 1995 onwards. Some trainees thought he was being picked on unduly while others thought that was the way the Army generally reacted to indiscipline.
- 5.171 A number of informants indicated that they thought Sean was giving up on personal standards during this period. One trainee¹⁷⁵ recalls that Sean looked skinny and unhealthy, which he found surprising as he felt that the Army fed their soldiers well. This statement gives some support to concerns raised by Sean's father in correspondence with the MOD, in which he stated that Sean weighed 12 stone when he was at home at Christmas in 1994 and only 8 stone 7lbs when the pathologist weighed his body at the post-mortem.
- 5.172 There is some indication that those NCOs running Sean's Troop were perhaps not as lenient with him after 13th April 1995 when the Army psychiatrist had confirmed, to their surprise, that Sean was not suffering from a mental illness.¹⁷⁶ One trainee, who was long-term injured, and therefore worked on light duties at Deepcut for a significant period of time, often in the company of the NCOs, stated:

*"[Benton] used to back chat the staff when they picked him up for anything and was considered a problem child. From the beginning it was common knowledge, between both staff and trainees, that Benton was regarded as psychologically unfit. Because of this staff tried to accommodate him and tolerate some of his abnormal behaviour. I know that, Benton was referred for psychiatric evaluation and was passed fit, much to everyone's surprise ... because Benton was now considered to be mentally fit, the staff were not as tolerant of his behaviour and lack of discipline and took formal action against him more often."*¹⁷⁷

If this is right, it does suggest some failure of communication, and a failure to grasp the Army Medical Officer's advice, given as early as February 1995, that Sean's future "has to be resolved by management rather than medicine."

- 5.173 Taking the history recorded in Sean's personnel file, alongside the evidence before the Coroner in 1995 and the product of Surrey Police's subsequent re-investigation, it does seem surprising that the Army did not take steps to finally reassess the future prospects of Sean's military career earlier than they did. However sympathetic some may have been to Sean's wish for a further opportunity to demonstrate that he could make a military career, the objective prospects of him successfully doing so seem, to this Review, to have been slight by April 1995. It cannot have been in anyone's interest to prolong investment of time and resources in a soldier who was unlikely to be able to meet the required standard of self-discipline.
- 5.174 In a meeting with this Review, it was put to Major Gascoigne, the Officer Commanding B Squadron, that he should have discharged Sean from the Army earlier than he did. His response was:

¹⁷⁵ See Appendix 5, entry 50.

¹⁷⁶ *Ibid*, entry 15. See paragraph 5.21. A number of NCOs recollect discussing the Army psychiatrist's decision with other staff.

¹⁷⁷ 21st March 2003.

*"I thought of this myself and you're probably right. He never should have got through Phase 1 training to begin with and we perhaps should have picked up earlier and said 'enough'. But the fact is that, having passed Phase 1 training, I was willing to give him a chance and, regardless of what you say about Private Benton, he was quite an affable fellow. He was not the sort of person who's ever going to be bullied either, he was not necessarily a loner or whatever. I think that actually when he was in there doing his thing he integrated quite well and when I spoke to him, I was constantly talking to him saying what was going on, I actually you know, I didn't feel sorry for him, but there was something about him that made me think 'yes this guy's actually worth a try'."*¹⁷⁸

In conversation with the Review, a convincing picture of Sean's real desire to stay in the Army emerged, one which is inconsistent with the picture painted above, by some trainees, of callous NCOs, and a brutalised and demoralised Sean. Major Gascoigne continued, explaining why he gave Sean another chance at driver training at Leconfield and then with the pioneers:

"I wouldn't have done it for Private [I]. And so I think, maybe I'm trying to protect myself I don't know, but the picture I'm trying to paint of Benton is that, yes, he was a real rogue and, yes, he kicked the windows in, but even when I spoke to the NCOs they were all saying, yes, he's probably worth another shout. I don't believe for a moment that he was being bullied. I don't believe that this sort of individual would put up with bullying. I think he would throw his right hand very quickly.¹⁷⁹ I don't think he was that sort of character. When he was in front of you, you only needed to talk to him and he'd say 'I really, really want to be in the Army, I really want to.' I would say, 'well, look you've messed up again, you've blown out everyone who trusts you.' He'd say, 'Oh god I really want to be, I'm so sorry, so sorry.'"

- 5.175 The Review is of the opinion that this description of Sean is strikingly consistent with the recollections of Sean that those recognised as closest to him make in the available documentation.¹⁸⁰ Later in the meeting with the Review, Major Gascoigne returned to his rationale for offering Sean further chances at a military career in spite of his disciplinary incidents:

"At the time, it's actually, when I remember him, he's coming back from these things and pleading to stay. 'I have nowhere to go, I don't want to do this, I really want to do this.' And you're constantly saying to him 'well, look you know, you do realise this is going to happen, what do you want me to do now?' 'Really, please, please don't kick me out, I want to stay.' And then we had discussions with the Sergeant-Major and the Second-in-Command saying 'well, look, you know, where do we stand on this issue? Are we going to go for an admin charge or not?' And I think the three-month warning order was the route that we'd taken. It was almost

¹⁷⁸ As explained in footnote 38 of Chapter 1, Major Gascoigne did not wish for the entire transcript of the meeting to be published. The transcript is, therefore, not reproduced in Appendix 4 to this Report.

¹⁷⁹ As well as the evidence of Sean throwing a punch at the Regimental Provost Corporal on the morning of 8th June 1995, Sergeant D told Surrey Police that when he was helping Sean after the window incident on 8th February 1995, Sean attempted to lash out at him and attack a group of soldiers who were nearby, see footnote 11 above.

¹⁸⁰ See paragraph 5.161-162 above.

a period to say 'right, well if you are absolutely adamant that you are going to want to stay in the Army as you're pleading to do, then prove it.' And he couldn't prove that and that's when we went for the discharge.

"Now yes, in retrospect, reading all of that, you could say that maybe we should have called time on him a little bit earlier, but I think in the Army we had an ethos that we will try and work with people if we possibly think it's feasible and that's what we were, I think we were doing no more than exercising that sort of ethos, we actually thought maybe he could do it. If I didn't think that, I wouldn't have let him stay. If I genuinely believed that he was going to be a complete write-off I had plenty of ammunition there to say 'enough is enough'. But at the time when you've got the individual pleading in front of you and when you've got the Second-in-Command saying 'well, what should we do, what should we do,' you give him one more chance and he is saying that his whole life is in this and that he's got nowhere to go, he doesn't want to go back home, ok, it might have been a bit of pity I don't know. But the fact is you see this young man in front of you pleading to stay and the fact that he was now willing to go for the pioneers and not do the driving and we did have the umbrella, if you like, of the three-month warning order. I think that probably persuaded me that even after all that time it was worth another go."¹⁸¹

Why did Sean Benton die?

- 5.176 There is evidence from former trainees and permanent staff at Deepcut that Sean, amongst others, was subject to verbal and physical sanctions from NCOs that went beyond the legitimate demands of even a necessarily robust training regime. It can be said that a combination of low staff ratios, enormous pressure and lack of resources on instructors, absence of clear disciplinary guidelines and standards, and weak supervision of NCOs by Troop Commanders, probably led to a situation where Troop Sergeants and Corporals had very considerable discretion to use informal sanctions unmonitored by Squadron Commanders, or above, in how they kept control of large numbers of trainees, many of whom were under-stimulated and disaffected. In such a state of affairs, there may be much room for differences of opinion and perception as to where discipline ends and harassment begins.
- 5.177 The volume of material collected by Surrey Police during their re-investigation strongly suggests that a significant number of trainees, whose accounts cannot readily be dismissed as fabrications or as inherently unreliable, perceived that their lives were in the unsupervised control of their Troop and Squadron NCOs. Furthermore, the trainees believed there was no effective channel of complaint against these NCOs, as they regulated every aspect of their lives, including the possibility of home leave. It is much more difficult to reach any specific conclusion on whether individual acts of bullying or assault were committed against Sean and, if so, by whom, when and why. The passage of time, the absence of contemporaneous complaint, the fact that many former trainees have

¹⁸¹ It is worth noting that at the inquest into Sean's death on 6th July 1995, Major Gascoigne's evidence to the Coroner included the following response: "It was quite clear that Private Sean Benton did want to be in the army even though he hadn't done particularly well, it was our assessment that he definitely was worth another try and he certainly wanted it and he was interviewed by a Major called the Senior Personnel Selection Officer who is in charge of the allocation of all trades within the Royal Logistic Corps and he was offered the chance to go and trade as a Pioneer which would mean that he would have to go and do infantry training prior to actually reaching the field army and he accepted that."

moved on in their lives and the possible corruption of memory and recollection by dramatic media reporting, suggest that similar difficulties would be faced by any future tribunal grappling with this material, or forensically examining all available witnesses.

- 5.178 What is clear, however, is that the evidence as a whole is inconsistent with a hypothesis that Sean wanted to leave the Army or complained to those officers he spoke to, or friends he confided in, about harassment or bullying. The evidence of his closer friends and his Commanders alike is that he was desperate to stay and considered departure a humiliating rebuff to his aspirations.
- 5.179 This is very much confirmed by the contents of the letters found near his body.¹⁸² The contents have not been publicly disclosed until now,¹⁸³ the Coroner understandably took the view that these were personal matters for the family and other recipients. However, a Review into the circumstances surrounding Sean's death would be substantially defective if the detail of the contents were not now brought into the public domain to explain the conclusions drawn.
- 5.180 As noted earlier in this Chapter, there are three letters from Sean: to his parents, to Sergeant B and to his friend, Private K. It is unfortunate that this last letter was never delivered to its intended recipient, who was unaware of its existence until he was interviewed for the first time in 2002 by Surrey Police. Sean intended the letter as proof of a bequest of his favoured football shirt that could doubtless have been handed to Private K at the time.¹⁸⁴
- 5.181 Sean's letter to his parents, with the spelling as written, includes the following paragraph:

"I really wanted to stay in and fight for the Country & I was ready to even die for this Country, I really wanted to make you proud of me, I don't think I could really come home again knowing that I've let you down after being discharge, I'm to embarresed by it, I'm sorry!"

- 5.182 The letter continues to mention the football shirt he is leaving to Private K. He suggests that there may be some insurance or other monies that the family could claim and that his family should contact a lawyer and look at his Army medical reports. He also mentions:

"For ages I been trying to apply for a weeks leave but they wouldn't let me have it (B, Sqn N.C.O.s & the SSM that is) & they all knew that I needed a brake from blackdown & that I was cracking up but they just said I wasn't entitled to it."

The full contents of Sean's letters are reproduced in Appendix 8 to this Report.

- 5.183 Of great significance, in the light of subsequent media attention and the allegations noted in this Chapter, is the letter to Sergeant B, reproduced here in full:

"To Sergeant [B],

"I'm sorry for what I'm doing but I just can't except being discharged I'm to embarresed to go home and I don't want to be on Civvy Street and I don't want to have a factory job I just wanted a career in the Army, I

¹⁸² See Appendix 8.

¹⁸³ Sean's letter to his parents was referred to in the BBC Panorama programme broadcast in December 2002. A very brief summary of the content of that letter was made but no reference was made to the two other letters.

¹⁸⁴ Indeed, the importance that Sean attributed to this gift is apparent from the fact that the shirt is mentioned in each of the three letters he wrote.

know it's my fault for the things that I done wrong but only if I got a weeks leave when I applied for it (many times that is) things could have been different, I could of calmed down, instead of building all my problems up & then getting drunk & bursting into flames.

"Sergeant, I'm leaving my Spurs shirt to a PTE [K]... It needs washing it's got splash marks of polish.

"Oh by the way can you thank Sergeant [L] Sergeant [D] & yourself & Sergeant [...] for helping me out when I were in trouble, & I didn't mean to say that you were an arsol, it just came out without myself thinking about it.

Benton."

- 5.184 There is no suggestion of complaint by Sean about his treatment by Sergeant B or any other NCO. Indeed, he goes out of his way to thank them for *"helping me out when I was in trouble"*. The reference back to the incident to calling Sergeant B an *"arsol"* is most likely the incident for which he was disciplined on 14th February 1995 for insubordinate behaviour. If that was the incident uppermost in his mind in the hours before he died, it does suggest that nothing else of substantial significance to him happened between February and June between him and Sergeant B.
- 5.185 Taking the three letters together, this Review is satisfied that Sean spent his last hours writing these letters and settling his affairs. The tone is that he could not live with the disappointment of failing to make a career in the Army and a return to *"Civvy Street"*. Indeed, Private K, the recipient of the third letter, made the following assessment of Sean in 2002:

*"... if I thought [Sergeant B] or the Army had caused his death I would have said something, and come forward, I was Benton's mate. I think that what caused his death was he was scared of leaving the army ..."*¹⁸⁵

- 5.186 In correspondence with the MOD, Mr and Mrs Benton have raised the question of whether the letters are consistent with an intention by Sean to go Absent Without Leave (AWOL) to avoid his troubles at Deepcut. In the opinion of this Review, the answer is no. The reference to distribution of property, and the acceptance that he is being discharged from the Army, indicates that what he is about to do is more permanent than going AWOL. Further, Sean acknowledged *"I know its my fault for the things I done wrong"*, rather than suggesting he was going to commit a serious disciplinary offence (i.e. go AWOL) to avoid the consequences of actions by others.
- 5.187 In the opinion of this Review, these letters give support to other material noted above that suggests that Sean had a strong sense of his own dignity and autonomy, could stand up for himself, and could be a likeable soldier endearing himself to many, not least his Officer Commanding, Major Gascoigne. It would be a disservice to Sean's memory, and what he regarded as important, to characterise him merely as a victim of bullying and his death a response to abuse. It appears to have been a deliberately thought through and executed

¹⁸⁵ 15th November 2002. Some trainees formed the impression that Sean did not want to be in the Army but it is clear, particularly from Major Gascoigne's and Private K's evidence, as well as Sean's own letters that he desperately wanted a career in the Army. If anything, perhaps he attributed too much importance to it.

decision, responding to what he perceived to be the unbearable humiliation of his failing to succeed in the Army. It is tragic that Sean could not see beyond the short term sense of failure and put his thoughts in a wider perspective.

Factors contributing to Sean Benton's death

- 5.188 It is true that Sean's letters to his family and to Sergeant B both refer to his regret that he did not get the week's leave that he had asked for. This was a topic that was explored at the inquest. Sean had recently been home for a long bank holiday weekend, between the 26th May and 30th May 1995, although that did nothing to prevent the incident in the public house with Lieutenant C and Lance Corporal(f) E on the 1st June. In the light of what is now known about disciplinary discretion and, as will become apparent in the later deaths, the overriding nature of the Squadron's needs for security duties, it may well be that weekend leaves were unavailable to Sean because of the combination of guard duty and disciplinary sanctions.
- 5.189 Of the four deaths at Deepcut with which this Review is concerned, however, it is only Sean's where there is substantial evidence suggesting bullying and harassment, whether by fellow soldiers or members of staff. Sexual harassment does not appear to be an issue in his death and consideration of the evidence relating to such incidents will be reserved until the next Chapter.
- 5.190 It is appropriate to note the themes that emerge from the material available concerning Sean's death. Subsequently, we shall examine the other deaths and other aspects of the events at Deepcut to see to what extent further material confirms or undermines these themes.
- 5.191 First, there is the persistent shortage of supervisory staff in the Training Regiment.¹⁸⁶ The field army usually works on a ratio of one Corporal to 12 soldiers and a supporting hierarchical structure. That means that Corporals get to know their soldiers as individuals. They can bond with them, empathise with them, know their strengths and weaknesses, frailties and vulnerabilities. An alert Corporal can detect signs of bullying by fellow soldiers and take preventive action. He or she can select proportionate sanctions for failures and misdemeanours and, if applying the modern Army Training and Recruiting Agency (ATRA) Code of Practice for Instructors, should be adopting the approach of training up to meet required standards, rather than grinding down to target those who cannot yet achieve them.
- 5.192 If this strong bond is removed, by substantially greater numbers of trainees to staff, and less opportunity to get to know them, then the pressure on the available staff becomes greater. Pressure to hold the soldiers in a Training Regiment with no real training or appropriate facilities will tend to lead to soldiers losing the discipline inculcated in the first intensive weeks of Phase 1 training. The Review has received evidence that Deepcut in 1995 could be an intimidating place after dark for trainees and staff alike. Poor supervisory ratios appear to have meant that there was little control over activity in the accommodation blocks, apart from the occasional patrol by the Provost and duty staff. There were frequent altercations in or outside the NAAFI, where alcohol was the primary entertainment on site. Excess alcohol or other indulgent activities may also have led to trainees avoiding duties, off-loading an increased workload on those who remained. Poor supervisory ratios may lead to less tolerance by staff of poor behaviour and an increasing

¹⁸⁶ For comments on supervisory shortages in this period, see Brigadier Evans' comments in Appendix A4/4.007 E – G and the account given to this Review by Colonel Josling in Appendix A4/9.005 D – 006 A.

tendency for punishments to be handed out without understanding of the individual, or even group punishment to encourage the Section or Troop to resolve its own disciplinary failures itself.

- 5.193 Secondly, if there is no clear criteria as to what an NCO can deliver by way of sanction, and it is left to the discretion of that individual, then one person's legitimate sanction may look like oppression and bullying to another, and, indeed, will be likely to stray into unacceptable practices in the absence of firm prohibition or standardisation. It appears that there was no prohibition on physical sanctions such as press-ups, runs, carrying weights and such like in 1995. The Review has noted the body of evidence suggesting that guard duty could be used as an informal punishment. This is a theme that will be considered further in the following Chapters. It may be that even some physical contact would not necessarily have been considered wrong by some, although the difference between a push and a punch may become blurred. In any case, a system of informal punishments not recorded and subject to review may lead to a power vacuum which can be filled by the discretion of NCOs who are in daily contact with soldiers.
- 5.194 Thirdly, the suitability of Deepcut as a location to hold young trainees may be open to doubt. Since much of the training was not conducted there, it gave rise to the SATT phenomenon we have noted in Sean's case. He spent nine months at Deepcut prior to his death, when really a few months, at most, should have been required. The nature of the accommodation and recreational facilities at Deepcut has already been noted.¹⁸⁷ The high costs of leaving the camp by taxi should be borne in mind, as soldiers complained they were frequently short of money.¹⁸⁸ In any event, the opportunities for leading a private life after work duties were completed were very limited at Deepcut given the nature of the accommodation.
- 5.195 Fourthly, weekend visits home, while in theory possible to all, in practice could be restricted by geography and the costs of going home, being subjected to ROPs for disciplinary reasons and the demands of guard duty, the consequence of which could be cancelled leave. The last two factors clearly played a role in Sean's unhappiness, as evidenced in his letter to his parents.¹⁸⁹ Guard duty is doubtless a tiring, tedious and repetitive chore,¹⁹⁰ but also something that a soldier needs to be able to learn to do. Whether armed guards at all gates was necessary at all is something beyond the competence of this Review to comment on, although dissenting military voices will be noted in later Chapters. Whether trainees straight out of Phase 1 training at ATR Pirbright should have been doing guard duty at all and, if so, for how long, under what supervision and how often, is a question that, as later Chapters show, may be nearer to the heart of these deaths. But even if the answer to those questions is that there is a legitimate requirement for trained soldiers who have passed their weapons training to perform such duties, there must be every reason to keep such duties to a minimum. Bored and unhappy soldiers being subjected to repetitive tedious guard duties with lethal weapons would seem, to this Review, to be at least an undesirable, and possibly a dangerous, combination. Further, there can be no good case for using guard duty as a punishment for poor performance. That achieves nothing more than making the underachiever feel even more disaffected and unhappy. And yet, as previously indicated, whether such a punishment was recognised in official policy or not, it was undoubtedly deployed in Deepcut in 1995.

¹⁸⁷ See paragraphs 4.76-7 above.

¹⁸⁸ At the time of visits by members of this Review team, the price of a taxi journey from Brookwood (the nearest train station) to Deepcut was £12.00 for a single journey and there is some evidence of high costs in 1995 deterring time out of the Barracks.

¹⁸⁹ See Appendix A8.001.

¹⁹⁰ In his meeting with this Review, Brigadier Evans describes guard duty as being "*unpopular with anyone*", see Appendix A4/4.015 A – B. See also Appendix A4/1.034 B – C, where Brigadier Brown acknowledges guard duty as a grievance factor.

5.196 Fifthly, the events described raise questions as to how the Army selects its instructors for Training Regiments and how they are trained and supported to perform the functions assigned to them. These questions in turn raise issues about the selection and reporting process, and the inter-relationship between different branches of the Army in ensuring that good practice is promoted and bad practice identified and eliminated.

Conclusions on the death of Sean Benton

5.197 In the opinion of this Review, it seems that one or more of these factors characterised the trainees' perception of the regime at Deepcut at the time. They cannot be said to have caused Sean's death, although they played a role in the combination of circumstances that may have led to it. These are themes that will be explored in other Chapters as we examine the other deaths and how the Army and the RLC responded to them.

5.198 However, it is appropriate to return to the three questions posed at paragraph 5.51 above:

- (i) Is there any evidence that has now emerged that undermines the verdict of suicide?
- (ii) Is there any evidence that the original investigation into Sean's death covered up evidence?
- (iii) If the verdict of suicide is not undermined, is there any evidence that Sean was driven to self-harm by bullying or harassment from those in authority, or by other trainees?

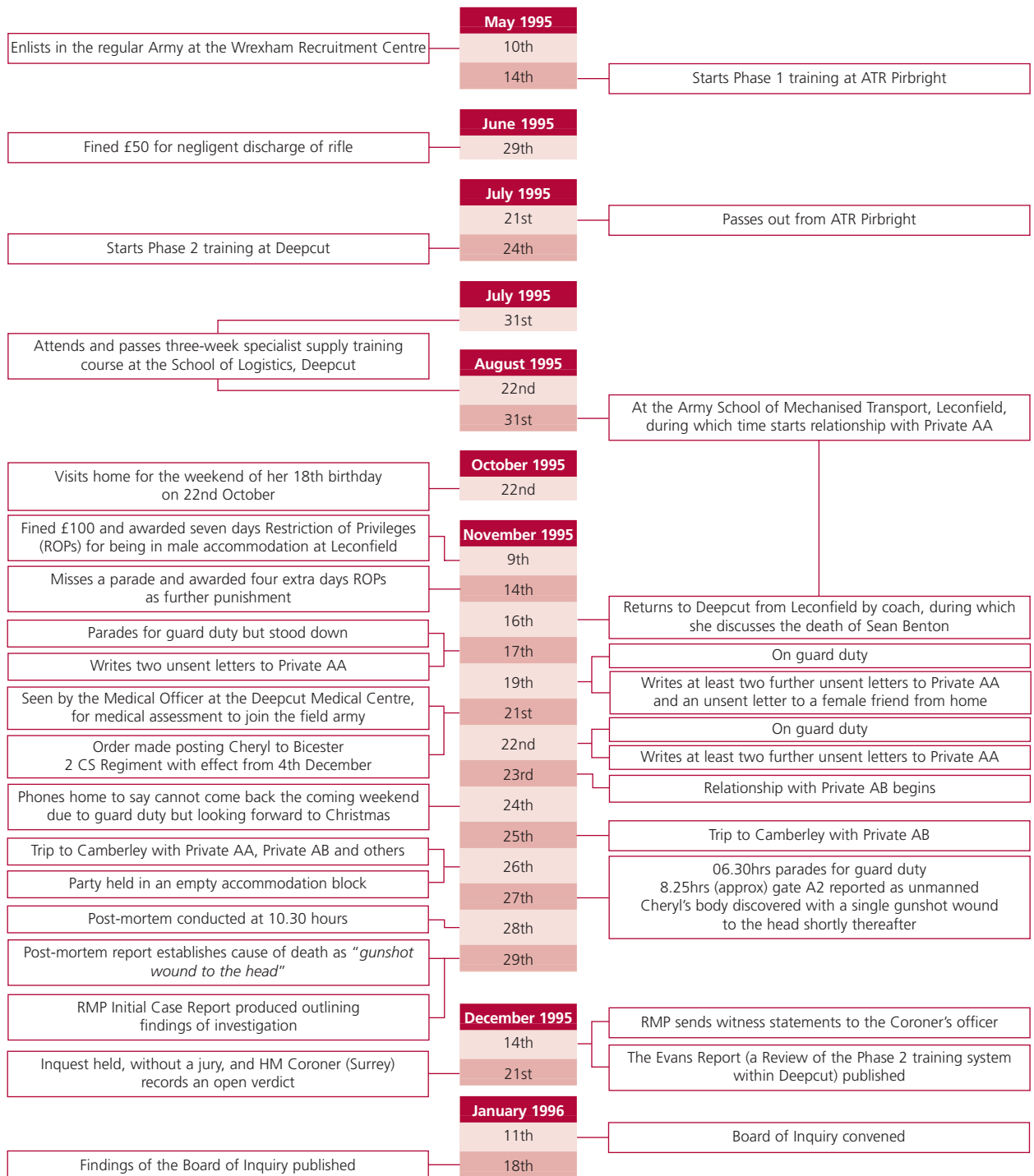
5.199 In light of the evidence seen, this Review is of the opinion that the answer to each of these questions is 'no'. The Review is satisfied that:

- (i) Sean died by his own hand as a result of a deliberate act.
- (ii) The original investigation did not seek to cover up evidence.
- (iii) Sean did not die because he was bullied by NCOs or other trainees.

6 The Death of Cheryl James

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Figure 6.1 Timeline – Cheryl James



Background and recruitment

- 6.1 On 10th May 1995, Cheryl Marie James enlisted in the Army at the Army Careers Information Office, Wrexham. Cheryl was then aged 17 years and seven months. Her enlistment was the successful outcome of a process begun on 31st October 1994 when she completed the application form and gave details of her medical and social history. In March 1994, she had applied to join the Navy but her application was rejected because her medical history had revealed a migraine attack some nine months before. This matter was sorted out in 1995, during the processing of Cheryl's application to join the Army, by her GP who explained that there was an error in reporting dates. Cheryl was to remember that a history of recent migraine could be a reason for discharge from military service on the grounds of medical unsuitability.¹ In her Medical History Questionnaire, certified as accurate by her mother, the negative box was ticked in response to the question whether she had ever suffered from *"any self injury or poisoning."*
- 6.2 Cheryl had been adopted at the age of four, although she had lived with her adoptive parents since she was a baby.² She had left school the previous summer with three GCSE passes, at Grades A to C, and started at college to study for A-levels, but did not find it was the right thing for her. There had been some adolescent tension resulting in Social Services' involvement and Cheryl leaving home. She had no police record and received good references. Both parents supported her application to join the Army. She was assessed an average grade C recruit because of some concerns about her fitness. The recruiting officer's comments in December 1994 were:

"Overall Cheryl is only a young woman that has fended for herself for over a year and is streetwise, has a sound reason for joining the army. Interviews well and has a bubbly outgoing personality. If she were to pass the medical I think she may have the determination to succeed."³

Cheryl's bubbly and outgoing personality was to be remembered by all who came into contact with her during her career in the Army. Her reasons for joining the Army, as noted on her application form, were perhaps typical of many young people:

"Good training. Good career prospects. Chance to travel. Hope to gain further qualifications. Give me more self-discipline. An exciting job with variety of prospects."

- 6.3 On enlisting, Cheryl signed a declaration that give a brief reminder of the nature of military life:

"In joining the Army you will be entering a disciplined Service which imposes restrictions not found in civilian life. For example you will be liable for duty at any time of the day or night, seven days a week ... Some other offences are regarded more seriously in the Armed Forces than they would be in civilian life ... it is considered to be an offence to be late for duty ..."

Elsewhere she was informed:

"No form of racial discrimination or harassment or sexual discrimination or harassment will be tolerated."

¹ See paragraph 6.34 below.

² See the transcript of the meeting this Review had with Mr and Mrs James, Appendix A4/7.035 C – D.

³ 14th December 1994.

The period of service for which she was enlisting was until her 18th birthday (on 22nd October 1995) and, thereafter, a period of 22 years' service, with her earliest date for a right to resign and be transferred to the Army Reserves being May 1998.

ATR Pirbright

- 6.4 Four days after enlisting, Cheryl started her Phase 1 training at the Army Training Regiment (ATR) at Pirbright with a view to joining the Royal Logistic Corps (RLC) as a supply specialist. She was at ATR Pirbright until 21st July 1995 and, may, therefore, have heard about the death of Sean Benton two miles away at Deepcut on 9th June. Cheryl's time at ATR Pirbright appears to have been hard work for her, with some concerns as to her fitness and some difficulty in passing her weapons test. Her Section Commander described her at the first assessment as *"another problem recruit ... having problems with every area of training."* Her personnel record reveals that she was fined £50 on 29th June for negligent discharge of her rifle. However, her commitment and effort was noted and on her passing out of ATR Pirbright her Platoon Commander made the following assessment:

"Pte James has continued to improve and this has brought her up to the required standard. She has very little natural aptitude for military life but has worked hard and needs to keep working throughout Phase 2. She has a sense of humour and an agreeable manner which has meant that people are willing to help her."

On the 24th July 1995, Cheryl started her Phase 2 training at Deepcut, joining B Squadron for which the Officer Commanding was Major Robert Gascoigne (who, as noted in the previous Chapter, is still serving in the Army).

Phase 2 training at Deepcut and Leconfield

- 6.5 Cheryl was to spend two periods of her training at Deepcut. The first was from 24th July until 31st August 1995. During this time from 31st July to 22nd August 1995 she attended, and passed, a three-week specialist supply training course at the School of Logistics. She applied for some leave at this time and was then back at Deepcut awaiting loading on to her driver training course. She was at the Army School of Mechanical Transport (ASMT), Leconfield from 31st August until 16th November, with a visit home for the weekend around her 18th birthday on 22nd October.⁴ These dates are taken from the course records attached to Cheryl's personnel file, rather than from Major Gascoigne's evidence at the inquest or the Royal Military Police (RMP) Initial Case Report into her death, both suggesting that her Leconfield training had finished on 16th October.
- 6.6 The second period that Cheryl spent at Deepcut was from 16th November until her death on 27th November, when she was awaiting her first posting to the field army. A copy of an Order dated 21st November posting her to 2 CS Regiment, Bicester with effect from 4th December 1995 was on her personnel file. It seems, from the subsequent re-investigation by Surrey Police, that Cheryl was unaware of this and it may only have been received in Deepcut from the RLC Manning and Records Office, Wigston, Leicester, on the day of her death. There is no conclusive information on Cheryl's personnel file as to which Troop she belonged to whilst at Deepcut. By this time, 'A' Troop had been renamed as '1' Troop, and was still commanded by Lieutenant(f) A and supported by Sergeant B, and 'B' Troop was now '2' Troop, and was still commanded by Lieutenant C and supported by

⁴See Appendix A4/7.008 F – G, where Mrs James told this Review that Cheryl came home on leave on the Friday and turned 18 on the Sunday.

Sergeant D. Lieutenant C and Sergeant D told Surrey Police in 2002 that Cheryl was not a member of their Troop. However, Sergeant B did not recollect her as being a member of his Troop either.⁵ The matter was clarified in January 2006 when Mr and Mrs James met the Commanding Officer at Deepcut during Cheryl's career in the Army, Colonel (formerly Lieutenant Colonel) Josling (still serving), for the first time. Colonel Josling confirmed that Cheryl was in 1 Troop.⁶ The name of the Troop Commander, Lieutenant(f) A, was new information to Cheryl's parents.⁷ Lieutenant(f) A had not attended the inquest into Cheryl's death or Cheryl's funeral. As Major Gascoigne has informed the Review, these were not Troops in the traditional sense of the word and the opportunity for commanders to get to know their soldiers and form strong bonds with them was very limited. Often, the staff had no recollection of their trainees unless they stood out as 'problem children'.⁸

- 6.7 Cheryl progressed through Phase 2 training fairly rapidly by comparison with others. She did not face any of the typical reasons for delay causing the Soldier Awaiting Trade Training (SATT) phenomenon at that time. Her provisional driving licence was issued promptly on 10th July whilst she was still at ATR Pirbright. She did not suffer muscle or other injuries in training causing back-squadding. She passed her courses, including her basic and large goods, or passenger carrying, driving test in October. Cheryl did not encounter serious disciplinary problems, although, during her time at Leconfield, she (along with another female friend, Private(f) AF) was formally charged, fined £100 and awarded seven days Restriction of Privileges (ROPs) on 9th November 1995 for being in the male accommodation block. She only came to the attention of the Medical Centres at ATR Pirbright, Deepcut or Leconfield for routine fitness assessments, vaccinations or minor ailments of no significance to this Review.
- 6.8 Cheryl was clearly an attractive and popular young woman who had no difficulty making friends and attracting admirers whilst in the Army. On enlistment, she declared that she had no regular boyfriend. Subsequently, two relationships with young men feature in the events surrounding her death. The first is with Private AA,⁹ whom she met whilst they were both training at Leconfield, and whose camp was at Blackwater, Camberley which was close enough to Deepcut to enable regular visits.¹⁰ The second was with Private AB, a RLC trainee like Cheryl, with whom she appears to have begun a relationship on returning to Deepcut from Leconfield in November. There may have been other relationships during her time in the Army but, if so, they have no apparent significance for the events examined in this Review.
- 6.9 Female trainees were accommodated in shared accommodation in the women's accommodation block at Deepcut, located quite close to the guardroom. Non-residents visiting the block had to obtain access by punching in a code or using a buzzer. The female block was officially out of bounds to male soldiers, although it seems that this rule was widely flouted at the time. At the Army Board of Inquiry (BOI) into Cheryl's death, Private AB gave evidence that women who were in long-term relationships would give their boyfriends the code to the female block. There was no video camera installed monitoring or recording access to the female block. Male accommodation at both Leconfield and Deepcut was also out of bounds to women, as Cheryl's offence for which she was charged on 9th November 1995 illustrates. More than half of the 16 students who passed the

⁵ Sergeant B has noted that some of Cheryl's friends were in his Troop and that he attended her funeral.

⁶ See Appendix A4/8.005 A – B, where Colonel Josling informed the meeting that Lieutenant(f) A was Cheryl's Troop Commander at the time.

⁷ *Ibid*, B – C.

⁸ The Review is aware of evidence from trainees to the effect that there was no real Troop structure.

⁹ Private AA' was a Sapper in the Royal Engineers (the equivalent of a Private in the RLC). For ease of reference he is referred to as Private AA.

¹⁰ Not to be confused with 'Blackdown'. See paragraph 3.54 above.

Specialist Class 3 employment course with Cheryl in August 1995 were women. Estimates given to the Review suggest that women may have comprised between one quarter and one third of the 500 or so trainees who made up B Squadron at any one time in 1995.¹¹

- 6.10 While there were substantial numbers of female trainees at Deepcut, there was a shortage of female NCOs.¹² It seems that there were permanent members of staff assigned to the female accommodation block when Cheryl was in residence. Lance Corporal(f) E had maintained a room in the block previously and, as noted in the previous Chapter, is recorded as being a female presence and a source of guidance by several of the young women with whom Cheryl was training.¹³ When Lance Corporal(f) E moved into the new accommodation block for permanent staff, a Private took on the role of block senior. According to Major Gascoigne at the BOI, Corporal(f) W was appointed resident NCO for the female block but she was away on training the week of Cheryl's death. There was only one commissioned female officer in the Training Regiment at this time, Lieutenant(f) A, who was Troop Commander of 1 Troop, Cheryl's Troop, in which Sergeant B was the Troop Sergeant. Lieutenant(f) A was, in theory, available to help female soldiers with welfare problems, although she was also away the week of Cheryl's death. We shall see that subsequent enquiries suggest that Lieutenant(f) A deferred to Sergeant B in the way the Troop was run.
- 6.11 The material available to this Review regarding Cheryl's military career, in addition to her personnel file and medical records, consists of the RMP Initial Case Report into her death, including the witness statements taken in 1995, the transcript of the inquest proceedings in December 1995, a record of the examination of witnesses at the BOI in January 1996, and the statements or interview transcripts of witnesses who were interviewed by Surrey Police as a result of their re-investigation, announced in 2002. No new informants with specific information about Cheryl have come forward to speak to the Review,¹⁴ although, since the appointment of the Review, Surrey Police have had to continue their investigations with further enquiries in response to allegations in the press relating to Cheryl, and the Review has benefited from access to information gathered in those further enquiries.¹⁵
- 6.12 There is very little reason to believe any events of significance occurred during Cheryl's first five weeks at Deepcut, before she left for Leconfield for driver training. In accordance with the Training Regiment's practice at the time, she would have been available for guard duties when not on trade training; this was a period of some two weeks only. Similarly, Cheryl would only have been available for guard duties at Leconfield for the first few days on arrival, as guard duty was not normally a feature of life there once trade training had started. It appears Cheryl may have expressed some unhappiness about Army discipline and guard duties in October 1995, but her parents detected no unhappiness or complaints from Cheryl at this time and there is no personal correspondence, known to this Review, that suggests this was a problem weighing on her mind at that time.¹⁶ Matters were to change within a few days of returning to Deepcut, and this is the period of greatest interest to the Review.

¹¹ See for example Colonel Josling, who estimates the intake of female recruits at the time to have been between 20 and 25%, Appendix A4/9.028 F.

¹² Colonel Josling pointed out to this Review that "... one of the acute difficulties that a number of training organisations faced was a lack of suitable female personnel ...", Appendix A4/9.002 G – 003 A.

¹³ However, Lance Corporal(f) E was to be removed from Deepcut in late 1995 and subsequently faced Court Martial for false accounting offences in respect of food and accommodation from a period in 1995. See paragraph 5.146 ff above.

¹⁴ Mr and Mrs James have passed on e-mails they have received from Private(f) AS and the female Captain who was a member of the Board of Inquiry into Cheryl's death.

¹⁵ See paragraphs 6.157-8 below.

¹⁶ At paragraph 6.21, and footnote 31, reference is made to a number of draft letters that Cheryl wrote whilst on guard duty at Deepcut in November, but it does not appear that she is expressing any specific discontent with being on guard.

6.13 Training at Leconfield seems, generally, to have been a happy period for RLC trainees, and Cheryl in particular. The instructors were mostly civilians. The length of the day was not arduous and learning might stop at 15.30hrs. New skills in driving Heavy Goods Vehicles (HGV) were being learned at a younger age than would be possible in civilian life and this represented a good investment in future life, in or out of the Army (see paragraph 6.37 below). There was plenty of free time for trainees to visit the nearby town of Beverley, a few kilometres away and readily accessible to them. Cheryl became friendly with Private(f) AC at this time, who has described how she and Cheryl enjoyed the social side of life. Private(f) AC had become the girlfriend of Private AD at Deepcut and was herself formally charged for having him in her room at Leconfield. Other female friends of Cheryl's included Private(f) AE, Private(f) AF and Private(f) AG. As noted, Private(f) AF was the friend who was jointly disciplined with Cheryl on 9th November for being in the male accommodation block at Leconfield.¹⁷ Private AA says he was regularly seeing Cheryl around this time but that they were never caught, so there may be uncertainty as to whom Cheryl and Private(f) AF were visiting. Apart from the financial penalty, there was the punishment of seven days ROPs.¹⁸ On Tuesday 14th November, Cheryl missed a parade she was due to attend and was awarded four extra days ROPs as a further punishment, which appears to have slightly delayed her return to Deepcut. It is uncertain whether her punishment slate was wiped clean before she returned to Deepcut on Thursday 16th November.

Private AA

6.14 As referred to earlier, it was during her time at Leconfield that Cheryl met Private AA and they formed a close mutual attachment. Private AA gave a statement to the RMP in 1995, the BOI in 1996 and also gave lengthy interviews to Surrey Police in 2002. He represents a useful source of information about Cheryl and her feelings in the weeks before she died. After her death, six letters written by Cheryl but apparently not sent were found amongst her property addressed to Private AA: two letters for each of 17th (Friday), 19th (Sunday) and 22nd (Wednesday) of November. In one of her letters dated 19th November, Cheryl writes: *"I probably won't post it to you anyway. I must of written you about six letters now and you haven't had any of them."*¹⁹ In fact, to that date, only four letters have been retrieved but in one of the 22nd (Wednesday) November letters, Cheryl explains that: *"This is the fifth letter I've written to you today but I keep starting again for some reason."* There is also a further draft letter dated 19th (Sunday) November addressed to a female friend from home, in which Cheryl mentions Private AA in enthusiastic tones.

6.15 Although all those who came into contact with Cheryl describe her in general terms as a happy, bubbly and fun-loving person, many of her friends note that there was a more fragile, vulnerable side to her personality, and there appear to have been various manifestations of unhappiness in the ten days before her death. Such unhappiness went unremarked by any of her NCOs and commanders in B Squadron, for whom she was an apparently happy and successful trainee on the point of being posted to the field army. There is no evidence to suggest that she was ever viewed by NCOs as a 'problem child', by contrast to the way that Sean Benton was described.²⁰

6.16 Cheryl's unhappiness was not the subject of exploration at the inquest, although Private(f) AC gave evidence that Cheryl was unhappy with the restrictions military life placed on her freedom and wanted to leave the Army. The letters addressed to Private AA, found in

¹⁷ See paragraph 6.7 above. Cheryl's personnel file includes a notification dated 10th November from Leconfield to Deepcut regarding the charge and punishment for being in the male accommodation block.

¹⁸ See paragraph 6.25 below for a description of ROPs, as provided by Major Gascoigne to the inquest into Cheryl's death.

¹⁹ 19th November 1995.

²⁰ See paragraphs 5.70, 5.145 and 5.172 above.

Cheryl's room, make reference to wanting to leave the Army. The letters are mentioned in the RMP Initial Case Report²¹ dated 29th November 1995 and in the witness statement, dated 14th December 1995, of an RMP Sergeant. The letters were not read out at the inquest and appear not to have been asked for by the Coroner's officer, although he had the RMP Sergeant's statement and the Initial Case Report that describes their general content.²² There is no basis for any conclusion that the letters were deliberately kept from the Coroner, but Mr and Mrs James have explained that they were originally unaware of their existence.²³ The Review has established that the letters were found when the civilian police searched Cheryl's room on the morning of her death. There was a cursory read through. Some letters belonging to Private(f) AF were mixed up with Cheryl's at some point. Some of Cheryl's letters were retained by the RMP for possible use in the inquest and others were given to the staff at the Training Regiment responsible for logging Cheryl's property. It seems that there may have been some concern that the content of some of the letters may have distressed the family and they were held back for a time. The family did receive the letters following correspondence with the Training Regiment after the inquest.²⁴

- 6.17 It may have been thought that it would be easier for the family to be left with an abiding image of their daughter as the Army, and her parents, thought her to be: with a desire to succeed in a military career. This Review has proceeded on the basis that families of children who die in tragic circumstances prefer the whole unvarnished truth, rather than any well-meaning, but counterproductive, attempt to protect feelings.²⁵ In any event, if the family did not have possession of Cheryl's draft letters on the day of the inquest, they would not have been in a position to explore their content.²⁶ The question of what, if anything, may have been causing Cheryl unhappiness is a subject that will be explored further in this Chapter.

The return to Deepcut from Leconfield

- 6.18 Cheryl returned by coach to Deepcut from Leconfield on Thursday 16th November 1995. It seems Cheryl was sitting next to an acquaintance, Private(f) AH.²⁷ It appears that Cheryl's closer friends returned slightly earlier, possibly due to the additional ROPs awarded to Cheryl. The details of the coach journey are discussed in greater detail later in this Chapter.²⁸
- 6.19 In his interviews with Surrey Police in 2002, Private AA, whom Cheryl had met and started a relationship with at Leconfield, described Cheryl's mood immediately prior to the journey back to Deepcut:

"While we were waiting for the bus, okay we were sat in the NAAFI in a one of the NAAFI areas in Leconfield in the barracks ... Cheryl was crying because she thought that she was going to get separated from me and

²¹ The RMP Special Investigations Branch (SIB) produced an Initial Case Report outlining their immediate actions but not a Final Report, as they did not consider they were conducting an investigation but assisting the civil police or the Coroner for the purposes of the inquest. See paragraph 6.63 below. In both Cheryl's and Sean Benton's cases, there is a further letter to the Coroner from the RMP providing the witness statements and other material sought. See paragraph 6.67 below and 5.91 above.

²² See paragraph 6.67.

²³ See Appendix A4/7.007 B to 008 E.

²⁴ Both Mr and Mrs James informed this Review that the letters weren't revealed to them until February 1996, three months after Cheryl's death, Appendix A4/8.039 E – F.

²⁵ Note the opinion of Fiona Murphy, see Annex C.

²⁶ See Appendix A4/7.008 D – E, where this point was explicitly mentioned by Mr James.

²⁷ See Appendix 5, entry 39.

²⁸ See paragraph 6.102 below.

*we wouldn't see much of each other cos we were seeing [each] other all the time and she was in floods of tears and she thought she wasn't going to see me as often as she would have liked to have done."*²⁹

6.20 In further answers, Private AA described Cheryl at this time in the following terms:

*"I think she appeared to be a chirpy character ... I think she just genuinely normally was a chirpy, like bubbly girl and I don't think that was front, however I think there were a lot of things that were suppressing that and making her unhappy ..."*³⁰

6.21 There may have been other reasons for Cheryl's apparent unhappiness as she contemplated returning to Deepcut. One factor mentioned after her death as contributing to her apparent unhappiness once back at Deepcut was the number and frequency of guard duties. After Leconfield, Cheryl had completed her trade training, was awaiting her posting to the field army and, in the meantime, was eligible to perform guard duties. The number of available trainees to fill the complement needed to mount a 24-hour shift was low and guard duties may have come round with the frequency of 24 hours on duty, followed by 24 hours off. Cheryl did not get weekend leave during this period. It is not entirely clear, from the available evidence, whether it was the fact that she was rostered for guard duty that prevented her having leave, or whether there was a restriction on leave, possibly as a result of outstanding ROPs, that made her available for frequent guard duties. It seems that, whatever the previous position had been, guard duties were very frequent and a source of great frustration for many trainees at that time. From her letters to Private AA, it appears that Cheryl paraded for guard on Friday 17th November but was stood down. She was on guard on Sunday 19th November, again on Wednesday 22nd November and we know that she was on guard duty on Monday 27th November 1995.³¹

6.22 On 18th July 1996, a letter from the Ministry of Defence (MOD) to Mr James, in response to queries raised by him, indicated that three guard duties in ten days was not unusual for Deepcut at the time. The letter also stated: *"guard duties do not form part of any punishment."* The first part of the answer may well have been accurate, in light of information now available, but the second part, although undoubtedly what the MOD believed to be the case, was not, as has been seen in the previous Chapter. The totality of the material available to this Review demonstrates that, from at least 1995 and the time of Sean Benton's career in the Army through to 1999, extra guard duties, and particularly weekend guard duties, were an available, informal and unrecorded punishment that could be awarded by Troop Sergeants for misdemeanours.³²

6.23 The issue is whether Cheryl was being assigned these guard duties as a form of informal punishment or because the Training Regiment was desperately short of available trainees. At Cheryl's BOI, Major Gascoigne, the Officer Commanding B Squadron, said:

"... the biggest problem in B Sqn regarding morale is guard duties. When Squadron numbers fall to a certain level the trainees are day on day off. So I can't afford to be too bullish on their time off. Trainees had the chance to catch up on sleep and do personal administration – I tried to give them enough freedom to have a normal life; At Pte James's death we were rock bottom – day on day off – we had problems carrying out training at all. We were down to 90 or 100."

²⁹ 23rd September 2002.

³⁰ 23rd September 2002.

³¹ The two draft letters of 19th November and one of the letters dated 22nd November are expressly stated by Cheryl to have been written while she was on guard duty. See also paragraph 6.12 above.

³² See paragraph 5.150 ff.

6.24 Private(f) AC told the RMP in 1995 that Cheryl was:

*"... fed up with doing guard duties seemingly every other day and was eager to get her posting out of here, but this was delayed because she was still serving Restriction of Privileges (ROPs) or other menial duties."*³³

In 2002, Private(f) AC told Surrey Police that this was not a situation unique to Cheryl:

*"If you messed about or got in trouble your posting would be delayed as punishment. I don't recall the names of anyone that this happened to however we all knew it did. Deepcut was very boring, as you would be day on day off guard."*³⁴

6.25 Major Gascoigne told the Coroner at the inquest in 1995 that, once back at Deepcut, Cheryl had to serve her ROPs accumulated whilst at Leconfield. He described ROPs as:

"... basically the smallest punishment that you can be given for a charge and it involves having to parade at the guardroom at certain times to prove that you can first of all be there on time and second that your kit your boots and everything is ironed and cleaned properly and you have to do that three times a day and that's part of the punishment."

6.26 In response to an express question from the Coroner, Major Gascoigne stated that ROPs did not involve extra guard duties. The evidence is contradictory as to whether Cheryl's outstanding ROPs were, in fact, waived at Deepcut or were served, and, if served, what type of duties they involved. In her two draft letters to Private AA dated 17th (Friday) November, Cheryl mentioned her outstanding Leconfield ROPs. In the first letter,³⁵ she was anxious as to whether her Squadron at Deepcut would be aware of them and make her and Private(f) AF do them. She noted she was not on guard that weekend but identified another reason why leave may have been restricted:

"... anyway i've just been and asked for leave and cant get it until my posting comes through ..."

In the second letter she states that they had been let off the ROPs as a Sergeant AI " ... accidentally on purpose lost our documents, what a shame, eh!". This Review understands that Sergeant AI was a Sergeant at Leconfield. The evidence of Private(f) AF to Surrey Police in 2002 suggests that the outstanding ROPs may have been waived by a Sergeant back at Deepcut.³⁶

6.27 However, in one of her two unsent letters dated Sunday 19th November to Private AA, Cheryl writes the following:

"I'm on guard at the moment and every time I start to write to you I get called to make cups of tea. I think I'm gonna be on guard at the weekend as I've been told I'll be on day on day off because of [Cheryl then explains she was called to make more tea] trouble we got into at Leccy [Leconfield] that's [Private(f) AF] as well."

³³ 29th November 1995.

³⁴ See Appendix 5, entry 2; 9th September 2002.

³⁵ In which Cheryl states it is being written at 11.00hrs.

³⁶ 19th September 2002.

- 6.28 Notwithstanding Major Gascoigne's statement to the Coroner, given the evidence this Review has seen regarding the informal nature of the assignment of guard duty as a punishment, it appears that those on ROPs, or otherwise perceived to have misbehaved, might well have been vulnerable to doing more guard duty than others, and in particular the guard duties at socially intrusive times. However, in the absence of surviving guard duty records for all B Squadron trainees at the time, it is difficult to assess whether Cheryl, or indeed Private(f) AC, who had a poor disciplinary record and has been quoted earlier, or Private(f) AF, who like Cheryl had her outstanding ROPs from Leconfield, were doing more than their fair share.
- 6.29 It may be, possibly in addition to extra guard duties, that the outstanding ROPs resulted in Cheryl and Private(f) AF doing additional tasks, including over the weekend, thereby restricting home leave. In both of Cheryl's unsent letters to Private AA dated Wednesday 22nd November 1995, she makes reference to the fact that she and Private(f) AF have been given jobs to do over the coming weekend:

"... I've been on guard twice now. I think I'm on day on day off. I won't be able to go home on the weekend either as me and [Private(f) AF] have got to do jobs on Saturday I think we're painting the kitchen in B Squadron offices and I'm on guard Sunday so I'm going to have a great weekend."

"I don't know if you wanted to come home or not that's home with me at the weekend but somehow I don't think I can go as me and [Private(f) AF] have been given jobs, yesterday we were picking up leaves all day, and on the weekend we have to paint the kitchen in the offices."

From all these letters, it would appear that some additional tasks, possibly including extra guard duties, were served at Deepcut as a result of outstanding ROPs from Leconfield. They appear to have prevented Cheryl from going home over the "weekend" – her intention appearing to be to invite Private AA home. Her impending posting to the field army may have been another factor to the same effect. As is noted later, however, it appears that, for whatever reason, the "weekend" of 25th and 26th November was, in fact, a long weekend also encompassing Monday 27th November. A number of trainees recall that the Monday was equivalent to a Bank Holiday.³⁷ Therefore, while it is known that Cheryl did not perform guard duty on Saturday 25th or Sunday 26th November, she may be referring to Monday 27th November as being part of the "weekend". However, whether Cheryl's inconsistencies in her letters as to the implications of her outstanding ROPs are an accurate reflection of events unfolding as she understood them, or an attempt to avoid seeing Private AA, is open to speculation. Certainly, in light of events that occur after Wednesday 22nd November, discussed below, the latter cannot be ruled out.

- 6.30 Two further pieces of evidence of interest, regarding the period after Cheryl's return to Deepcut from Leconfield, have come to light during Surrey Police's re-investigation. Private(f) AJ,³⁸ who states she became friends with Cheryl at ATR Pirbright, formed the impression that Sergeant D, the Troop Sergeant of 2 Troop,³⁹ was interested in Cheryl and that he arranged for her to be on guard duty at the same time as he was due to be in charge of the guard:

³⁷ See paragraphs 6.114-5 below.

³⁸ See Appendix 5, entry 28.

³⁹ As noted at paragraph 6.6, Cheryl was in 1 Troop, although these were Troops in a very loose sense.

"I knew of a NCO, Sgt [D], who fancied her, it seemed that when he was on guard duty, so was Private James. I got the impression he arranged this. I can't say what if anything happened, but he had this girl in his sights. I think this was after she had been up to Leconfield on her driving course."⁴⁰

6.31 Another female trainee, Private(f) AK, who stated that whilst Cheryl was not a close friend they were part of the same group, told Surrey Police that, on her return to Deepcut from Leconfield, Cheryl was first offered the more desirable duties and tasks⁴¹ by Sergeant D who 'fancied' her. However, when there was no reciprocation by Cheryl, she was awarded extra guard duties by him *"just to muck her around, and so that she couldn't get home on leave."*⁴² According to Private(f) AK, Cheryl told her she was annoyed by Sergeant D and considered she was being picked on.⁴³ Other than these two trainees, none of Cheryl's other friends or confidants mention this Sergeant. As far as this Review is aware, these allegations were never put to Sergeant D by Surrey Police but in correspondence with the Review, he has firmly denied any such conduct or having anything to do with awarding Cheryl extra guard duties. His responses are considered in more detail later in this Chapter.⁴⁴

6.32 Private AB gave evidence at the BOI, convened after Cheryl's death, to the following effect:

"There are rumours around that when at Leconfield she got ROPs and they started messing her about when she got down here. Some of the jobs she was given weren't very nice but I didn't really think so. She didn't mention it to me. She didn't seem to be given more duties than anybody else."

6.33 There is no direct evidence of sexual propositioning of Cheryl by any NCO or officer at Deepcut. In the statements detailing her conversations with her friends, Cheryl is only reported to have mentioned propositioning at Leconfield. The question of whether she may have been the subject of unwanted attention will be reviewed below in light of the general material about abuse of authority by staff at Deepcut.

Cheryl James's discontent with the Army?

6.34 On Tuesday 21st November 1995, Cheryl was seen by the Medical Officer, the resident civilian doctor, at the Deepcut Medical Centre for her medical assessment to join the field army. In one of her letters of Sunday 19th November to Private AA, Cheryl indicates that she will raise the issue of migraines as a possible excuse to get out of the Army. The Medical Officer, in her statements in 1995 to the RMP and subsequently to Surrey Police, indicated that Cheryl was concerned lest her migraines prevented her from being posted to the field army at the end of her training. She assured Cheryl that they would not.⁴⁵ In

⁴⁰ 11th March 2003.

⁴¹ The evidence seen by the Review suggests that trainees preferred those duties that involved being indoors rather than duties such as litter picking, weeding, etc.

⁴² 12th May 2003.

⁴³ Private(f) AK also alleges that Sergeant D behaved differently towards her after an NCO is alleged to have assaulted her. She could, therefore, have an animus against Sergeant D.

⁴⁴ See paragraph 6.116 below.

⁴⁵ Some informants to this Review have suggested the Medical Officer was unsympathetic to the needs and welfare concern of trainees. Others have expressed sympathy for her predicament and suggest she was placed in a difficult position between the interests of the Army to process as many trainees as possible and the representations of the trainees that they be excused duties for medical reasons. The Review is also aware of concerns expressed by the Army as to the efficiency of this Medical Officer (various Commanding Officers mentioned conflict between her and other members of the Medical Officer as being a source of difficulty). None of these seem to have had any relevance to the medical treatment Cheryl received or the reasons for her death.

both her letters of Wednesday 22nd November to Private AA, following her medical assessment, Cheryl states that the “nurse” had intimated that she would not mention migraines but that if Cheryl were to mention them once posted to a unit of the field army she would be “straight out.”

- 6.35 Despite the above, it does not appear that during her medical Cheryl was actually trying to leave the Army and she was, in fact, assessed fit for service in the field army. It is possible that she used the migraine issue to place a marker down in case she did want to leave the Army in the future, having missed the occasion of her 18th birthday in October when she could have departed as of right. Certainly Private AA, in his subsequent interviews with Surrey Police, suggests that Cheryl was not, in fact, suffering from migraines at the time.

The future of the relationship with Private AA

- 6.36 What emerges in Cheryl’s unsent letters, all written within six days since she left Leconfield, and Private AA’s interviews, is that Cheryl was concerned about being posted far away from Private AA in the near future. She was contemplating leaving the Army, and encouraging him to do the same, in order not to break up their relationship. In one of her letters dated 19th (Sunday) November to Private AA, Cheryl writes:

“It’d be great to be with you all of the time out of the Army. We’d get no shit at all. No chance of being caught and it wouldn’t matter anyway.”

On 22nd (Wednesday) November, Cheryl concludes another of her unfinished letters to Private AA with the comment:

“I think it’d be great to be with you and do anything we want without some stupid rules and regulations.”

- 6.37 The sequence of unsent letters also suggest an increasing sense of insecurity about her relationship with Private AA, as there does not appear to have been much contact between them since Cheryl’s return from Leconfield on 16th November.⁴⁶ In the unsent letter to a female friend from home dated 19th (Sunday) November, written whilst on guard, Cheryl expresses her love for Private AA and notes:

“... he’s the only really good thing that come out of the Army so far. I suppose I have got my licences though. We both really want to leave the Army but I know my Dad would go mad.”

Cheryl describes hating the Army, although she has got used to it:

“I’m just pretty glad I’ll be posted soon, the reason I hate it so much is I’ve got some real good mates and we’re all getting posted different places which is shit even though it is easy to meet people here and most people are your mates anyway.”

- 6.38 The Review considers that Cheryl’s letters are important as they may be the only reliable record of her thoughts and emotions at the time, as opposed to recollections of what others recall she said or felt. Private AA was clearly important to her and uppermost in her

⁴⁶ In one of her unsent letters of 22nd November, Cheryl confesses to having kissed another trainee (not Private AB) at Deepcut the night before. She is clearly concerned about telling Private AA but decides it is better that he hears from her rather than from someone else. This may explain why, by her own account, she writes at least five draft letters on that day.

mind from 16th to 22nd November 1995. However, on 23rd November a new character enters Cheryl's personal life, leading to a conflict of emotions over the weekend of 25th and 26th November, that may well directly bear on her state of mind on the morning of 27th November. Although what follows relates to personal matters in the lives of three young people in 1995, this Review believes that some broad account of these events, and how Cheryl was feeling as a result of them, is important to understanding, in so far as possible, the events of 27th November 1995.

Private AB

- 6.39 Private AB was born in June 1978 and was therefore 16 years and ten months old when he joined the Army in April 1995 and went to ATR Pirbright for Phase 1 training. He had some disciplinary problems at ATR Pirbright that resulted in some delay in completing his training and arrived at Deepcut in July 1995. He had known Cheryl both at ATR Pirbright and at Deepcut before she went to Leconfield.
- 6.40 By his own account, Private AB had a poor disciplinary record in the Army. One of his closest friends was Private AD, who also had a habit of getting into trouble and was the boyfriend of one of Cheryl's closest friends, Private(f) AC. A flavour of Private AB's activities can be obtained from the extract from his 2003 statement to Surrey Police:

"[Private AD] and me became really good mates at Deepcut; we were always in trouble for silly things, just messing about. We would drink too much on Sunday evenings and arrive at Monday parade in a bad state. The Sergeants were good to us and would tell us off in a messing about way. I recall once I ended up with a girl miles away from camp after a night out, I had to walk back to camp and again I was late for parade. I had to go in the prison for three days, just silly things really. We were known as the bad boys of Blackdown."⁴⁷

- 6.41 Private AD became the boyfriend of Private(f) AC, Cheryl's friend, whilst they were at Leconfield. Private AB had not been sent up there at the same time because of injuries. Private(f) AC and Private AD were regarded by the Training Regiment at Deepcut as bad influences and some of the worst trainees they had.⁴⁸
- 6.42 Private AB gave two statements to the RMP in 1995. He gave evidence briefly to the Coroner and to the BOI into Cheryl's death. In 2002, he gave a statement in the form of extensive interviews with Surrey Police and in 2003 a lengthy statement was made, from which the extract above is taken, seeking to set out the full position to the best of his recollection and clearing up contradictions. Different details have emerged from his account at different times, and there may be some doubt as to his reliability to recall times and specific details.
- 6.43 However, the consistent picture that emerges from Private AB's evidence is that some time after 22nd November 1995, Cheryl made it clear that she was interested in him. According to Private AB this mutual interest had manifested itself by Thursday 23rd November. He would have been 17 years and five months at this time. It is over the weekend of 25th and 26th November that this relationship develops. Private AB and Cheryl went shopping in Camberley on the Saturday morning and went to a public house where the trainees spent a lot of their spare time. They started a sexual relationship back in the male

⁴⁷ 21st May 2003.

⁴⁸ As regards Private AB, he is mentioned as one of 14 'B squadron problem cases' in Annex C to the Evans Report and is described as a "constant thorn in side of NCOs", see Appendix A11.017, entry 8. See also paragraph 6.72 ff below.

accommodation rooms at the Deepcut Barracks that evening. Private AA then discovered that Cheryl had been seeing Private AB and he entered the room where Cheryl and Private AB were in bed together. Cheryl then spoke to Private AA alone.

- 6.44 On Sunday 26th November there was another trip to Camberley when Private AA, Private AB and Cheryl went together as part of a group of trainees. Private AB was annoyed that Private AA was still hanging around. There was a party in an empty accommodation block on the Sunday evening. Alcohol was brought in and drunk. Private AB thought that Cheryl was quite drunk on the Sunday evening but that she had sobered up during the night. Private AA again turned up on Sunday night and Cheryl spent some time with each of the young men. Cheryl was in the male block with Private AB, in the room that he shared with another trainee, Private AL. She was in bed with Private AB there until about 02.00hrs on the morning of Monday 27th November, at which time she left to prepare her kit for guard duty before parading around 06.30hrs.
- 6.45 As noted at paragraph 6.14 above, Private AA gave a statement to the RMP, gave evidence to the BOI and has given substantial further interviews to Surrey Police. He states he saw Cheryl on Thursday 23rd November and all seemed to be well with their relationship and they arranged to meet on Saturday. When he arrived at the camp on Saturday, Cheryl was not there. He went looking for her in Camberley and heard that she had been seen kissing Private AB in a public house. He caught up with Cheryl later on in the NAAFI at Deepcut and he told the RMP in 1995 that they had the following conversation:

*"I then sat down with them and asked Cheryl whether what had happened was true. She told me that it was, i.e. she was seeing or having a relationship with [Private AB], and told me that I was too nice to her and that I should just dump her. The conversation then seemed to get a bit confused as one minute Cheryl would tell me that she still wanted to go out with me, then she did not. By this time we somehow were alone together. As I still loved her I tried to talk to her calmly and indirectly find out the reasons why she was seeing this other person and what was wrong with her. She did tell me that she could not help going out with other men and that whilst in Camberley that day she had had her palm read and was told that she was having problems with a boyfriend (presumably me) whom she was hurting and as her feelings had changed she was still showing that she loved the person but did not really feel that any more. Cheryl also told me that something terrible was going to happen. She told me that she knew what it was however she would not tell me despite my desperate attempts to find out what this was. Cheryl then said that we should not see each other for a week, however I did not want this, I still wanted to be with her, however at the end of the conversation we agreed that we would not see each other again because I believed that she would continue to see [Private AB]. At no time during this conversation did I shout or argue with her. I was pleading with her to try and save our relationship however Cheryl was confused and I did not know if she still wanted me or [Private AB]."*⁴⁹

- 6.46 Later that Saturday evening, Private AA discovered Cheryl with Private AB but did not cause an argument. Cheryl and Private AA spoke for some time and eventually they went to sleep, Private AA sleeping in a separate bed to Cheryl's in the female accommodation that Saturday night. He went out with her to Camberley on Sunday (there is no mention by him of Private AB being present) and Cheryl was affectionate to him and told him that

⁴⁹ 28th November 1995.

she wanted to go back out with him. Some of the group had been drinking in Camberley. There was some more drinking during a social gathering in an empty block after returning to Deepcut at about 17.30hrs. Private AA was under the impression that permission had been granted for this event, but there is no other evidence that anyone had sought it. He describes the mood thereafter:

"... a number of the girls got quite drunk and had arguments with their respective boyfriends, other soldiers serving with Cheryl. About 21.00hrs, when the party came to an end, Cheryl and I visited the NAAFI, where she drank a few more drinks which seemed to make her quite drunk. Cheryl's mood then started to swing to and fro. One minute she was close and affectionate with me, but the next minute she would push me away and behave aggressively towards someone else before returning to me and continue to be nice again. This did concern me and I tried to look after her. One of her friends [Private(f) AM] did speak with me at one point and told me that I was stupid going out with Cheryl because of the way she treated me and the fact that she had been giving [Private AB] the eye all night. Once [Private(f) AM] had gone Cheryl asked me what we had said and I told her however she merely laughed it off. I then went away to speak to another friend and when I returned to Cheryl I saw her talking with [Private AB], who I heard arranging to see her later on. I could not believe this as she had told me that she wasn't going to see him again and that I was the one she wanted. As Cheryl saw me at this point she pulled a face as if to say "oh no I've been caught." She then came up to me and began kissing me and being affectionate as though I had not seen her. At this point I did not say anything to Cheryl. I suppose it had not really sank in at that point what I had seen. Cheryl then told me that she wanted to talk to me and she lead me to a dark quiet corner near the discotheque."⁵⁰

- 6.47 Private AA says that he and Cheryl had a moment of intimacy in the disco before they returned to her room and he collected his belongings. On the way there, they visited the guardroom where Cheryl was angry with something one of the female trainees on guard had said about her and was minded to have a fight with her, but Private AA dissuaded her:

"I told Cheryl that I had to go. We then walked a short distance together to a phone box where she told me that she was sorry for upsetting me. I did actually feel upset at this point because of what had happened with [Private AB], however I told her that I was not upset. She asked me to come back and see her again the following day (Monday) however I reminded her that she was on guard duty, so she asked me to see her again on Tuesday. This I agreed to and after her telling me that she was going to prepare her kit for guard duty and then go to bed we kissed for about ten minutes before I left to return to camp saying goodbye. This was the last time that I saw Cheryl."⁵¹

- 6.48 Private(f) AC told the RMP in 1995 about conversations she had with Cheryl about her personal life over the weekend:

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

*"We did talk about her relationships with both [Private AA] and [Private AB] and she just could not make up her mind which one she wanted to stay with. She compared the sexual relationships and their personalities with me but still could not decide who she wanted. [Private AA] loved Cheryl and she did not want to upset him and [Private AB] made her laugh. I did tell her that she should really make her mind up and decide because at the end of the day somebody would get hurt if she kept seeing both of them. During last weekend I do know that Cheryl slept with both [Private AA] and [Private AB]."*⁵²

The events of the morning of 27th November 1995

6.49 As noted earlier, these events in Cheryl's personal life were taking place against the background of very frequent guard duty for Phase 2 trainees. On Friday 24th November 1995, Cheryl had phoned home to say that she could not come back that weekend because of guard duty but was looking forward to Christmas. The requirements of guard duty were perhaps disappointing in the light of her social plans as outlined in her draft letters. Having done guard duty on Wednesday 22nd November, it seems that she did not have to report again for duty until 06.30hrs on Monday 27th November 1995. Private(f) AC performed two guard duties over the weekend and was also rostered for the Monday morning, as was Cheryl's other close female friend Private(f) AF.

6.50 The RMP took a formal statement from Private(f) AC on Wednesday 29th November 1995 as to Cheryl's state of mind, although the RMP Case File Diary notes that they had informally spoken to Private(f) AC and Private(f) AF in the hours after Cheryl's death.⁵³ In her statement, Private(f) AC said that when she greeted Cheryl on the Monday morning whilst parading for guard Cheryl started to:

*"... smile and giggle in her normal way. Cheryl to me seemed her normal self and although she did look a bit tired, she certainly did not seem to be hung over as I was."*⁵⁴

Private(f) AC recalled that, at one point, Cheryl was laughing with the rest of the guard when the NCO parading them shared a recollection regarding a previous guard duty.

6.51 Private(f) AC did tell the RMP, however, that there was a reference back to their previous conversation regarding Cheryl making up her mind between the two young men in her life:

*"We then went into the guardroom where she collected her rifle as she was on first stag (07.00 – 09.00 hrs). As she was doing so, Cheryl spoke to me and asked me not to mention that she was sleeping with both [Private AA] and [Private AB]. I told her straight that I thought other people knew about her already anyway and that she should make up her mind, choose one of them and let the other one go gently. She did also tell me that she still could not make up her mind. During this brief conversation Cheryl was her usual self and she did not show that anything was deeply wrong or troubled her other than making her mind up about the lads."*⁵⁵

⁵² 29th November 1995.

⁵³ Noted in the case diary records. The RMP Sergeant's contemporaneous notes record "no different information" next to Private(f) AF's name.

⁵⁴ 29th November 1995.

⁵⁵ *Ibid.*

- 6.52 Private(f) AC says that Cheryl planned to meet her at dinner time. In light of the subsequent Surrey Police re-investigation, it seems quite possible that Cheryl was more concerned about the choice between the two young men than this account suggests.
- 6.53 Lance Corporal Y was a Regimental Provost⁵⁶ NCO whose responsibilities included Provost and security duties. He was not, therefore, an instructor but a permanent member of the guard staff. He paraded the guard on Monday 27th November where routine briefings were gone through at 06.30hrs, before the first guard stag commenced at 07.00hrs. In his statement to the RMP, he stated that he knew Cheryl to speak to as she had carried out guard duties over the previous couple of weeks. He did not notice anything wrong with Cheryl's mood and she did not appear hung over or overly tired. He said he did not smell alcohol on her breath, and would not have assigned her a weapon and ammunition if he had suspected she was not fit to carry out her duties. Although some informants have suggested that Cheryl was drunk on the Sunday evening, others thought she was not, and the statement from the forensic scientist who carried out a post-mortem analysis of her blood confirmed that she had not consumed alcohol, or any drug substance, immediately prior to her death.⁵⁷
- 6.54 Lance Corporal Y said Cheryl "*appeared to be her normal happy self*,"⁵⁸ although whether he had cause to notice her particular disposition amongst the other 11 trainees who would have been paraded may be doubted.
- 6.55 Cheryl was assigned to guard the 'Royal Way' Gate, known as A2 ('Alpha Two').⁵⁹ Private(f) AC recalled in her statement to the RMP that when the NCO parading the guard ask for volunteers to do the 'stag' (guard duty) at gate A2 "*initially nobody replied, but when he said it would be quiet there Cheryl volunteered.*"⁶⁰ Lance Corporal Y said he detailed that she "*was to carry out her guard duties on this particular gate on her own.*"⁶¹ The Royal Way Gate was not open 24 hours a day, but only at selected times to allow officers and staff coming from the RLC Headquarters Officers' Mess, married quarters or other locations to the north of the Barracks to enter in the morning, return at lunch time and go home in the evening. As part of an attempt to reduce the number of trainees required for guard duty on this rather large and sprawling site, the Training Regiment had applied for approval to reduce the guard requirement at this gate to one person during its hours of opening. The Training Regiment's standing orders, therefore, identified this gate as a one-person gate without reference to gender.
- 6.56 However, it appears that the United Kingdom Land Forces Anti-Terrorist Security Measures (UKLF ATSM) prevented females from performing armed guard duty alone,⁶² and so the one person assigned to this post should not have been female. Lance Corporal Y would not appear to be responsible for the lack of consistency of local orders with the UKLF ATSM's instructions on this issue. It appears from his statement that at least four of the five trainees he dropped off for the first guard duty stag that morning were female, and it is unlikely that the guard complement could have been met without breach of this policy. At 07.00hrs on a November day, dawn would probably just be breaking. The gate would most likely have been quiet until shortly after 08.00hrs when staff would be arriving to

⁵⁶ Regimental Provost is also sometimes referred to as 'Regimental Police' but are concerned with provost and security duties within the Regiment and are not to be confused with the RMP.

⁵⁷ 11th December 1995.

⁵⁸ 27th November 1995.

⁵⁹ See the map of Deepcut at Figure 1.1.

⁶⁰ 29th November 1995. The Review is aware of other statements taken by Surrey Police that support this recollection. See also paragraph 6.115 below.

⁶¹ 27th November 1995.

⁶² Rule 8(3) of Annex D to Chapter 5, UKLF ATSM. See paragraph 11.21 for the text of this Rule.

open up the training school and offices for 09.00hrs.⁶³ It may have been that, in order to avoid questioning about her predicament with Privates AA and AB, Cheryl preferred to be alone for that first stag.

- 6.57 The next recorded information available concerning Cheryl is Private AB's statement to the RMP in 1995 when he said that, having got up at 07.00hrs, he went to meet Cheryl at 07.30hrs at the gate where she was on guard:

*"... she was happy and laughing ... she jokingly said that she was going to sit in the woods and let the traffic enter the camp, I did not take her seriously as she often joked about things like this ... She told me how tired she felt but that she had a great night the night before and was looking forward to the next time we could go out together. She did not seem worried or concerned about anything and all she wanted to do was to rest and sit down as she was hung over. After talking with her for about forty five minutes (08.15) we gave each other a kiss and arranged to meet each other at 15.00hrs that day. I then said goodbye and returned to my block. This was the last time I saw Cheryl ... She did not give any indication whatsoever that she was going to take her own life. I do not know of anyone who Cheryl did not get on well with as she was such a happy person."*⁶⁴

It will be necessary to return to the conversation between Private AB and Cheryl later in this Chapter when the product of the Surrey Police re-investigation is examined.

- 6.58 In 1995, a Major confirmed to the RMP that he rode his bicycle through the Royal Way Gate at about 08.15hrs on 27 November. The gate was then manned by a female guard and he noticed a young man nearby whom he spoke to. The young man knew he should not be there and was told to leave which he said he would. The Major noticed nothing else of significance.
- 6.59 Within the next ten minutes, it was to be reported that Cheryl had left the guard post. It seems that a Staff Sergeant, Regimental Sergeant-Major AO and the Adjutant, Captain Whattoff (later Major, now retired), all came through the gate and saw Cheryl on guard. Regimental Sergeant-Major AO estimates he came through at approximately 08.20hrs. He criticised Cheryl for failing to address him as 'sir' but her manner was nothing untoward.⁶⁵ Captain Whattoff told the BOI that he came through the gate between 08.15 and 08.20hrs and that Cheryl seemed perfectly normal for a trainee on guard duty. The Staff Sergeant puts the time he came through the gate and was recognised by Cheryl at about 08.30hrs. The BOI thought this estimate a little late, in light of the other evidence. Another witness who passed through commented on the fact that the female on guard looked dejected.
- 6.60 Captain AP's statement to the RMP dated 29th November 1995 stated that, as he had to open a building in preparation for the first lesson at 08.30hrs, he left his house at "about 08.20 hrs and drove the short, three or four minute journey to camp." The typed version of his 1995 statement must contain an inaccuracy as it suggests that he passed through the gate at "0850 hrs" when on the rest of the content of the statement it should clearly have stated about 08.23 or 08.24hrs. He did not give evidence at the BOI. On arriving at the gate, he noticed that it was unmanned and that the barrier used to block access

⁶³ The Regiment may have been quieter than usual on this day as it was on stand down. See paragraph 6.115 below.

⁶⁴ 29th November 1995.

⁶⁵ Surrey Police took a statement from another witness who was in the car behind waiting to pass through the gate and recalls seeing Cheryl 'brace up' in response.

through the gate was in the up position (see Figure 6.3). This contrasts with the position it was in at 07.40hrs.⁶⁶ Captain AP stopped his car, got out and inspected the guard hut, which was empty. His statement indicates that he was the first to drive to the guardroom to report that the gate was unmanned and that they should check it out. He then continued to the Education Centre where he arrived at 08.30hrs. Lance Corporal Y states that Captain AP attended the guardroom to report the unattended gate at 08.30hrs. Lance Corporal Y then drove to the scene to investigate.

- 6.61 From the evidence obtained at the time, it would seem reasonable to surmise that Cheryl remained at the guard post until roughly 08.20hrs and was noticed missing within a few minutes and the matter reported to the guardroom at 08.30hrs thereafter. Although more informants who passed through the gate have subsequently come to light as a result of Surrey Police's re-investigation, they do not materially affect this estimate of time.
- 6.62 Lance Corporal Y arrived at the gate and found the guard radio in the hut but no sign of Cheryl. Thinking that she may have gone to the toilet, he took over the guard duty, checking the identification of cars entering the camp. He then became aware of a combat jacket by a tree some 15 to 20 metres from the guard post in the wooded area next to the gate on the right hand side of the road (see Figure 6.2). He flagged down another Lance Corporal who was leaving the camp by vehicle (having previously entered around 07.40hrs and had his identification checked by Cheryl) to assist him and together they found Cheryl's body by a tree (see Figure 6.3). Her head was pointing down the slope towards the road, with a large wound to the front of her head and an SA80 lying by her side. She was found to be dead. The alarm was raised and the emergency services were called out and arrived shortly thereafter.

Figure 6.2: A photograph of the view from the Royal Way to the area where Cheryl James's body was discovered



⁶⁶ The Lance Corporal who was flagged down by Lance Corporal Y as he was leaving (see paragraph 6.62 below) gave a statement to the RMP at 15.30hrs on Monday 27th November 1995 in which he stated he entered the camp at 07.40hrs. It is clear from his statement that Cheryl checked his ID. His statement also recorded that: "As I approached the gate, I noticed that the left hand gate was closed and the right hand gate open, but it had a red and white manual barrier across, effectively blocking the road. This is a normal condition for the gate to be in when it is opened."

Figure 6.3: A photograph of the view from the area where Cheryl James's body was discovered towards the Royal Way Gate (A2)



The 1995 investigation

- 6.63 The general position with regard to who had primacy for the investigations into the four deaths at Deepcut has been discussed in Chapter 3. Just as in Sean Benton's case, Surrey Police were called to the scene immediately, attended and conducted some enquiries, but subsequently do not appear to have either conducted their own investigation or formally handed it over to the RMP Special Investigations Branch (SIB). It appears that the first civilian police officer was on the scene by about 08.55hrs and five other uniformed officers, including one with the rank of a Chief Inspector and two Detective Constables, attended the scene before leaving around 11.00hrs. One of the most influential personalities on the scene was the Coroner's officer – an experienced former police officer. He appears to have taken charge of the crime scene and the enquiries on the day. The most senior RMP SIB officer on the scene was a Sergeant, who appears to have taken responsibility for statement taking and the retention of exhibits. The Surrey Police re-investigation in 2002 concluded that an informal decision was taken by those present to hand the investigation over to the RMP SIB. The RMP believed they were assisting the Coroner for the purposes of the inquest. It is clear that, by the standards of investigation into a suspicious death, the initial investigation was perfunctory and the opportunity to test key exhibits has been lost. However, on the common understanding of the protocols outlined in Chapter 3, by withdrawing from the investigation Surrey Police were making a statement that they did not regard Cheryl's death as suspicious, and it would appear neither did the Coroner's officer. Indeed, the RMP Case File Diary includes an entry for 27th November 1995: *"Coroner's officer requested SIB carry out enquiry."*
- 6.64 A sketch plan, some photographs, the spent cartridge and a magazine with one missing round from the normal ten, led to an early conclusion that Cheryl had died from a single round fired by her rifle at close quarters. There was no exit wound, which is unusual for

such a high velocity rifle, but the subsequent Surry Police re-investigation has revealed expert evidence that a bullet fired into the forehead can become unstable in its trajectory and may be deflected from passing straight through the skull.

- 6.65 These early assumptions by Surrey Police in 1995, however, meant that there was no ballistic testing of the bullet to confirm if it had been fired from Cheryl's weapon. There was no testing of Cheryl's hands or her forehead to see if the black marks recorded in the photographs were sooting from gunshot residue. Similarly, Cheryl's clothing was not retained for examination. There was no other detailed forensic recording of the scene. All of this makes it impossible today to demonstrate, beyond doubt, precisely how Cheryl died.
- 6.66 A post-mortem was carried out at 10.30hrs on 28th November 1995 and the subsequent report dated 29th November recorded the cause of Cheryl's death as *"gunshot wound to the head."* The report listed the attendees at the post-mortem as being four RMP personnel. No Surrey Police presence was recorded.
- 6.67 The RMP took witness statements on the day of Cheryl's death from those most concerned with the events leading up to the death, but, as noted earlier, they also spoke informally to a number of her friends. By 29th November 1995, two days later, an RMP Initial Case Report with the title 'Suspected Suicide (Assistance to HM Coroner's Office)' was prepared outlining the findings of the initial investigation. After the summary of the circumstances of Cheryl's death, the report noted: *"It has been requested by HM Coroner's office, Camberley, that SIB RMP record witness statements from the appropriate unit personnel concerning this incident which when to hand will be forwarded direct to HM Coroner. Although no further report will be submitted by this unit appropriate addressees will be notified of the findings of the Coroner's Inquest which will be held in due course."* The summary made reference to Cheryl's letters noting *"she did not enjoy Army life and was planning on leaving the service"* and that she had written to Private AA in which *"she related her deep feelings for him and that she wanted to live with the soldier once they had both left the Army."* The witness statements taken by the RMP were, indeed, subsequently provided to the Coroner's officer, at *"HM Coroner's office, c/o Surrey Police"*, under cover of a letter dated 14th December 1995.
- 6.68 The inquest into Cheryl's death was held on 21st December 1995 and was scheduled to start at 10.45hrs. The proceedings, in fact, started at 11.15hrs. It was a short affair. Mr. James was amongst those who gave evidence and the report of the inquest by the Training Regiment suggested that the Second-in-Command and Major Gascoigne had spoken to the family and expressed their deepest regrets for their loss. An RLC officer handed Mr James his card.⁶⁷ Lieutenant Colonel Josling, the Commanding Officer, attended the inquest but did not give evidence and the family have no recollection of speaking to him or receiving a letter of condolence.⁶⁸ The question of perceived poor communication between the Training Regiment and Mr and Mrs James was ventilated at their 6th January 2006 meeting with Colonel Josling arranged by the Review.⁶⁹
- 6.69 There was no suicide note or any other evidence adduced before the Coroner of an intention to self-harm. There was no clear evidence that Cheryl was in an unhappy or desperate frame of mind at 07.00hrs on 27th November 1995 or any time thereafter. Her family believed she was looking forward to making progress in her military career. None of

⁶⁷ See Appendix A4/7.033 F – G.

⁶⁸ See Appendices A4/7.026 C – D and A4/8.003 B – C and A4/8.004 A – B. There was no condolence letter on the personnel file or in Mr James's extensive correspondence file. Major (Retd) Whattoff assured the Review one had been drafted, see Appendix A4/16.031 E – G. Colonel Josling was *"almost certain"* that it was sent. If so, it does not appear to have been received by Mr and Mrs James.

⁶⁹ The transcript of the meeting is set out in full in Appendix 4/8 to this Report.

the young men or women she had been associating with in the previous 24 hours suspected that she might self-harm or try to kill herself. At the end of the inquest, the Coroner directed himself as follows:

"In order to conclude that someone intended taking their life, that they committed suicide, I have to be satisfied beyond all reasonable doubt as to their intention. What we have here is a girl who, on the outside, appears to be very bubbly, a happy personality, very fond of the army by all accounts, no evidence at all of any bullying, maybe the one fly in the ointment is having two admirers and undecided as to which she preferred. But nothing that comes to my attention which seems to require the enormity and unreverseable effects of suicide. She left no note, and whilst therefore there is no evidence to suggest that any other person caused her death I [have] certainly not [had] produced to me today any evidence as to her state of her mind suggesting her intent. In the circumstances, the only conclusion I can reach is an 'Open Verdict', which may not be or may not sound to be very satisfactory, but what we are effectively doing is saying whilst we have taken this investigation as far as we can there remains that doubt, which we certainly give to Cheryl in this case, so that we don't presume suicide ever. It has to be proved and demonstrated beyond all reasonable doubt. As I say, there are missing gaps and I am unable to explain to [myself], just as I believe her father is unable to come to terms with how it is that a girl, who one moment seems to be bubbly and outgoing, should the next moment have been found dead with a bullet in her."

- 6.70 Although there was insufficient evidence for the Coroner to be satisfied, to the criminal standard, that Cheryl had killed herself, and he considered accident was improbable, there was no evidence of any third party involvement or any reason to believe that Cheryl had been killed by another. A lack of satisfaction on suicide does not mean that the intervention of a third party was a probability or even a reasonable hypothesis.⁷⁰
- 6.71 By the time the BOI was complete on 18th January 1996, there was perhaps a little more material available suggesting that Cheryl might have had some inclination to harm herself around the time she died. This material will be considered compendiously with the results of the subsequent Surrey Police re-investigation of Cheryl's death.

Incidents of self-harm by trainees

- 6.72 The BOI into Cheryl's death had the benefit of the RMP report, a short report of the inquest and the Report of Brigadier Evans's review of training (the Evans Report),⁷¹ conducted in response to Sean Benton's and Cheryl's deaths. The Evans Report and its recommendations will be considered in greater detail in the next Chapter, when the Review will consider what lessons were learnt in the aftermath of Cheryl's death, occurring within six months of Sean's. It is pertinent to note that Brigadier Evans compiled two schedules to his report: one of which gave details of five other trainees who had self-harmed by either cutting their wrists or taking an overdose of paracetamol between 12th July and 6th November 1995;⁷² the other which gave details of 14 'problem cases' in B Squadron i.e. trainees with poor discipline records.⁷³

⁷⁰ See the criteria for Coroners' verdicts as set out in paragraphs 2.27-30 above.

⁷¹ As reproduced in Appendix 11 to this Report.

⁷² See Appendix A11.015.

⁷³ See Appendix A11.016 ff.

- 6.73 The schedule of incidents of self-harm record comments from the resulting RMP investigations into the incidents. The comments appear to show that the causes of the incidents ranged from personal problems, to difficulties with relationships, to an inability to settle into service life. One of the five trainees was being discharged from the Army, another was on a three-month warning, and discharge had been applied for, and a third was facing a Court Martial. None of the five mentioned bullying to the RMP as a reason for their self-harm. During their re-investigation, Surrey Police made contact with those identified in the schedule as having self-harmed. The reasons they gave at that time for having self-harmed ranged from: boredom; depression at not making any progress; a quick way to get out of a career now hated; and the way that females were treated by NCOs after the death of Cheryl. None made any complaint of bullying, though one informant, not in the schedule, referred to slashing his wrist because of the hard time he received from his Sergeant-Major.
- 6.74 This Review has called for and reviewed the personnel files and medical reports of some 26 trainees who were reported to the RMP for self-harming over the period 1995 to 2002. In none of them is bullying at Deepcut mentioned as a factor in their records.⁷⁴
- 6.75 The schedule to the Evans Report that included 14 'problem cases' among the trainees in B Squadron listed those trainees that had poor disciplinary records. All five trainees in the self-harm schedule are also listed in the problem cases schedule. Again, there is no information recorded that the problem cases were being harassed or ill-treated. One female trainee, who is in both schedules, is recorded as having claimed to be having a relationship with a Sergeant in B Squadron. This is noted as having been dismissed by RMP as 'fantasy'.⁷⁵ Subsequent enquires by Surrey Police in 2002 revealed it was not, as the woman later had a child by, and a committed relationship with, the Sergeant in question.

The Army Board of Inquiry

- 6.76 The BOI into Cheryl's death convened on the 11th January 1996. It was headed by a Major. A redacted version of the BOI's report is set out in Appendix 10 to this Report. At paragraph 36, the Board states it was satisfied that Cheryl had shot herself between 08.19 and 08.24hrs. Recently, an e-mail was forwarded to the Review by a member of the Board, whose recollection was that no such conclusion had been reached. This Review is satisfied that this was an error of memory. The BOI also noted that the dislocated nature of Phase 2 training at Deepcut made the progressive training envisaged by the Single Entry Implementation Plan difficult to achieve. It noted at paragraph 29 of its Report that:

*"No amount of excellent management processes and formal welfare provision can hope to compensate for the lack of sustained exposure to excellent junior leadership which the present regime imposes on recruits."*⁷⁶

⁷⁴ One trainee mentioned bullying at Bassingbourn. Some of the 26 positively certify they have not been the subject of bullying. See paragraph 9.53 below.

⁷⁵ See Appendix A11.016, entry 1.

⁷⁶ See Appendix A10.012.

- 6.77 The BOI recommended a radical review of Phase 2 training or, alternatively, the development of either a better Phase 1 screening process for recruits more suitable for military life, or the development of supervisory ratios that *"will be costly to man and which defeat the laudable aim of progressively developing self-discipline."*⁷⁷
- 6.78 The BOI heard evidence from Private(f) AC and Private AB about the activities of the weekend before Cheryl's death and the way in which Private(f) AC, at least, had combined her guard duty obligations with her social and personal life. On the subjects of alcohol, sexual liaisons and supervision of the accommodation the Board concluded:

"31. It is the opinion of the Board that existing arrangements to occupy the working hours of Phase 2 recruits, are generally good. It was noted, however, that recruits were apparently free during rest periods while on guard duty, to return to their accommodation. In future this should be more rigorously controlled. More significant is the problem of off-duty supervision and the Board makes the following observations:

"32. Alcohol. Alcohol is presently routinely taken into barrack accommodation. This is a particular problem when large quantities of drink are purchased outside camp by recruits. The physical layout of the camp means that recruits have no difficulty whatsoever in avoiding the guardroom when bringing drink into camp; thus the requirement to book in has no deterrent effect at all. The Board recommends that HQ RLC Trg Gp investigate the possibility of using MGS [MOD Guard Service]⁷⁸ personnel at the main gate to check whether recruits are bringing alcohol into barracks.

"33. Sexual Behaviour. Anecdotal, but nonetheless convincing, evidence was given to the Board to the effect that virtually all female recruits had boyfriends, and that virtually without exception they were having regular sexual intercourse in barracks. Despite clearly knowing they are in breach of military regulations, no attempt is made to hide these activities and punishment is no more feared than discovery! There was no evidence of civilian involvement. Clearly this has wider implications for the public image of the Army and its duty of care towards recruits, as well as an impact on operational effectiveness. Such behaviour demonstrably undermines good order and military discipline within The Princess Royal Barracks. To what extent the prevailing conditions of sexual freedom contributed to W/Pte James state of mind is impossible to judge. Clearly though they did nothing to limit the consequences of her tangled relationships!

"34. Off-Duty Supervision. While the Board welcomes the proposal to increase the female Permanent Staff to 25%, it notes that most misbehaviour involving drink and sex, occurs in male accommodation and/or in unoccupied accommodation blocks. OC [Officer Commanding] B Sqn is fully aware of the need for off-duty supervision and, in the opinion of the Board, rightly believes that this must, in appearance at least, be relatively informal. Only in this way can the requirement of the Single Entry

⁷⁷ *Ibid*, at paragraph 30.

⁷⁸ The MOD Guard Service were unarmed civilian guards as opposed to the later armed Military Provost Guard Service.

Implementation Plan to give recruits progressively more freedom, be matched to a continuing need for supervision. A traditional, holistic training structure would mean the presence of Permanent Staff during off-duty hours would not be resented.”⁷⁹

- 6.79 The Board recommended various measures to improve supervision: remove the unsavoury influence of those assigned to C Squadron⁸⁰ over the lives of B Squadron trainees; have control checks on the bringing of alcohol into the camp⁸¹ and activities in the NAAFI;⁸² greater supervision of the female accommodation;⁸³ and the installation of video cameras to monitor access to the female accommodation.⁸⁴ In the final paragraph of the report the Board recommended that the Commander of the RLC Training Group:

“takes steps to prevent soldiers held at the Training Regiment and Depot RLC for disciplinary and/or administrative reasons, from adversely influencing recruits.”⁸⁵

- 6.80 The Board noted that the Training Regiment was mistaken in believing it could employ service women armed and alone on guard duties and that that practice conflicted with the UKLF ATSM. The Board seems to have been unconcerned as to why this state of affairs had come about, and who was responsible for failing to translate policy into local unit standing orders, merely noting that the discrepancy had now been corrected. The Board appeared to doubt the wisdom of the UKLF instruction, as it pointed out the need to double up women on armed guard added to the strain on numbers at the Training Regiment and, in the light of the evidence of sexual activity, it had noted it did not recommend paired guards of men and women. It clearly concluded that Cheryl died as a result of self-harm.⁸⁶
- 6.81 The Review notes that one of the three members of the Board issued a dissenting opinion. He disagreed with the recommendation that a review of Phase 2 RLC training be conducted, and believed that some of the lines of enquiry and recommendations about sexual activity were misogynistic. Unfortunately, this member has since passed away and this Review has been unable to clarify what specific issues he considers should not have been addressed. There may well be some rather inappropriate language in the Report of the BOI about the nature and sexual behaviour of trainees. However, the provision of female accommodation reasonably safe from male entry at night, seems to have been a legitimate concern and was a founding principle of the Single Entry Implementation Plan. The justification of the Army's concerns in this respect will be seen in the following two Chapters.

The Surrey Police re-investigation in 2002

- 6.82 Following the inquest and the BOI, Mr and Mrs James pursued some issues in correspondence with the MOD about Cheryl's letters, guard duty and reports of abuse of authority at ATR Pirbright and elsewhere in the Army. That correspondence appears to have concluded in about 1997. As with Sean Benton's family, it was the death of James Collinson in March 2002 that gave fresh impetus to Mr and Mrs James's concerns about how their daughter died.

⁷⁹ See Appendix A10.013.

⁸⁰ See Appendix A10.015, paragraph 42. See paragraph 4.67 above for the depot function in place at Deepcut at this time.

⁸¹ See Appendix A10.014, paragraph 41(b).

⁸² *Ibid*, at (c).

⁸³ See Appendix A10.015, paragraph 41(d).

⁸⁴ *Ibid*, at (e).

⁸⁵ *Ibid*, paragraph 42.

⁸⁶ See Appendix A10.014, paragraph 36.

- 6.83 As noted in Chapter 1, in July 2002 Surrey Police decided to re-investigate Cheryl's death and the circumstances surrounding it. The Review has had access to the product of that re-investigation and concludes that three themes have emerged relevant to this Review:
- (i) First, whether Cheryl's death is consistent with a self-inflicted gunshot wound or whether any evidence inconsistent with that hypothesis or tending to suggest that her death was inflicted by a third party has come to light.
 - (ii) Secondly, whether there is evidence suggesting Cheryl had expressed thoughts about self-harm or was otherwise a candidate for self-harm by reason of factors in her past.
 - (iii) Thirdly, whether there is evidence that NCOs at Deepcut were sexually harassing female trainees at Deepcut or otherwise acting inappropriately to young women, and whether Cheryl was the target of such activity.

(i) Evidence supporting or undermining the hypothesis of self-harm?

(a) The infliction and nature of the wound

- 6.84 In 1995, all those concerned with the investigation into Cheryl's death concluded that there was nothing suspicious about it. To fire an SA80 a number of steps would have to be taken. The magazine containing 10 rounds of live ammunition would need to be taken from the pouch, where it should be kept according to procedures required at the relevant alert state, and inserted into the rifle. The rifle would need to be cocked so a round entered the chamber from the magazine. The safety catch needed to be switched off. The weapon would need to be directed at the entry point of the bullet on the bridge of the nose; and pressure would need to be applied to the trigger of the weapon to discharge a round. The weapon was set to 'repetition', thereby releasing only a single round per trigger depression, rather than to 'automatic' fire, as in Sean Benton's case. Accidental discharge was, therefore, discounted on the basis that these steps could not be taken by accident.
- 6.85 There were no signs of any struggle or injury on Cheryl's clothing and body, as recorded in the post-mortem report, the visual recollection of the witnesses and the photographs. There was no evidence of a struggle or injury in the immediate area of the guard hut. It would appear that Cheryl had moved, from the site of the guard hut to the place where she was found, of her own motion. Cheryl was assigned a rifle and ten rounds of ammunition, and a rifle and nine rounds were found with a spent cartridge, strongly suggesting that she had died with her own weapon, although no ballistics checks were carried out to confirm this. No other weapon or ammunition has been identified that might have been used in her death, either in the original investigation or subsequently as a result of Surrey Police's re-investigation. No weapon or ammunition was reported as missing.
- 6.86 The timing of Cheryl's death was during daylight at the busiest time of day for the gate in question with officers coming into work at the camp. As can be seen from the photographs (see Figures 6.2 and 6.3), the location where Cheryl's body was found was lightly wooded without much ground vegetation at that time of year. It was not a spot concealed from the road or invisible to road users. It would not be a good time or location for a pre-planned assault on a vulnerable female guard. It is also noteworthy that the

manual barrier was found to be in a raised position when Cheryl's absence was first noticed by Captain AP. The raised manual barrier suggests a deliberate act to avoid attracting attention to the guard's absence.⁸⁷

- 6.87 The question has, nevertheless, been ventilated as to whether there is evidence contradicting the hypothesis of a self-inflicted wound. It would appear that Frank Swann, an independent forensic expert, has expressed such an opinion. The basis for that opinion has not been disclosed to this Review or Surrey Police or to any peer review by forensic experts. The Review cannot speculate on what he might have added to this first question. The Review is, however, fully satisfied from an examination of the scientific investigations commissioned by Surrey Police from the German BKA (the Forensic Institute of the German Federal Crime Bureau or Bundeskriminalamt, Kriminaltechnisches Institut) that self-infliction is a possible and plausible cause of death in this case. The nature of the injury to the skin was typical of a shot at very close range. If the black residue to the forehead noted in the photographs had been chemically analysed and proved to be powder from the shot, this would also have been confirmation of a near point blank shot. If Mr Swann has held, or still holds, a contrary opinion it would be completely inconsistent with the impressive and persuasive analysis by the BKA. The burden of proving that such a means of death is impossible is a very high one. It is considerably higher than a scientific opinion that such a method is possible, without seeking to eliminate other possible means. In any event, a full evaluation of how Cheryl met her death cannot be based solely on scientific evidence, but on a total assessment of all available evidence that is, or may be, reliable.
- 6.88 It is apparent from the analysis of the size of the weapon and the location of the trigger, already noted in the case of Sean Benton, that it is possible for an SA80 weapon to be reversed to point to the head of a person holding it and the trigger engaged, even with the potentially shorter reach of a female soldier. The BKA conclusion was that the totality of forensic evidence now available is totally consistent with self-harm, while noting that it is not possible to definitively exclude a third party hypothesis. This conclusion is based on: the location of the weapon and the spent cartridge; comparison with a known case of self-harm using the same weapon in a similar way to the self-harm hypothesis; analysis of the photographs of the broken skin surrounding the wound; observation from the photographs of blackish deposits on the face between the eyebrows and the left eye and bridge of the nose; blackish deposits on the left hand in the region of the thumb and index finger; whitish/blood coloured adhesions on the right sleeve; and control tests as to the behaviour of the bullet.
- 6.89 If the scientific evidence is totally consistent with self-inflicted death, the question is whether there is any other evidence suggestive of third party involvement. The RMP only questioned those in the office nearest to the scene as to whether they had heard a shot. No one had, and the RMP do not appear to have asked anyone else. Surrey Police's re-investigation identified at least 11 individuals who recall hearing a shot. As there was no sign of a struggle, a third party hypothesis must focus on the proposition that someone known to Cheryl persuaded her to go to the scene of death and hand over the weapon or directed her to use the weapon on herself. No one had any identifiable reason to do this. Cheryl was a popular and much-loved young woman.
- 6.90 On the evidence, the only plausible candidate for such a hypothesis could have been Private AB, although it is emphasised that there is not a shred of evidence to even suggest that he did or wanted to carry out such an action. Nevertheless, the Surrey Police re-investigation has added further detail to the circumstances surrounding Cheryl's death as known at the time of the inquest and the BOI.

⁸⁷ It may also provide some support for Private AB's account to the RMP in his statement dated 29th November 1995 that "she jokingly said she was going to sit in the woods and let the traffic enter the camp", see paragraph 6.57 above. See also paragraph 6.60 and footnote 66 above.

(b) Fresh information from Private AB

- 6.91 At the BOI, Private AB indicated that, on the morning of 27th November 1995 after he had been sent away from Cheryl by the Major who passed through the gate, he went back to his block and saw Private AD who was riding a newly-acquired bicycle. According to Private AB, Private AD was going to ride out to Cheryl's post and see her to apologise for something that had happened the night before. At the BOI, Private AB suggested that the next thing he heard was when he was told by someone that Cheryl was dead. He then went to the guardroom and when it was confirmed to him he was stunned.
- 6.92 In one of his interviews with Surrey Police, Private AB suggested that Private AD may have ridden out to see Cheryl, could not find her and reported this back to Private AB. When Private AD was interviewed, he denied having done so or intending to do so.
- 6.93 In the final version of his accounts of events that he gave to Surrey Police, Private AB indicated that the conversation he had with Cheryl at the gate on the Monday morning may not have been completely amicable. There was more to it than had previously been explained. It would seem that on the Sunday night, after Private AA had left, Cheryl went to Private AB's room for sexual intimacy and at some point Private AL, one of Private AB's roommates, had entered the room and seen the couple naked on top of the bed. Some sexual comment Cheryl made to Private AL⁸⁸ in these unusual circumstances appears to have caused Private AB some concern as to where he stood in Cheryl's affections. This was a matter he canvassed with her the following morning, leading to an argument. Private AB thought he could have sorted the matter out if he had not been sent away by the Major for distracting Cheryl during her guard duties.
- 6.94 This fresh material may lead to Private AB being treated with some caution as a reliable historian of the precise details of the sequence of events with Cheryl, and the nature of the emotional bonds between them. However, they do nothing to suggest a fresh hypothesis as to the cause of death.
- 6.95 Nevertheless, any disagreement over Cheryl's behaviour towards Private AL the previous night might have added to Cheryl's emotional turmoil on the Monday morning. Two further pieces of evidence retrieved in the re-investigation may have added to the fact or degree of such turmoil. Private AD suggests that in the course of the Sunday evening his girlfriend, and close friend of Cheryl's, Private(f) AC, had argued with Cheryl about the way she was treating Private AA with respect to Private AB. Private(f) AC's recollections have already been noted at paragraphs 6.48-52 above.
- 6.96 Secondly, another close friend of Cheryl's, Private(f) AF was interviewed by Surrey Police and her evidence was to the effect that she had had an argument with Cheryl about the same subject on the Monday morning as they paraded for guard duty together, and that other female trainees added their own comments and referred to Cheryl as a 'slag'. Cheryl told Private(f) AF to mind her own business.
- 6.97 Taken together, and alongside what is known of Cheryl's activities over the weekend, a picture of a period of tiring activity and little sleep, combined with emotional turmoil, emerges. Cheryl was aware that she was hurting the man for whom she had expressed such affection a few days previously and whom she had indicated she wanted to leave the Army to live with. Her new relations with the younger man, Private AB, would appear have been based largely on sexual activity and in circumstances where she was being criticised by, and had arguments with, her two closest female friends. She now also appeared to

⁸⁸ When interviewed, Private AL supported the fact that Cheryl had said something to him.

have had an argument with Private AB about the strength of her relationship and future commitment to him. Other friends or acquaintances may also have been critical of her. Overall this would increase the evidence supporting the hypothesis that her tangled personal life was the dominant factor in her thoughts and in the events leading to her death.

(ii) Evidence of Cheryl James's intention to self-harm?

- 6.98 Private AA, in his statement to the RMP and his evidence to the BOI, suggested that, although she was happy and affectionate and was the dominant partner in their relationship, there was a darker side to Cheryl and that she might have been drinking to forget core problems. At the BOI, he mentioned that he had understood from Cheryl that she had a favoured cousin who had committed suicide by carbon monoxide poisoning three years before and that that experience had affected her. This recollection is also borne out by the statements of other trainees and friends with whom Cheryl came into contact.
- 6.99 From subsequent enquiries, it seems that such a tragedy did occur on 14th December 1992. Mr and Mrs James have pointed out to this Review that Cheryl was aware of the heartache and grief this event caused the family and this was one reason why they believed Cheryl would never seek to inflict similar pain on anyone else.⁸⁹ It has further come to light that 22 days after the suicide of the cousin, Cheryl herself was admitted to hospital following an overdose of paracetamol taken after an argument with her mother. Cheryl's Medical History Questionnaire⁹⁰ was, thus, inaccurate in respect of previous self-harm attempts, however transitory may have been the difficulties arising at home with a teenage daughter shortly after the tragic death of a favoured cousin.
- 6.100 It seems from Cheryl's letter dated 19th November 1995 to her female friend from home that a mutual friend had also died recently, in October 1995, in a car crash.⁹¹ In that letter, Cheryl alluded to the previous experience of losing her cousin:

"I was pretty shocked to hear about [...], as I know how it feels yet as I'm not there really it doesn't affect me like you lot, also now when people die I feel sad but I think I'm used to it, I mean it sounds bad but everybody dies at one time or another I think that's how I've been trained to think. Its just a shame he was so young the same as [name of cousin] really yet I suppose a different situation."

- 6.101 Whether the loss of the mutual friend preyed on Cheryl's mind is unknown but about this time she had also mentioned Sean Benton's death by gunshot wounds to one or two of her friends.
- 6.102 In her statement to Surrey Police, Private(f) AH stated that, on the way back from Leconfield in the coach, which we know to be 16th November 1995, Cheryl mentioned Sean Benton's death and said: *"if you think about it you know Benton, it must have been dead easy, you won't feel no pain."*⁹² Private(f) AC had also recalled Cheryl mentioning Sean Benton in her 1995 statement to the RMP:

⁸⁹ See Appendix A4/7.008 A – B.

⁹⁰ See paragraph 6.1 above.

⁹¹ See Appendix A4/7.007 F for Mrs James's comments about this death.

⁹² See Appendix 5, entry 39; 20th September 2002. Private(f) AH also states that she thought Cheryl's comment was so odd that she told an NCO back at Deepcut, who it would appear was Lance Corporal(f) E. Surrey Police's report to the Coroner noted at paragraph 5.4.16 that this was put to Lance Corporal(f) E and she has no recollection of Private(f) AH or anyone else expressing such a concern.

“Cheryl never discussed killing herself at all other than joining in general conversations with everybody else in B Sqn, talking about Private Benton who shot himself a few months ago and that it was the general opinion that if a person was going to kill themselves then shooting yourself in the head would be the best way of doing it. She never gave any indication or told of doing anything like this whatsoever and if she had, nobody would have taken her seriously and would not believe that she would do such a thing.”⁹³

- 6.103 There was other evidence, available in 1995 but considered too slender to call before the inquest, from an electrician who was working in the female accommodation block on 23rd November 1995. It appears Cheryl was tasked to accompany him while he worked in the female block. He recalls overhearing and then joining a discussion between some of the trainees during which Cheryl said that, if you could not afford to buy yourself out of the Army, the only way to get out was to put a gun to your head. He thought this remark was said in jest as she was laughing when she said it.⁹⁴
- 6.104 None of this amounts to a clear expression of intention to commit suicide, but from the scientific evidence collated by psychiatrists and psychologists who have studied the phenomenon of suicide, it would appear that people who have previously attempted to kill themselves are more likely to try again and succeed.⁹⁵ Further, it appears that those who are contemplating self-harm may try to raise the suggestion with friends or acquaintances to gauge reaction. The evidence of these ‘suicide risk factors’ specific to Cheryl were assessed on behalf of Surrey Police by an expert psychologist. Her opinion was that Cheryl’s death was:

“the result of an impulsive decision to take her own life when she had the means to end her life quickly and apparently painlessly ... this decision, whilst impulsive, was made in the context of a number of highly important suicide risk factors.”⁹⁶

(iii) Evidence of sexual harassment of Cheryl James?

- 6.105 The third theme of the Surrey police re-investigation was the gathering of information about sexual propositioning or harassment of young female trainees by members of staff at Deepcut or Leconfield.
- 6.106 The RMP Initial Case Report dated 29th November 1995 stated: *“None of the aforementioned [evidence from Cheryl’s friends or any notes] made any mention of the soldier being mistreated during her military service.”* Similarly, the Evans Report, published in December 1995 in response to Sean Benton’s and Cheryl’s deaths, was to note *“... there is no indication of mistreatment within Training Regiment and Depot RLC.”* However, subsequent evidence was to throw into question these early statements. One possible cause for Cheryl’s apparently low state of mind on her return to Deepcut was that she had allegedly been the subject of sexual propositioning by a named Corporal at Leconfield.⁹⁷

⁹³ 29th November 1995.

⁹⁴ The Review is aware of a statement from another trainee that supports this account.

⁹⁵ See House of Commons Defence Select Committee: Duty of Care-Third Report of Session 2004-05, Vol II, Ev 73 ff, quoted in the footnote to paragraph 12.133 below.

⁹⁶ 10th December 2002.

⁹⁷ For the avoidance of doubt, the named Corporal is not to be confused with Sergeant AI who Cheryl mentions in her second draft letter to Private AA dated 17th November 1995 as the NCO that let her and Private(f) AF off their outstanding ROPs. See paragraph 6.26 above.

Private AA mentioned this was something Cheryl had told him about when he gave evidence at the BOI into her death in January 1996. The fullest details are recorded in the record of his evidence:

Ans: He told her to polish the front when she came in, when she came back and finished he asked her, do you want would you like to fuck me and he touched her, she returned to the guard room,

Qn: What do you mean by touched?

Ans: He touched her shoulder and rubbed her back, didn't last long, she fobbed him off and left,

Qn: So would the phrase 'tried it on' be more appropriate than abused?

Ans: Yes sir, this was.

Qn: Was she upset by this?

Ans: Yes she was upset.

Qn: Did this upset last?

Ans: Yes she said she was frightened of him and angry or cross, she always hid her feelings and the matter wasn't discussed again, that's right yer."

Private AA has confirmed this account in subsequent interviews with Surrey Police during their re-investigation.⁹⁸

- 6.107 In a statement to Surrey Police in 2002, Private(f) AE, a female friend of Cheryl's who had known her since their time at ATR Pirbright, gave support to this suggestion, giving an account of how Cheryl was upset about the actions of the Corporal at Leconfield on her return to Deepcut. Two other former trainees refer to the allegation but appear to be repeating rumour. The only other indirect evidence appears to be contained in manuscript notes taken by the RMP Sergeant in 1995, most probably during a call with the Adjutant. On deciphering them in 2003, the Sergeant noted that they purport to record a 'rumour' regarding Cheryl and a named Corporal in Leconfield and simply state: "*she flirted with him, he tried it on.*"⁹⁹
- 6.108 There is no other supporting evidence despite enquiries made of NCOs at Leconfield by Surrey Police. The Corporal in question has been interviewed at length by Surrey Police and denies making a sexual approach. He suggests that Cheryl had been flirting with him on a previous occasion. He has repeated this account in correspondence with the Review.
- 6.109 Private(f) AC is quite sure Cheryl would not have been pressured into a sexual relationship she was unwilling to have.¹⁰⁰ Cheryl makes no mention of such an incident in her unsent letters to Private AA or in her letter to her female friend from home dated 19th November, written three days after she returned from Leconfield. Rather, in that letter Cheryl describes the troubles she got into at Leconfield with show parades and getting jailed twice, but continues:

⁹⁸ 23rd September 2002.

⁹⁹ 10th July 2003.

¹⁰⁰ See paragraph 6.184 below.

"I suppose it was a bit of a laugh as me and my mate just pissed ourselves laughing the whole time. I mean we did get on with the sergeants even though we got in trouble as half of them were in the same position as us at one time or another."

- 6.110 Whatever Cheryl may have told Private AA and Private(f) AE, no complaint was made at the time and therefore no investigation was carried out revealing any direct evidence of sexual harassment. In any event, this Review concludes that, if, indeed such an incident did occur, it had no impact on subsequent events. In particular, this Review does not believe that if Cheryl was sexually propositioned by a Corporal at Leconfield, that this was a lasting concern affecting her state of mind by 27th November. If she had been upset by any such acts, it is likely that she would have referred to it in her letters where she was frank as to her feelings and state of mind.
- 6.111 Another possible source of concern in relation to NCO attention towards Cheryl was Private(f) AK's evidence, noted at paragraph 6.31 above, that on Cheryl's return to Deepcut from Leconfield, Sergeant D was alternately generous then seemingly harsh towards her because he was attracted to Cheryl but she did not reciprocate his attentions. Private(f) AK is alone in suggesting Sergeant D was in any way oppressive towards Cheryl, although Private(f) AJ supports the proposition of some interest in her.¹⁰¹
- 6.112 Private(f) AK's account suggests that this was something she saw herself as well as heard from Cheryl.¹⁰² It is as follows:

"I got the impression she [Cheryl] wasn't interested in him. This caused her a problem, because in the end, he – Sergeant [D], started picking on Private James. I think we all picked up on this and his change of mood towards her. He came down on her a lot harder if she mucked up, and he started giving her extra guard duties, just to muck her around, and so that she couldn't get home on leave. Private James died on the 27th November 1995, and about a week and a half prior to that date, I noticed a change in Sergeant [D], and the way he was treating Private James. His body language changed, and he stopped showing a caring side towards her. If Private James was about, and if Sergeant [D], crossed her path he would have a go at her. A good example of this was, if in a group, Private James would be picked upon, to pick the litter up, if seen close to the group. He, Sergeant [D] would seem to "home in" on her, Private James and pick on her. I recall a group conversation, where Private James referred to Sergeant [D] as a "wanker", as he had been picking on her."¹⁰³

- 6.113 Private(f) AK further states that on the 'weekend' before Cheryl's death, she and Cheryl had agreed to travel together for part of the train journey home but Cheryl was unable to go home due to extra guard duty awarded by Sergeant D. As quoted earlier, Cheryl, in one of her unsent letters to Private AA dated Sunday 19th November, attributed her being due to be on guard duty that "weekend" to the outstanding ROPs from Leconfield.¹⁰⁴

¹⁰¹ See paragraph 6.30 above. It's not clear from Private(f) AJ's statement that any guard duty Cheryl was allegedly performing when Sergeant D was on duty was as additional duties.

¹⁰² As noted earlier, at footnote 43, Private(f) AK also alleges that Sergeant D behaved differently towards herself after an NCO is alleged to have assaulted her. Private(f) AK could, therefore, have an animus against Sergeant D.

¹⁰³ 12th May 2003.

¹⁰⁴ See paragraph 6.27 above.

- 6.114 Another female trainee, Private(f) AS, who like Cheryl was also from Wales, recalls saying goodbye to Cheryl on Friday 24th November. She does not suggest Cheryl was left with a sense of grievance at not being able to go home:

*"... I finished early on the Friday for some reason. It was not a Bank Holiday but we had an extended weekend. I did not have to be back on duty until the following Tuesday instead of the usual Monday, I really can't remember why that was, but the Monday was like a Bank Holiday and I didn't go to Blackdown til late on the Monday ... I said something about 'enjoy guard duty', as she was on guard duty that weekend, she just laughed, and I left. She was no different to any other time that I have spoken to her. I knew her enough to see that she accepted that she was on guard and okay with it. If she was not she would have said something, she did not."*¹⁰⁵

- 6.115 This recollection of Monday 27th November being the equivalent of a Bank Holiday and, therefore, the weekend being a long weekend, is consistent with the recollections of other trainees. Private AB stated in his interviews with Surrey Police *"Monday 27th November was a Bank Holiday or something; at least we had the day off for some reason."*¹⁰⁶ Similarly, when recalling that Cheryl volunteered to do her first stag at gate A2, Private(f) AC said in her statement to Surrey Police: *"It was however a Bank Holiday or similar and [Lance Corporal Y] was saying that it would not be busy for that reason and it would be an easy job."*¹⁰⁷ In a meeting with the Review, Captain Whattoff confirmed: *"The Regiment was on stand-down because we had just hosted the corps shooting competition so there were a lot of people working over the weekend, and the CO [Commanding Officer] said, right, in lieu of all that, there will be a regimental stand-down."*¹⁰⁸
- 6.116 The allegation by Private(f) AK that Cheryl was on guard that 'weekend' as a result of a deliberate act by Sergeant D was never put to Sergeant D in his interviews with Surrey Police. The Review has corresponded with him about them. He has emphatically denied the suggestion in the following terms:

"I most unreservedly deny any inappropriate behaviour towards [Cheryl]. I hardly knew her and had no interest in her whatsoever. All duties for trainees were co-ordinated by civilian staff and the Sergeant Major and could not be used as a punishment without the direct involvement of the Officer Commanding. I do not know why two trainees would suggest that I would have done this sort of thing and I can assure you that I did not."

- 6.117 Earlier in this letter, he notes:

"Home leave was cancelled from time to time due to military reasons and it was not always possible to give explanations. Much effort was made to ensure that this did not happen but did sometimes occur."

- 6.118 The evidence summarised above is far too insubstantial for any conclusion either that Cheryl was sexually harassed at Leconfield or at Deepcut on her return from Leconfield or that such harassment led her to take her own life. Nevertheless, sexual harassment and the treatment of women trainees by NCOs is a theme of concern.

¹⁰⁵ 14th August 2002.

¹⁰⁶ 25th September 2002.

¹⁰⁷ See Appendix 5, entry 2; 9th September 2002.

¹⁰⁸ See Appendix A4/16.030 F – G.

6.119 The Review has already noted the issue of cancelling home leave in the context of Sean Benton's death.¹⁰⁹ Similarly, in the previous Chapter, the Review has highlighted material that indicates that there was an informal regime of disciplinary sanctions beyond the policy and purposes of the Army training doctrine. In this section, we shall examine evidence relating to sexual misconduct by NCOs and others that may have contributed to make Deepcut an unhappy place for some trainees who were passing through it.

(a) Allegations of sexual misconduct by NCOs at Deepcut

6.120 Private(f) AM, was a female trainee at Deepcut in 1995 and shared a room with Cheryl James there.¹¹⁰ She was also part of the first guard stag on 27th November 1995. In her interview with Surrey Police she made the following point:

*"Women [had not] been in the regular army very long ... [the instructors] certainly didn't know how to treat women well of our age ... and they got away with a lot."*¹¹¹

6.121 She was critical of the regime at ATR Pirbright¹¹² and Deepcut, and suggests that fraternisation between female trainees and staff was rife at both establishments but that the nature of the regime at Deepcut particularly tended to generate such relationships. She knew most of the instructors there and in her opinion:

*"A majority of them were at it, sleeping with the recruits or arranging to meet them."*¹¹³

6.122 Such arrangements could be advantageous for the trainees, as some favoured people appeared to do fewer guard duties than others and avoided unpleasant chores. Although Private(f) AM had relatives in the Army, she did not regard herself as part of the favoured group. She recalled being hit and kicked by Sergeant B while on parade and regarded him as a *"total psychopath."* She noted his eccentric style of monitoring trainee performance particularly of those on guard duty:

*"People were scared when they were on guard or whatever because it was common knowledge he'd find himself a little hiding place and spy on people ... we are talking seventeen old kids with guns and you know we used to be scared in them days."*¹¹⁴

6.123 Another female trainee, spoke of the predicament of the young trainee:

*"I was young and trying to cope with Army training, living away from home in a dormitory style room with at least twenty other people and being constantly verbally harassed by the training NCOs. The NCOs classed this as 'character building'."*¹¹⁵

¹⁰⁹ See paragraph 5.150 ff.

¹¹⁰ See paragraph 6.46 for the previous reference to Private (f) AM.

¹¹¹ See Appendix 5, entry 24; 20th November 2002.

¹¹² A number of female trainees have identified ATR Pirbright as a place where sexual fraternisation with instructors took place, as well as at associated Phase 1 adventure training locations.

¹¹³ *Supra* footnote 110.

¹¹⁴ *ibid.*

¹¹⁵ See Appendix 5, entry 27; 4th March 2003.

On top of these problems she was aware that at Deepcut, as well as at Phase 1 training:

*"Some NCOs offered inducements such as less guards, less menial tasks in return for sexual favours."*¹¹⁶

6.124 Another female trainee told the police:

*"There was sexual abuse to young female recruits by the female NCOs at the barracks at that time. I cannot remember their names, the NCO would have a girl in her room to watch videos. The girl would not be treated the same as the rest of us."*¹¹⁷

6.125 This view was not confined to trainees. Lance Corporal Y, who was the Regimental Provost NCO who assigned Cheryl her guard duty and discovered her body, told the police in 2002:

*"During my service at Deepcut I was aware that there were a number of staff, both RP [Regimental Provost] staff and training NCOs (non-commissioned officers) were 'less than professional' in their conduct. By that I mean these individuals would use their position to give recruits 'inducements' such as less guard duties, easier jobs around the camp etc in return for occasionally, sexual favours. There also appeared to be 'a one rule for the recruits, another rule for the NCOs and officers' attitude, although I cannot recall any specific incidents. Therefore because certain NCOs etc had their 'favourites' other recruits conversely had the worst jobs and a larger amount of guard duties."*¹¹⁸

6.126 Private(f) X confirmed the general picture:

*"Sex was a passport for getting off all sorts of things, getting off duties, getting a long weekend at home. I call it career 'shagging' and I don't agree with it."*¹¹⁹

6.127 It is more difficult to move from these general statements of opinion, that are repeated by others, to seeking to find out which NCOs were abusing authority, against which trainees and what, if anything, was done about it. Allegations of past sexual fraternisation were, and continue to be, a rich source of hearsay and rumour at Deepcut.¹²⁰ Some of these have reached the press and not infrequently, what is reported in the press as observed fact turns out to be based on information passed on by a third party about someone else and may well be wrong or mistaken.

6.128 There are a number of trainees who make direct allegations of sexual propositioning (rather than sexual assault) against NCOs at Deepcut.¹²¹ At least five female trainees have made specific and independent allegations that they were the subject of sexual propositioning from Sergeant B. These allegations have all been denied by him in his extensive interviews with Surrey Police, as well as in correspondence with this Review. There were no complaints made by the females at the time. Sergeant B makes the point that it was many years after

¹¹⁶ *Ibid.*

¹¹⁷ *Ibid.*, entry 18; 20th September 2002.

¹¹⁸ *Ibid.*, entry 3; 16th January 2003.

¹¹⁹ *Ibid.*, entry 29; 30th January 2003.

¹²⁰ See Appendix 5. Entries 4, 29, 34, 35, 37 and 40 of the 1995 Duty of Care Schedule contain rumours of relationships between NCOs and female trainees. A number of trainees also allege that NCOs attended block parties and the NAAFI to socialise with female trainees. See also paragraphs 1.64, 6.135, 6.141, 6.150, 6.157 and footnote 161 below.

¹²¹ At least ten entries from the 1995 Duty of Care Schedule contain direct allegations of sexual propositioning by NCOs at Deepcut. The Review is also aware of other allegations from Surrey Police's re-investigation. A further two entries relate to ATR Pirbright.

his departure from Deepcut that he first became aware of these allegations that are completely inconsistent with all official assessments made of him at the time and a subsequent successful career in the Army Welfare Service. It is not feasible for the Review now to evaluate whether these individual claims are well-founded. As noted in the previous Chapter, there is some considerable risk that Sergeant B has attracted attention because of his profile in the media. He also makes the point that it is possible that in respect of these claims he may be confused with other NCOs. Indeed, most of the other Sergeants and Corporals in B Squadron, and holding other positions in the Training Regiment, including Corporal F, Corporal O, Sergeant D, Sergeant L and Sergeant V, have been named as having or seeking sexual relationships with female trainees, either directly or by rumour and reputation.¹²² Most of those mentioning these matters did not, in 2002, want to make formal complaints to Surrey Police or permit their statements to be passed to the RMP SIB for investigation.¹²³ Some informants did want specific allegations, unrelated to any NCOs referred to in this Report, of serious sexual assault investigated by the police but these enquiries have not resulted in criminal charges. None of the informants have communicated with the Review or otherwise suggested a public inquiry into these allegations is necessary or desirable.

- 6.129 It is an offence of disobeying standing orders for a male NCO to be in the female accommodation other than on duty.¹²⁴ This would appear to have been a regular occurrence at Deepcut from 1994 to 2002, although it is only in the latter period, particularly under the command of Lieutenant Colonel Laden,¹²⁵ that the Commanding Officer's interview book records a regular number of NCOs appearing before him for such offences. In the earlier periods, either such conduct was not taking place, it was not being reported or it was being dealt with at a lower level by the Officer Commanding, where removal from post could not be effected. Sexual contact that did not transgress the out of bounds rules, but consisted of a relationship between an NCO and a trainee was considered unacceptable by ATRA and individual Commanding Officers, although does not appear to have been the subject of a specific disciplinary offence or standing order.
- 6.130 Despite the real difficulties in making any assessment of allegations against individual NCOs, this Review is of the opinion that it is more probable than not that such fraternisation did take place in breach of military standards, although not necessarily in breach of criminal law, having regard to the consistency of allegations generally made in this regard. The question of sexual fraternisation was addressed by one informant to the Review who responded to its appeal for information. He was a trainee at Deepcut in 1996 and states that he was aware of NCOs who had slept with trainees as a matter of course and identifies other names, not listed above, as well as substantial rumours regarding more senior personnel. He also points out that some female trainees solicited such relationships for their own purposes.¹²⁶ Further, in reaching its opinion, the Review is particularly influenced by the example set by Regimental Sergeant-Major Z, the senior soldier of the Training Regiment until October 1995.

¹²² Some NCOs have admitted to Surrey Police that they formed consensual relationships with female trainees but that these were conducted off camp.

¹²³ See, for example, paragraph 6.151 below. See also paragraph 1.22 ff.

¹²⁴ Brigadier Evans described to this Review that even as the Commander, he was unable to enter the female accommodation unaccompanied by a female NCO. *"It was the only place in the whole barracks I couldn't walk into"*, see Appendix A4/4.017 D.

¹²⁵ The Commanding Officer of the Training Regiment at the time of the deaths of Geoff Gray and James Collinson. See Chapter 10.

¹²⁶ The same informant paints a familiar picture of life at Deepcut at the time: *"[After basic training] you're expecting to finally gain some self dignity, and become a proper soldier, to find when you get to Deepcut you're still a 3rd Class citizen, and boredom does take hold and attacks your very soul] especially living the way you do, in those barracks. You lose your self identity and follow the sheep to the NAAFI, drink lots, get in trouble and general discipline breaks down."*

(b) Regimental Sergeant-Major Z

- 6.131 The Regimental Sergeant-Major is a key personality in any Regiment. He or she will be working directly with the Commanding Officer to set the standards for the Regiment. The Regimental Sergeant-Major is in charge of the Sergeants' Mess. It is the top posting available to a Warrant Officer. NCOs will defer to the Regimental Sergeant-Major's judgement.
- 6.132 Regimental Sergeant-Major Z (no longer serving) arrived at Deepcut in the autumn of 1994. In conversation with this Review, Colonel Josling indicated that he had some concern as to whether Regimental Sergeant-Major Z was the right man for the job as he was a single man who had acquired some reputation for a bachelor lifestyle earlier in his career.¹²⁷ Nevertheless, Lieutenant Colonel Josling's correspondence with the Manning and Records Office indicates that he was anxious for the post to be filled and aware that a Training Regiment had a low priority for personnel.
- 6.133 Regimental Sergeant-Major Z's confidential reports up until the decision had been made to post him to Deepcut had all been exemplary. However, the confidential report from his previous Commanding Officer (dated 17th October 1994 and, therefore, after it had already been decided to post him to Deepcut) was not exactly encouraging as a basis for taking on this key role:

*"Whilst undoubtedly looking the part of a potential Regimental Sergeant-Major in a training unit, he can give the impression to others that he is self-interested, arrogant and uncaring. At the same time I am not totally sure of the true depths of his sincerity. He is not widely respected within the Regiment ... [his] strengths and qualifications may be best suited to the training field. However, he needs to re-examine his style and consider the impact of some of his actions on others ... Whilst I continue to support this recommendation for promotion it is not without some unease concerning his forthcoming appointment as Depot Regimental Sergeant-Major."*¹²⁸

- 6.134 In interview with this Review, former Regimental Sergeant-Major Z believes that this unflattering report was partly a consequence of a personality clash and his over frankness with his previous Commanding Officer.¹²⁹ He believes it is of importance that the Commanding Officer told him that he would not be the Regimental Sergeant-Major at Deepcut within a year of his appointment. As it turned out, within a year Regimental Sergeant-Major Z was, indeed, to ask to leave Deepcut early when it was made clear to him by his new Commanding Officer, Lieutenant Colonel Josling, that his position had become untenable in light of rumour and suspicion as to his personal conduct, that has reverberated ever since.¹³⁰
- 6.135 For reasons that will become clearer later in this Chapter, this Review has spent some time trying to piece together an accurate account of what led to the premature departure and a critical report from Lieutenant Colonel Josling, that would seem to justify the unease expressed by the previous Commanding Officer. As the new Regimental Sergeant-Major arriving at Deepcut in a Jaguar motorcar and owning a motorcycle, Regimental Sergeant-Major Z certainly made an impact on staff and trainees alike. It was in the summer of 1995,

¹²⁷ Colonel Josling indicated to the Review that Regimental Sergeant-Major Z had been described to him as "a bit of a lad", see Appendix A4/9.021 B – C.

¹²⁸ 17th October 1994.

¹²⁹ See Appendix A4/17.018 A – F.

¹³⁰ See the transcript of this Review's meeting with Colonel Josling, Appendix A4/9.050 D – E.

whilst the Regimental Sergeant-Major was on holiday, however, that allegations came to the attention of Lieutenant Colonel Josling.¹³¹ A number of informants to Surrey Police associated Regimental Sergeant-Major Z's departure with an allegation of sexual misconduct on a staff coach trip to France. However, it is clear to the Review that this is one example of a false association, as not only does Regimental Sergeant-Major Z deny being on the trip at all, believing he was on holiday at that time,¹³² but the Commanding Officer is sure that this allegation, that came to his attention, concerned another Warrant Officer who had failed to prevent sexual acts taking place and was sacked from his job on 9th October 1995.¹³³ It is understandable how the connection would be made, as the Commanding Officer's interview book between September and November 1995 has five entries for disciplinary interviews with NCOs about various concerns as to their conduct, while there were no such entries for the previous 18 months.

- 6.136 There are, however, different allegations connected to Regimental Sergeant-Major Z in September 1995. None of these were ever the subject of disciplinary proceedings or an RMP investigation. Some concerned his stewardship of the Sergeants' Mess and a suggestion that the bar was open at all hours and part of a hard-drinking culture.¹³⁴ It is in relation to this part of his responsibilities that Regimental Sergeant-Major Z's behaviour is alleged to have caused at least one female member of the bar staff to make a complaint.
- 6.137 Another of the allegations concerned Regimental Sergeant-Major Z and a named female trainee. Major Gascoigne,¹³⁵ has a distinct recollection that there was an investigation into these matters and felt that the trainee concerned may have been in need of some support and counselling during and after the events leading to the departure of the Regimental Sergeant-Major. Further, the new Adjutant, Captain Whattoff, who had arrived at Deepcut in September 1995, can clearly recall immediately being tasked by the Commanding Office to travel to Leconfield to interview a number of female trainees there at the time about allegations of sexual misconduct by Regimental Sergeant-Major Z.¹³⁶ A female Corporal, Corporal(f) W, recalls being tasked to drive Colonel Josling and Captain Whattoff to investigate these matters. As well as investigating allegations against Regimental Sergeant-Major Z, Corporal(f) W recalls also sitting in on interviews with females while investigating alleged sexual allegations made against Lieutenant C, which will be addressed later in this Chapter.
- 6.138 In his interviews with Surrey Police, Lieutenant Colonel Josling has given the following account of what first directed his attention to Regimental Sergeant-Major Z:

"I became aware that a young Trainee, a Private soldier in B Squadron, had confided in another member of the staff here in Deepcut Garrison, that [Regimental Sergeant-Major Z] had made an improper suggestion to her, I believe on the dance floor in, in a disco. That information was relayed to the Chief of Staff at the Garrison Headquarters and it came to me downwards, if you like, from my Garrison Headquarters instead of coming upwards through the Chain of Command within the Regiment. I immediately asked to speak to the young soldier concerned and asked her

¹³¹ See Appendix A4/9.049 F – G.

¹³² See Appendix A4/17.025 C – D.

¹³³ See Appendix A4/9.054 D – E.

¹³⁴ See Appendix A4/9.048 D – F. Former Sergeant Major Milne confirmed that there was a culture of "heavy drinking in the Sergeants' Mess", see Appendix A4/12.019 C – D. However, see paragraphs 6.139 and 6.156 below.

¹³⁵ In his meeting with this Review. The transcript of this meeting is not published as an Appendix to this Report, see Chapter 1, footnote 38.

¹³⁶ See Appendix A4/16.010 C – D.

if there was any substance to this. And whether or not she was prepared to make a complaint. And, unfortunately, she was, she was not prepared, to make a formal complaint."¹³⁷

- 6.139 In conversation with the Review, Colonel Josling has explained what led him to conclude there may have been substance in rumours of inappropriate behavior and what triggered his loss of confidence in his Regimental Sergeant-Major. He said it was the confirmation by Squadron Sergeant-Major Milne that the Regimental Sergeant-Major presided over a hard drinking culture.¹³⁸ When this was put to Squadron Sergeant-Major Milne by the Review,¹³⁹ he was surprised that his conversation with his CO was the reason for the loss of confidence in the Regimental Sergeant-Major.¹⁴⁰
- 6.140 The information available to this Review indicates that two female Privates have admitted fraternising with Regimental Sergeant-Major Z, though there are rumours concerning others. One was approached by the Regimental Sergeant-Major in a club in Camberley and he asked her out for a drink, to which she agreed. They met and she has stated that nothing further happened but that she did feel intimidated by his position. This is the same Private referred to by Major Gascoigne and she has stated to Surrey Police that she was told by Lieutenant C, her Troop Commander, to make a written statement when word got out later that she had met with the Regimental Sergeant-Major. The other female Private has admitted to a sexual encounter with the Regimental Sergeant-Major following a ball held on camp, to which she had been invited. In his interviews with Surrey Police and this Review, Regimental Sergeant-Major Z has admitted to an encounter at a ball with someone whom he subsequently discovered was a soldier.¹⁴¹
- 6.141 It seems that trainees and staff attended the same nightclub in Camberley. One line of enquiry suggests that Lieutenant C, one of the Troop Commanders, became aware of these allegations against Regimental Sergeant-Major Z when he was taking trainees out on a sailing trip. In his interview with Surrey Police, Lieutenant C stated:

*"The conversation revolved around Regimental Sergeant-Major [Z], who it was alleged by a young female soldier, she had been invited back to his room, and 'offered sex', which she declined/refused to have with him. According to her, Regimental Sergeant-Major [Z] had then said or implied if she had sex with him it would be – 'in her interest or her life would be hell', but the offer was still refused."*¹⁴²

Another officer was on the boat at the time and so it appears that the matter may have proceeded along two potential routes to Lieutenant Colonel Josling, as described by him in his interview with Surrey Police – through his chain of command from Lieutenant C and/or down from the Garrison headquarters. In light of the rumours with which this Review has had to grapple, it is appropriate to highlight that a source of confusion appears to be that Lieutenant C was, himself, the subject of rumour regarding alleged inappropriate conduct.

¹³⁷ 26th February 2003.

¹³⁸ See Appendix A4/9.047 F - 048 F.

¹³⁹ See Appendix A4/12.020 F – 021 C.

¹⁴⁰ See also paragraph 6.144.

¹⁴¹ See paragraph 6.151 below. Regimental Sergeant-Major Z also admitted this when the Review met with him, see Appendix A4/17.026 A – B.

¹⁴² Record of Interview 10th January 2003.

- 6.142 It appears that in September 1995, Regimental Sergeant-Major Z was away on holiday with a friend from another Barracks, when the Commanding Officer tasked the Adjutant, Captain Whattoff, to make enquiries. The Review is surprised that it was decided that enquiries of sexual impropriety by the Regimental Sergeant-Major should be conducted by regimental staff rather than through the formal use of the RMP. The result has been that no records have been retained of whatever came to light, although, according to Captain Whattoff, a number of documents were created.¹⁴³
- 6.143 Colonel Josling has explained that he had been informed by the RMP that they could not act without some evidence of an offence.¹⁴⁴ Others have explained that the RMP are there precisely to investigate to see whether any evidence can be obtained. It must have been extremely difficult for trainees or staff to provide to other personnel in the Regiment inculpatory evidence against their Regimental Sergeant-Major who, despite being on holiday, was still in post. It is perhaps not surprising that Captain Whattoff and Corporal(f) W described the trip to Leconfield as evidentially unrewarding, as the female trainees were apparently reluctant to give information.¹⁴⁵
- 6.144 Despite the paucity of evidence, Lieutenant Colonel Josling confronted Regimental Sergeant-Major Z immediately on his return from holiday on 28th September 1995, arranging for a car to bring the Regimental Sergeant-Major from the airport straight to his office.¹⁴⁶ As previously noted, Lieutenant Colonel Josling explained to the Review that he had lost confidence in Regimental Sergeant-Major Z by reason of widespread rumours of allegations as to his behaviour in the Sergeants' Mess.¹⁴⁷ Regimental Sergeant-Major Z, in his interviews with Surrey Police and this Review, explained that the allegation arising from a conversation on a sailing boat was put to him by Lieutenant Colonel Josling. Regimental Sergeant-Major Z was concerned that there had been no formal investigation by the RMP and that he was being condemned on hearsay. Nevertheless, later that day Regimental Sergeant-Major Z asked to be relieved of his duties and he was transferred out of Deepcut to a new posting shortly thereafter.
- 6.145 The subsequent confidential report written on former Regimental Sergeant-Major Z in November 1995 is somewhat more suggestive of substance than Colonel Josling's present recollections. The Second-in-Command of the Training Regiment wrote:

*"The period of this report has been one of significant professional success for WO1 [Z] but also one where he has demolished his own credibility as the principal guardian of standards over the soldiers ... his failure to maintain consistent personal standards both on and off duty."*¹⁴⁸

Lieutenant Colonel Josling added in his comments:

*"... his off duty indiscretions ruined all this fine work. There were few signs of this until quite recently when these incidents, minor though each of them may have been, made him the object of rumour and speculation."*¹⁴⁹

¹⁴³ See Appendix A4/16.012 C – 013 B.

¹⁴⁴ See Appendix A4/9.060 B – G.

¹⁴⁵ See Appendix A4/16.013 D – F.

¹⁴⁶ See Appendix A4/17.019 B for what Regimental Sergeant-Major Z told this Review. See also the transcript of the Review's meeting with Squadron Sergeant-Major Milne, Appendix 4.

¹⁴⁷ See Appendix A4/9.046 A – B and A4/9.050 B – C.

¹⁴⁸ 2nd November 1995.

¹⁴⁹ 3rd November 1995.

- 6.146 Rumour and speculation there has certainly been but also some direct evidence has emerged of Regimental Sergeant-Major Z's 12 months at Deepcut. Hearsay is not normally the appropriate currency for publication in a Report such as this, but where the allegations concern the leading soldier of the Training Regiment, from whom others take their lead, it is considered relevant and in the public interest to note them. If others believed rumours of his conduct to be true, it may have affected their own behaviour or willingness to report on the conduct of others.
- 6.147 When interviewed by Surrey Police in 2002, a former Regimental Provost Corporal at Deepcut, the same Corporal whom Sean Benton attempted to punch when he paraded for guard on 8th June 1995,¹⁵⁰ said:

*"I have been asked to comment on NCOs – males towards females, young phase two female soldiers. The main person, whose name always was being spoken about was Regimental Sergeant-Major [Z], who as the story goes, would give girls a card he saw on stag-guard duty. He would pick the girl up, outside the camp, and they would ride back into the camp, with a crash helmet on, or as the story goes, in the boot of his Jag. What ever transport that was used, the female wouldn't have been checked if in the company of the Regimental Sergeant-Major."*¹⁵¹

- 6.148 Another Corporal who gave a statement to Surrey Police in 2002 said:

*"The Regimental Sergeant-Major at the camp was Regimental Sergeant Major [Z], I recall on one occasion him contacting me in the admin office requesting three female recruits to clean his flat for him. He was insistent that it was to be females at the time I thought his request was odd, but I didn't say anything, because of who he was. I later heard that he had contacted the office on a further occasion and had requested the same three girls again to clean flat."*¹⁵²

- 6.149 One of the managers of the Sergeants' Mess told the police:

*"I do recall [Regimental Sergeant-Major Z] and his NCOs bringing back local girls to the mess. I also think maybe some Phase 2 recruits were brought back. This like the local girls was both to the mess and the accommodation areas. I cannot be any more specific than this. At around 1995 when [Z] was the Regimental Sergeant-Major, there was a macho culture at Deepcut that was promoted by [Z] and maintained by his NCOs. I believe that the NCOs ran the recruits life while they were doing their Phase 2 training. Recruits were made to believe that NCOs had the power of life and death over them. This was what I believe but I cannot offer up any examples as I had very little to do with the recruits. I do know that the recruits at Deepcut spent two thirds of their time doing nothing. Regimental Sergeant-Major [AO] took over from [Regimental Sergeant-Major Z] at the Sergeants' Mess and the culture changed almost overnight."*¹⁵³

¹⁵⁰ See paragraph 5.27 above.

¹⁵¹ See Appendix 5, entry 23 of the 1995 Duty of Care Schedule; 31st January 2003.

¹⁵² *Ibid*, Entry 54; 10th December 2002.

¹⁵³ 7th March 2003.

- 6.150 A male trainee who was long-term injured and worked in the stores gave his version of the rumours as follows:

"I particularly remember rumours surrounding Regimental Sergeant-Major [Z]. He had a flat in an annex of the Sgt's Mess. He used to have a motorcycle and a black dog. It was commonly believed that he used to take a different female recruit to his flat every night and have sex with them. I believe he was sacked in the end because of this.

"Although the relationships I have described were the subject of rumour and gossip in the camp, nothing ever seemed to be done about them."¹⁵⁴

- 6.151 One specific encounter, referred to at paragraph 6.140 above, between Regimental Sergeant-Major Z and a female Private was described by her in the following terms:

"... I was once invited to a Staff Sergeant's ball because I was working in the Quartermaster gym at the time which was unusual as I was a private. Later on in the evening I was drunk when [Regimental Sergeant-Major Z] told me to take I think a bottle of wine to his room which I did. I was sent like an order, as he was the Regimental Sergeant-Major I didn't argue. He arrived in his room a short time later, he was also drunk. He said come in sit down sit here. He asked questions about my family and we ended up kissing. We had sex but I remember thinking before how can I get out of the situation I was in because he was the Regimental Sergeant-Major. I didn't want to have sex but I was concerned about the consequences of knocking him back. I felt quite stupid then why I hadn't realised that by taking wine to his room he had other intentions. I do not want to take the matter any further but he was abusing his position. The next time he saw me he just stared right through me and didn't speak."¹⁵⁵

- 6.152 As noted earlier, in his interviews with Surrey Police and with this Review, Regimental Sergeant-Major Z accepts that he had a consensual sexual relationship with a woman at the time of a Sergeants' ball whom he subsequently found out was a Private. He denies instigating the relationship. In conversation with the Review, he was asked whether this incident would have been sufficient justification to have him removed from post. His reply was:

"Had I been completely sober, had I taken that soldier to one side on a parade and said "meet me tonight", knowing full well that you are a Private soldier, yes, yes, without doubt."¹⁵⁶

- 6.153 Pressed further as to whether a Regimental Sergeant-Major sleeping with a trainee would have triggered formal disciplinary action or was considered acceptable at the time, he acknowledged:

"No it wasn't acceptable. It wasn't something that I advocated. It wasn't something that I was aware that there was anything endemic going on. So you know for anybody whether it was an officer or an NCO or a junior NCO. Quite possibly at that time though it was something that, as opposed to now and how they might have tightened up things or giving

¹⁵⁴ 21st March 2003.

¹⁵⁵ See Appendix 5, entry 74; 15th April 2003.

¹⁵⁶ See Appendix A4/17.028 A.

more advice as to how you should conduct yourself or whatever. At that time, because it was relatively new, there was probably more occasions where mistakes were made as such. But I didn't, I didn't think that there it was a problem."¹⁵⁷

- 6.154 Sergeant V, who worked in the stores, had the following to say about Regimental Sergeant-Major Z:

*"Regimental Sergeant-Major [Z] was a power-crazed bastard and the worst thing that could have happened to Deepcut. He used to order girls to his room to make him breakfast and to tidy up. I was aware that he was having some sort of sexual relationship with a girl called [...]. This was obvious he was just a womaniser."*¹⁵⁸

- 6.155 The Review is conscious that some trainees have also suggested that Sergeant V conducted inappropriate relationships with trainees. It is matter of regret that senior NCOs, such as Sergeant V, did not report up the chain of command at the time any concerns that they have subsequently expressed. It may be that this is the inevitable consequence of the wrong tone being set by the leadership and an unwillingness in staff and trainees alike to report matters up the chain of command in respect of such an important soldier such as Regimental Sergeant-Major Z. The Review is, similarly, aware that some NCOs may be diverting attention from themselves in now making such allegations.

- 6.156 Squadron Sergeant-Major Milne (no longer serving) of B Squadron, who was at Deepcut until September 1995, has made it plain to this Review that he considered that Regimental Sergeant-Major Z had been forced to leave with insufficient investigation or basis to challenge his behaviour.¹⁵⁹ Mr Milne made the point that that the confirmation he gave to Lieutenant Colonel Josling that there was heavy drinking in the Sergeants' Mess was hardly unique in the Army or considered to be a disciplinary offence, let alone grounds to dismiss a Regimental Sergeant-Major.¹⁶⁰ He thought that Colonel Josling's loss of confidence in his Regimental Sergeant-Major must have been based on something other than concerns about alcohol. Like Regimental Sergeant-Major Z, Squadron Sergeant-Major Milne believes there was insufficient formal investigation into the basis of concern. This Review is inclined to agree.

(c) Regimental Sergeant-Major Z and Cheryl James?

- 6.157 The events surrounding Regimental Sergeant-Major Z's departure have been principally reviewed above due to the potential example he would have set for other NCOs in the Training Regiment. However, Regimental Sergeant-Major Z does come into the narrative of events surrounding Cheryl James's death more directly. In December 2004, a newspaper article appeared quoting an informant, a former trainee at Deepcut, who stated that Regimental Sergeant-Major Z had ordered Cheryl to his room and was sexually propositioning her. The informant has been subsequently interviewed by Surrey Police and, in fact, it was in response to these allegations that Regimental Sergeant-Major Z was himself interviewed for the first time. Dramatic as these allegations are, this Review is not minded to conclude that the informant is an accurate and reliable informant on this issue.

¹⁵⁷ See Appendix A4/17.027 A – B.

¹⁵⁸ See Appendix 5, entry 73; 18th March 2003.

¹⁵⁹ See Appendix A4/12.018 F – G.

¹⁶⁰ See Appendix A4/12.019 C – E.

- 6.158 Any relationship between Cheryl and Regimental Sergeant-Major Z at Deepcut would have had to have taken place in August 1995 before she went to Leconfield and before he was removed from post in September, whilst she was still at Leconfield (as she did not return to Deepcut until November). There is no reason to believe that such a relationship took place in this period, and Regimental Sergeant-Major Z was certainly not a name she is alleged to have mentioned to any of her friends or colleagues. No one else has suggested that there was such a relationship. The informant in question further identified Regimental Sergeant-Major Z's regime with that of Lieutenant Colonel Harding as Commanding Officer, whereas Lieutenant Colonel Harding only took over in January 1996, some four months after Regimental Sergeant-Major Z had departed. There are other reasons to treat this informant with caution that need not be recited here. Only where an allegation has been properly investigated by the competent authorities can an effective evaluation be made of credibility and cogency. There have been other reports in the press of relations with Cheryl and NCOs but frequently, when pursued, these have turned out to be recycling of hearsay.¹⁶¹ More than once in the course of its work, the Review has identified rumours that have subsequently proven to be misconceived.
- 6.159 Both Surrey Police and this Review have tried very hard to see what credible evidence there may have been to connect Regimental Sergeant-Major Z directly with Cheryl, without success. Late in this Review's process when the Adjutant, Captain Whattoff, was seen by this Review, he informed it that he believed he had been told by someone at some time (he could not be any more specific) that Cheryl might have been one of the female trainees he interviewed at Leconfield on his trip there to investigate allegations surrounding Regimental Sergeant-Major Z.¹⁶² He cannot recall himself whether that is, indeed, the case or not or why he would have been interviewing her, whether as a witness to, or as a victim of, sexual harassment. The notes of his enquiries have not been retained and, despite attempts to locate them, would appear to have been routinely destroyed under the Army's document retention policy. Whether this recollection is, itself, the product of hearsay or supposition is unclear. If Cheryl was, indeed, a name suggested to the Adjutant as someone whom Regimental Sergeant-Major Z was suspected to have approached, it is important to note that no evidence in support of that suggestion came to light. That remains the state of affairs today, and the Review does not believe any further lines of enquiry are available to take this matter further forward.

Lieutenant C

- 6.160 Regimental Sergeant-Major Z was not the only figure in authority in B Squadron in 1995 who has been alleged to have set poor standards for the trainees and the staff. Lieutenant C was a Troop Commander whose role in the events surrounding the death of Sean Benton has already been noted in the previous Chapter. It is plain that his staff did not hold him in high esteem.
- 6.161 It has been noted that Lieutenant C was the subject of rumour regarding inappropriate conduct with trainees.¹⁶³ There is no RMP record of it having conducted an investigation into such matters.

¹⁶¹ Indeed, in September 2005 a story appeared in the Independent on Sunday that quoted an anonymous informant who suggested that Cheryl was harassed by an NCO at Deepcut. The Review was able to identify the informant and clarify that no new allegation was being made and that the informant was merely repeating hearsay of which the Review was already aware.

¹⁶² See Appendix A4/16.011 C – E. See also paragraphs 6.137 and 6.142-143 above.

¹⁶³ See paragraph 6.137 and 6.141 above.

- 6.162 However, the re-investigation by Surrey Police has also brought to light a body of allegations against Lieutenant C by female trainees along the lines that he was overly familiar with them, made inappropriate comments and that he sought to fraternise with them in Camberley and elsewhere. One of these is an allegation made to Surrey Police by a female trainee that Lieutenant C propositioned her when she was on a sailing trip. It is not clear whether this is the same trainee who is said to have made a contemporaneous allegation that may have led to the investigation recalled by Corporal (f) W, and noted above at paragraph 6.137, but, if it is, Lieutenant C states that this was a malicious allegation made as a result of an incident when a trainee fell off her bunk on top of him, and that he was at all times in the presence of Sergeant V. The trainee in the incident that was uncovered by Surrey Police states that she attempted to complain at the time to Sergeant V but he was engaged in sexual relations with another female trainee.
- 6.163 The difficulty for this Review is the background of alleged frequent fraternisation made by females. Rumours of activity on such trips are mentioned by more than one former female trainee to Surrey Police:¹⁶⁴

"I have been asked to confirm how females were treated at Deepcut. NCOs were not shy in coming forward, at chatting up young Phase two female soldiers. Some formed relationships, slept with girls and these included married Sergeants, who I do not wish to name."¹⁶⁵

The same informant to Surrey Police continues:

"But a male that I will name is a Lieutenant [C] who did sailing trips in Portsmouth and who it would appear took along young females with a couple of ugly male soldiers as cover, and I think this was his way of forming relationships, or trying to form relationships."¹⁶⁶

- 6.164 It is impossible to assess whether such rumours were based on solid ground or malicious gossip, but another trainee was emphatic in her recollection:

"Lieutenant [C] was horrible, he was into girls in a big way. One time he took us all ice-skating. His hands were all over you. Because we were in civvies you could tell him where to go but he used to try things with the girls when they were in uniform and when he was in uniform and of course because of that you couldn't say anything. He had a particular thing about a girl¹⁶⁷ ... He kept asking her out ... He used to say things like 'nice arse' but only when there were few people around ... When in PE kit and when it was cold day he used to see which girl had the biggest nipple erection ... Some girls slept with him. I think he used his rank."¹⁶⁸

- 6.165 The Private who had a sexual encounter with Regimental Sergeant-Major Z after a ball, had also met with Lieutenant C socially:

¹⁶⁴ See Appendix 5, entries 29 and 61. See also entry 11.

¹⁶⁵ *Ibid.*, entry 61; 12th December 2002.

¹⁶⁶ *Ibid.*

¹⁶⁷ Not Cheryl James.

¹⁶⁸ See Appendix 5, entry 67; 17th February 2003.

*"Lieutenant [C] was a sleaze bag. He was always after the women, he was a smarmy twat. He was always asking us to meet and giving me his mobile number. I did meet him once out in Camberley. There was an incident in his car in which I ended up kissing him and some petting went on but I didn't have sex with him. He made it obvious he was an officer which was difficult being seventeen years old at the time. There were rumours which involved me going to Sergeant-Major Milne. He warned me that if they were any truths in the rumours that it wasn't allowed and couldn't happen."*¹⁶⁹

6.166 When Mr Milne met this Review he had some recollection of issuing such a warning to a female trainee.¹⁷⁰ Another trainee, who remained at Deepcut working in the stores for a long time due to an injury, recalls Lieutenant C and a fellow officer paying for two hotel rooms for a night where they took her and a friend. Her opinion was that Lieutenant C used his rank and position to impress the younger more naïve trainees.

6.167 Sergeant V was characteristically blunt in his assessment of Lieutenant C:

*"Lieutenant [C] was a complete knob. When he came into the store I remember him talking about female recruits and making various comments about their bodies ... He used to do it in front of them. He was a bad manager... I did go sailing with him a couple of times. Generally with the recruits he was over the mark in a lot of things. He forgot that he was an officer. Because of his character people did not go to him for advice no one had any faith nor respect for him ... [Sergeant D] had no respect for [Lieutenant C] but then who did. That attitude filtered down to the Corporals ..."*¹⁷¹

However, it is appropriate to recall that Sergeant V has, himself, been the subject of allegations of fraternisation by trainees, as noted above (at paragraph 6.162) in relation to one sailing trip.

6.168 The conclusion to Lieutenant C's career is considered in Chapter 7.¹⁷² Taking all the material now available, the Review considers that he does not appear to have been the most suitable person to have commanded a Troop in the Training Regiment. The Review has been able to make contact with Lieutenant C, late in its work, through correspondence and he has replied with helpful comments on a number of allegations made against him. He denies the allegations of sexual impropriety and believes he has been the subject of malicious comment by others. To his credit, he does not disagree with the assessment made above as to his suitability, although notes that he did not choose to be posted to Deepcut, was never trained as to his responsibilities for Phase 2 trainees at any stage and was never given direction as to the requirements of the position until Major N (who is discussed in the next Chapter) arrived. Lieutenant C notes that Deepcut was hugely under-resourced with little staff or support. He states that at one stage his Troop consisted of 400 people with one Senior NCO and two Junior NCOs.

¹⁶⁹ 15th April 2003.

¹⁷⁰ See Appendix A4/12.025 E – F.

¹⁷¹ 18th March 2003.

¹⁷² See paragraph 7.92 ff below.

Lieutenant(f) A

- 6.169 The other Troop Commander in B Squadron was Lieutenant(f) A. The Review has noted that Lieutenant(f) A is mentioned as playing a role in 1996 in dealing with the concerns of female trainees over their security in the barracks.¹⁷³
- 6.170 Two former trainees seen by Surrey Police indicated that Lieutenant(f) A was having an affair with Corporal O.¹⁷⁴ Others had heard rumours to this effect. The Review has written to Lieutenant(f) A but has had no response. However, in correspondence with this Review, Corporal O has stated: *"I accept that I was in a serious and long term relationship with [Lieutenant(f) A], which was in breach of army regulations. I deny that this has any relevance to the subject matter of your enquiry."* The Review disagrees. In its opinion, if young officers, such as Lieutenant(f) A, were ignoring Army regulations on relationships with those under their command, and forming emotional attachments to those whom they may have had to receive complaints about in the course of their duties, the system of maintaining standards was likely to be rapidly undermined.
- 6.171 In fact, it seems, according to the opinion of Squadron Sergeant-Major AR, who succeeded Squadron Sergeant-Major Milne, that in training and in disciplinary matters, rather than setting standards, both Lieutenant(f) A and Lieutenant C, the two Troop Commanders of B Squadron, deferred to their Troop Sergeants.¹⁷⁵ Lieutenant(f) A described her role as Troop Commander to Surrey Police in the following terms:

*"My role was essentially one of an administrative head to one of the Troops. I was assisted by a team of senior NCO's one of whom was a Sergeant [B]. My daily responsibilities were mainly within the office. The 'hands on' training of the recruits I left in the capable hands of Sergeant [B]."*¹⁷⁶

- 6.172 A notable example of how 'hands off' Lieutenant(f) A was is revealed an incident at the Hickstead Horse Show, when Sergeant B selected a team of trainees to assist in setting up the horse jumps. There was a party after the show organised by Sergeant B. Lieutenant(f) A described the scene:

*"I recall that everyone had a few drinks and some were later drunk. I made the conscious decision to stay sober. I remember that Sergeant [B] organised a number of games to play. I decided to remove myself from becoming involved. I admit that I was nervous of the fact that soldiers and alcohol do not always mix too well. I was concerned that things could get out of hand. I went to sit under one of the trees alone. I cannot now recall how long I sat beside this tree, when someone called me over back."*¹⁷⁷

- 6.173 It transpired that what caused Lieutenant(f) A to return was that one of the trainees had injured his back in some drunken messing around when a chair was removed from under him. The trainee subsequently alleged that Lieutenant(f) A discouraged him from complaining about the incident, as it would cause trouble to Sergeant B, although this is disputed by her, and other trainees do not recall being similarly discouraged.

¹⁷³ See paragraph 7.24 below.

¹⁷⁴ See paragraph 5.144 above for the previous reference to Corporal O.

¹⁷⁵ This suggestion is also supported by the opinions of former trainees whose statements the Review has seen.

¹⁷⁶ 2nd June 2003.

¹⁷⁷ 2nd June 2003. See also paragraph 5.109 above.

- 6.174 Clearly the ability of trainees to have confidence in the chain of command as the route for complaints against NCOs is undermined if Troop Commanders are having relationships with NCOs other than in a professional capacity.

Discretion of NCOs

- 6.175 As has been seen in the previous Chapter,¹⁷⁸ the Review has a clear impression that at Deepcut in 1995, NCOs were afforded considerable latitude to run things as they saw fit with little interference from their Troop Commanders. This extended to informal punishments and sanctions.
- 6.176 Former Squadron Sergeant-Major Milne's comments to the Review regarding the breadth of discretion available to instructors to award informal disciplinary sanctions, including guard duties and physical activities, have already been noted in the previous Chapter.¹⁷⁹
- 6.177 Squadron Sergeant-Major Milne's replacement, Squadron Sergeant-Major AR, when he gave a statement to Surrey Police in 2003, expressed concern about the power available to instructors when he arrived at Deepcut in 1995:

*"When I first got to Deepcut I was surprised how much power the instructors had. I felt there was a general air of superiority over the recruits and this attitude was not my style ... The Sergeants' Mess was a mess, the Regimental Sergeant-Major [Z] had just been sacked. I believe that this attitude would not prevail with a good Regimental Sergeant-Major running the Squadron. I took over from Graham Milne whose style was very authoritarian. The likes of Sergeant [B], [D] had their own timetables and their own favourites who they would take on outings like to Hickstead Horse Shows for example. Lieutenants [A] and [C] I felt were under the influence of Sergeant [B]. He was a man who if you gave him an inch he would try and take a mile."*¹⁸⁰

- 6.178 Regimental Sergeant-Major Z has also stressed that the level and form of punishments were very much down to the experience of the NCO concerned.¹⁸¹ In his opinion, there were no discipline guidelines in Deepcut at the time. He also stressed that the Troop Commander sets the tone for the Troop:

"It is the whole system. It is like a good or a bad company run by a good or a bad managing director. If the ship is run badly or not looked after in the right way then the person that is supposed to clock on at 8, clocks on at half 8 and that applies equally to a Troop. So I would expect a Troop Commander is doing what he is supposed to do. That he is looking after the soldiers in his care. And if the soldiers in his care in this case and not just the case of the soldiers but they are actually the Troop Corporals and the Troop Sergeants. Now the Troop Commander going to a training establishment is probably on his second tour. So he has had a troop in Germany or whatever but this is the first time he has properly experienced trainees. Nevertheless he has had experience to look after his troops. So

¹⁷⁸ See paragraphs 5.117 – 118 above.

¹⁷⁹ See paragraph 5.117 above. See also Appendix A4/12.004 D – 006 B.

¹⁸⁰ 16th September 2003. However, see paragraphs 7.24 and 7.31 in respect of Squadron Sergeant-Major AR.

¹⁸¹ Appendix A4/17.008 B – C. See also paragraph 5.118 above.

*he would be at the helm ... And he would be ultimately the one to supervise what was going on with his troop. He would need to know if there were any problems. You would certainly not expect, would you, and I wouldn't, that a Troop Commander is the one that is actually giving the bad example."*¹⁸²

- 6.179 However, Regimental Sergeant-Major Z also pointed out that the Sergeants will usually be more experienced than the Lieutenants and will in effect run the show. He noted:

*"Practically everywhere I have been I have had a young Troop Commander. I take them under my wing and I produce good Troop Commanders who have now gone on to be full Colonels. So yes I would say that the troops are sometimes pretty much manned by the relationship between the Troop Sergeants and Troop Commander. A good Sergeant he has got more experience for one thing so unless you have a Troop Commander who has done it before and they then begin to impose themselves more, generally you find the Troop Commander takes a back seat."*¹⁸³

It certainly seems that a combination of personalities in B Squadron in 1995 resulted in the Troop Commanders taking a back seat when it came to discipline, supervision of NCOs and getting the know the trainees under their command.

- 6.180 Doubtless Regimental Sergeant-Major Z has his own reasons for dissatisfaction with the way he was treated and came to leave the top job available to him as a Warrant Officer. His frank conclusion in interview with this Review may be of importance in an acknowledgement of, at least, his own personal failures:

*"I do believe that the regime from the Brigadier down and even higher than the Brigadier surrounding Blackdown wasn't as it should be. My departure, whether or not largely due to factors outside my control, decisions made in my absence will never be uncovered but there is certainly something there that hopefully will make people think, because it was just not done the way it should have been done. My behaviour from a personal and professional point of view was not always as it should be and I hold my hand up to that. Was my behaviour an influence on how younger members of permanent staff saw how they could conduct themselves? It might have been an influence, but I followed a poorly led camp. I certainly wasn't aware that, if it was, it could have been so damaging. ... To put my hand on my heart I don't believe that there is anything I could have done apart from a couple of misconduct occasions and sleeping with this recruit, I could have done different in as much to prevent if any these accidents or if they are anything other than accidents, then be prevented. The correlation between what happened to me and what's happened to these. There is a tendon in there somewhere but I am at pains to try and find where it is, but I do think that should the regime have been tighter and more closely focused on the duty of care to these servicemen and women things might have been wholly different, I do believe that and that is where the link, that is where this small tendon of linkage comes."*¹⁸⁴

¹⁸² See Appendix A4/17.008 E – 009 A.

¹⁸³ See Appendix A4/17.010 B.

¹⁸⁴ See Appendix A4/17.043 A – E.

Conclusions on the death of Cheryl James

6.181 Much more has emerged about the background to the Training Regiment at Deepcut in 1995 than was apparent at the inquest or the BOI convened into Cheryl's death. Although there is no reason to believe that Cheryl was assaulted or the victim of bullying, the possibility that she was the subject of sexual attention by an instructor cannot be dismissed as fanciful, in light of the background evidence summarised above. However, even if Cheryl was the recipient of such attention, the Review is not of the opinion that it caused her any lasting concern.

6.182 For the Review, while Cheryl's own draft letters to Private AA reveal some insecurity regarding his affections for her, what emerges in the recollections of Cheryl, given by her friends and colleagues, is not her weakness and vulnerability in sexual matters but her strength of mind and determination. In her actions, she appears to have been the dominant personality with respect to her relationships with Privates AA and AB. She appears to have been able to reject advances she did not favour, even if they came from NCOs at Leconfield or elsewhere.

6.183 Indeed, Private(f) AS, who like Cheryl was from Wales and has been quoted earlier, gave the following portrait of Cheryl:

*"My opinion of Cheryl James is that she had a strong personality and if she was being harassed she could handle it, in fact if anything she would not stand for it. I remember one time she had a fight with a girl on the stairs over something stupid, she did stick up for herself. She also had a close circle of friends that if she was having such problems she would have told them."*¹⁸⁵

6.184 As in the case of Sean Benton, it is worth pausing to consider the opinions of those closest to Cheryl, who not only knew her well but in whom she would most likely have confided in if she had had any concerns. Private(f) AC, who has described herself as a "very good" friend of Cheryl's, and is recognised as such in the statements from other former trainees, has consistently indicated, to both the RMP and Surrey Police, that she does not believe Cheryl would have accepted sexual harassment without complaint. In 2002, having confirmed that she was not aware of Cheryl having had any problems at Leconfield, she said:

*"[Cheryl] was definitely never forced into anything and she never would have been, she was too full of herself and confident to allow anyone to take advantage of her. She never complained to me about any harassment."*¹⁸⁶

6.185 The Review has also been assisted by the opinion of Major Gascoigne. He has emphasised that he did not believe that female trainees like Cheryl James and Private(f) AC would have suffered in silence:

"Ans: I know that [Private(f) AC] was friendly with Cheryl James ... believe me if she would have any recourse to moan about anything she would have been the first person who would voice it, I have no

¹⁸⁵ 14th August 2002.

¹⁸⁶ See Appendix 5, entry 2; 9th September 2002.

doubt about that. If there was anything untoward I am convinced that she would have come forward then and said it because I gave her every opportunity to, I really did and nothing, nothing came forward, and she was someone who would complain about pretty much anything and would always do that and if there had been something there I satisfied myself then that she would have said something. I remember talking to her and saying "look she's your friend", you know, I even offered them counselling, I did all the stuff that I thought was correct and right and I said "look, you know if you need to give the training a drop for a while, let me know, let me know how you are feeling, if you need some medical help please let me know and we will provide that but in the interim can you please let me know what is going on, what has happened here, is there anything we can do" and nothing came forward.

"Qn.: Just boyfriend problems?

"Ans.: And so that's what makes me sceptical about a lot of the things that have subsequently been said because I just can't get it around my head that the individuals that were in that room that I spoke to, not one of them would have come forward and said this was happening. I take your point about the fact that at the time they might not have realised that what was happening was wrong but in the extreme side of things about coercion and sexual harassment that's not something that anyone doesn't realise is wrong. They were very close friends. She was certainly very cut up about the fact that she was dead and quite angry at the Army I have to say, for no reason other than the fact that we were in charge and because of that as well she had a chance to explain and she would say it now."¹⁸⁷

- 6.186 In the opinion of this Review, the portrayal of Cheryl as a vulnerable woman too frightened to voice concern or report inappropriate conduct, even to her friends, if not formally, does not sit easily with the material it has seen. That does not appear to be the character of the woman whose draft letters have been preserved, nor does it accord with the impression or memory of those whose lives she touched.
- 6.187 Just because sexual propositioning of trainees may have been taking place at Deepcut, that does not mean that Cheryl was propositioned or that, if she was, it played any role in her death. It would be to impose an inappropriate stereotype of vulnerability on someone whose vivacious personality still lives in the memories of those who knew her, admired her and loved her.
- 6.188 Although certainties are not possible at this distance from the events at hand, in the opinion of this Review, the strong likelihood is that Cheryl James fired the fatal bullet at herself with her own rifle at point blank range causing gunshot residue to her forehead and a ragged puncturing of the skin.
- 6.189 In the absence of any considered explanation from herself as to why she may have done so, the causes of such an irreversible act cannot be the subject of clear determination. A period of low self-esteem generated by tiredness, uncertainty as to her future career and

¹⁸⁷ Taken from the conversation this Review had with Major Gascoigne. See footnote 38 of Chapter 1.

her future private life, the change of affections she felt for Private AA, her difficulty in choosing between partners, the recent calling into question by Private AB of her feelings for him, and her awareness at the damage of her actions to her reputation in the eyes of both her closest female friends and colleagues are likely to have played a part.

- 6.190 The frequent guard duties assigned to Cheryl, and others, in the week leading up to her death, and the unrewarding nature of the Phase 2 regime at Deepcut at the time, cannot have helped. If these factors made her vulnerable to an impulsive decision, then the opportunity to imitate Sean Benton's example was presented by lone guard duty with a lethal weapon unsupervised by more experienced soldiers.
- 6.191 For the Review, it is precisely because young people may be vulnerable to such impulses that the central question is posed by this second death, within six months of the first, as to whether the Army was required to assess the risks of requiring trainees to perform such duties and, if so, whether they did.
- 6.192 However, before this Report continues to consider that central question, it is appropriate to return to the three themes (first noted at paragraph 6.83 above) that the Review identified as emerging from the product of Surrey Police's re-investigation of Cheryl's death:
- (i) First, whether Cheryl's death is consistent with a self-inflicted gunshot wound or whether any evidence inconsistent with that hypothesis or tending to suggest that her death was inflicted by a third party has come to light.
 - (ii) Secondly, whether there is evidence suggesting Cheryl had expressed thoughts about self-harm or was otherwise a candidate for self-harm by reason of factors in her past.
 - (iii) Thirdly, whether there is evidence that NCOs at Deepcut were sexually harassing female trainees at Deepcut or otherwise acting inappropriately to young women, and whether Cheryl was the target of such activity.
- 6.193 This Review is satisfied that:
- (i) Cheryl's death is consistent with a self-inflicted gunshot wound. There is no evidence inconsistent with such a hypothesis or that suggests any involvement in her death by a third party.
 - (ii) There is evidence that Cheryl expressed thoughts about self-harm on two occasions in the 11 days prior to her death. A close family member had committed suicide three years before and in the weeks after that tragedy Cheryl had self-harmed.
 - (iii) There is evidence to suggest that NCOs at Deepcut may have been sexually propositioning female trainees. However, there is only very fragile evidence to suggest that Cheryl may have been the recipient of inappropriate propositioning by an NCO at Leconfield. If this incident did, indeed, occur, there is no evidence to suggest it was a lasting concern to Cheryl.

7 Deepcut from 1996 to 1998

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The Army's response to the deaths of Sean Benton and Cheryl James

7.1 Cheryl James's death prompted three official responses following the Royal Military Police (RMP) investigation: 'a review of the Phase 2 training system within Deepcut', conducted by Brigadier Evans, prompted also by the death of Sean Benton, (the Evans Report)¹; the inquest held on the 21st; and the Board of Inquiry (BOI),² that was completed by 18th January 1996. In January 1996, Brigadier Evans's tour as Commander of the RLC Training Group came to an end and he was succeeded by Brigadier Dalby-Welsh (since retired). At the same time Lieutenant Colonel Josling's period as Commanding Officer of the Training Regiment came to an end a few months early and he was succeeded by Lieutenant Colonel Harding (since retired). The task of learning any lessons and implementing any changes in response to the events of the previous year were, therefore, primarily for the new management team. The inquest and the BOI have already been noted in the previous Chapter. The Evans Report merits some further consideration.

(i) The Evans Report

7.2 Brigadier Evans decided to conduct a review of Phase 2 training at Deepcut in the wake of Sean Benton's and Cheryl James's deaths. He completed it on 14th December 1995, within 17 days of Cheryl's death, and before the inquest into her death held on 21st December 1995. Brigadier Evans carried out his review of his own initiative and was not specifically commissioned to do it by his superiors.³

7.3 In his report, Brigadier Evans appeared to pre-empt the verdict of Cheryl's inquest by use of the word 'suicide'.⁴ Indeed, it may be said to have contradicted it. This has, understandably, been the subject of concern by Cheryl's family. In the opinion of this Review, it was not inappropriate for Brigadier Evans to have sought urgently to consider whether there were factors in the training regime that may have caused trainees to self-harm. Indeed, the Army's current procedures require a 'learning account' to be opened within 48 hours of a death. In making his report, Brigadier Evans was responding to Sean Benton's death, where a verdict of suicide had been returned at the inquest, as well as that of Cheryl James, where an inquest had yet to be held but where the RMP investigation had not uncovered any evidence of third party involvement in her death. Subsequently, as discussed in the previous Chapter, neither the Coroner at the inquest, nor the Surrey Police re-investigation in 2002, have uncovered any evidence of third party involvement. It would have been better for Brigadier Evans's conclusions to have been phrased in terms of 'suspected self-inflicted death', rather than an apparent conclusion of suicide. This is now addressed in a defence instruction.⁵ An alternative would have been for the report to have been finalised only after the inquest and the BOI into Cheryl's death, although Brigadier Evans was addressing broader issues, and was no doubt conscious that any obvious issues of concern should be addressed as soon as possible.⁶ His imminent departure may also have affected the timing of his conclusions.

¹ See Appendix 11 to this Report where the Evans Report is reproduced.

² See Appendix 10 for the Report of the Board of Inquiry into the death of Cheryl James.

³ See Appendix A4/4.015 D - F.

⁴ See Appendix A11.001, paragraph 1.

⁵ Casualty Procedure 2000, paragraph 0224 B.

⁶ See Appendix A4/4.016 B where he told this Review that "I wanted to get full clarity as quickly as possible. Not because it necessarily needed to be quick, but because I felt it was important to catch every piece".

- 7.4 In 2004, the House of Commons Defence Select Committee (HCDC) commissioned an analysis of the various reports produced by the Army that touch on the deaths at Deepcut and the duty of care regime.⁷ It noted that the Ministry of Defence (MOD) did not accept some of Brigadier Evans's recommendations regarding changes to be made outside of the Training Group at Deepcut itself because it had not commissioned the report.⁸ If the Army had wanted to institute its own learning account at a senior level into the two deaths in 1995, with hindsight, it would have been preferable to have brought in a third party able to review all the factors at Deepcut that may have contributed to the deaths.
- 7.5 Although the BOI process enshrined in the Army Act 1955 is the primary means of learning lessons and avoiding repetitions of avoidable errors, both Boards that had been convened to date had been chaired by a Major and their terms of reference did not have the breadth of scope that Brigadier Evans addressed. It is unclear whether the BOIs ever received the attention of DG ATR. It seems that Army practice is to convene a BOI without waiting for the inquest because the Board addresses a different issue. In the case of the later deaths of Geoff Gray and James Collinson this practice has been departed from, at the request of Surrey Police.
- 7.6 Furthermore, it now appears that there was some tension between Brigadier Evans and Lieutenant Colonel Josling as to how the Evans Report was produced,⁹ and who bore primary responsibility for some issues that arose during both their tours.¹⁰ The Evans Report's aim was to "*identify any underlying reasons for the suicides and attempted suicides ... [and] will also highlight procedures and working practices which may have a bearing on the attitude and motivation of both soldiers and instructors serving within B Squadron.*"¹¹ Although it did ask the question to what extent did Deepcut contribute to making these trainees unhappy, it did not purport to be a comprehensive analysis of such factors. Such a comprehensive review of the risks to Phase 2 trainees at Deepcut was only undertaken following the death of James Collinson some six years later. As it was an internal report for Deepcut, the Evans Report did not lead to wider learning within the Individual Training Organisation (ITO), later to become the Army Training and Recruiting Agency (ATRA). Although Brigadier Dalby-Welsh and Lieutenant Colonel Harding read the report,¹² succeeding generations did not read it on first taking up their appointments. It seems that Brigadier Elderton, the Commander from 2002, had not heard of the Evans Report until two months after assuming command.¹³ This would appear to be an example of a short collective memory, where the Army style is to address a problem and move on. At least the Evans Report has not been lost. In light of events that were to follow, it addressed issues that would have informed future generations of Commanders.

⁷ House of Commons Defence Select Committee: Duty of Care - Third Report of Session 2004-05, Vol I, Annex B, p. 155 ff.

⁸ *Ibid*, p. 157.

⁹ See Appendix A4/9.020 E, where Colonel Josling explained to this Review that he "*strongly disagreed*" with some of Brigadier Evans's initial findings.

¹⁰ In interview with this Review, Colonel Josling gave two examples. First, the implementations of the recommendations of a security review which might reduce the frequency of guard duty for trainees, see Appendix A4/9.004 C – 005 D. Secondly, Colonel Josling did not think Brigadier Evans was sufficiently emphasising the need for additional staff up the chain of command, see Appendix A4/9.005 D – 006 B.

¹¹ See Appendix A11.001, paragraph 4.

¹² See Appendices A4/6.004 D – E and A4/2.022 A – B.

¹³ See Appendix A4/3.006 C – D.

- 7.7 The Evans Report is certainly a useful repository of evidence obtained from the Training Regiment, its staff, trainees and the documentation then available. It is the first Deepcut-specific analysis of the deaths of Sean Benton and Cheryl James. In this respect, it remains the only analysis, until the Deputy Adjutant General's (DAG) final report of December 2002, in response to the last two deaths.¹⁴ In contrast to the conclusions of DAG's final report, that will be discussed in Chapter 11, the Evans Report noted at paragraph 28 under the sub-heading 'Suicides':

*"With the help of RMP(SIB) investigations, we can be confident that there is no obvious link, between the 2 suicides. Indeed, there is no indication of mistreatment within Training Regiment and Depot RLC."*¹⁵

- 7.8 A redacted copy of the Evans Report is reproduced as Appendix 11 to this Report, with names and personal details of those who are mentioned removed where there is no greater public interest in identifying them. As referred to at paragraph 6.72 in the previous Chapter, the Evans Report itself contained two Annexes that listed those who had self-harmed or who had disciplinary problems in the Training Regiment. It appears that these would have been drawn from the precursor of the welfare committees that the Evans Report recommended should be formally established.¹⁶
- 7.9 The Evans Report ended with a list of conclusions and recommendations. The topics addressed are already familiar from Chapters 4, 5 and 6. They will become increasingly so as this Report proceeds chronologically through the available material relating to events at Deepcut. The complete list of recommendations reads as follows (with those of particular interest to the Review underlined for emphasis):

"33. External Recommendations.

The following recommendations should be staffed through the chain of command:

- a. A review of suicide and attempted suicide incidents in Phase One and Phase 2 units in order to identify possible trends.*
- b. A revision of the Land Command instruction on the reporting of suicide attempts in order to ensure uniform reporting standards.*
- c. A reconsideration of recruiting procedures in order to even out the distribution of recruits as far possible.*
- d. A review of screening procedures prior to enlistment to minimize the number of unsuitable recruits entering training.*
- e. A review of assessment procedures within ATRs [Army Training Regiments] to ensure that soldiers are not only physically fit but also mentally and psychologically capable of coping with the rigours of Army life.*
- f. Introduction of a performance measure which views Phase One and 2 wastage statistics together in order to establish a true wastage rate.*

¹⁴ See Appendix 15 to this Report, where "Deepcut Investigation – DAG's Final Report", 3rd December 2002 is reproduced.

¹⁵ See Appendix A11.008, paragraph 28.

¹⁶ See footnote 13 of Chapter 5.

- g. The funding of an increase in MGS [Ministry of Defence Guard Service]¹⁷ at Deepcut and other recommended security enhancements.

34. Internal Recommendations.

The following recommendations are to be actioned by HQ RLC Training Group:

- a. The Training Executive must review the programme of Phase 2 courses against the output of ATR Pirbright and make recommendations to reduce the time between the completion of the Induction Course and the commencement of Phase 2 training.
- b. The SO2 G2/G3 is to obtain from LSP [Logistic Support Policy] 1 approval to number and rename the Squadrons within Training Regiment and Depot RLC to help encourage corporate identity.
- c. The DCOS [Deputy Chief of Staff] is to examine the feasibility of making use of local civilian welfare services.
- d. The Training Executive is to introduce systems and procedures which ensure that soldiers spend the minimum time within the RLC Training Group prior to posting.
- e. The Training Executive is to develop and introduce an Induction Course for newly arrived instructors within Deepcut.

35. Internal Recommendations.

The following recommendations are to be actioned by Training Regiment and Depot RLC:

- a. Revisit the recent review of guard commitments and make recommendations to the SO2 G2/G3, HQ RLC Training Group. The review should concentrate on a further reduction of the military manpower requirement.
- b. Develop existing Phase 2 management procedures to involve the military welfare agencies more often and increase the awareness of their role amongst the military staff.
- c. Make available to soldiers information on local welfare services.
- d. Review the welfare training required by instructors and make recommendations to the Training Executive, HQ RLC Training Group.
- e. Establish a welfare group comprising all interested agencies which is to meet on a regular basis to review welfare cases and to coordinate support.

¹⁷This is an unarmed, civilian guard force. They are not to be confused with the MPGS, the Military Provost Guard Service, which is a body of ex-service personnel who are armed. The MPGS were not at Deepcut at this time. See paragraph 11.113 below.

- f. *Identify and establish a single focus for welfare of all soldiers under training.*
- g. *Review existing induction procedures for newly arrived instructors and make recommendations as to the content of the Induction Course to the Training Executive.*
- h. *Task A Squadron to provide the training support to B Squadron. In the event of difficulties the School of Logistics should be tasked to assist.*
- i. *Introduce an imaginative and progressive training programme for soldiers who are forced to remain within the Regiment prior to Phase 2 training or posting. The training programme must be published on a regular basis and made available to all trainees.*
- j. *Ensure that, where appropriate, greater use is made of leave and unit attachments.*
- k. *Ensure that soldiers who are forced to remain within the Training Group for an extended period are given worthwhile employment.*
- l. *Publish guard rosters at least 4 days in advance.*
- m. *Introduce and monitor systems which improve communication between instructors and soldiers.*
- n. *Review with PB10 [Posting Branch 10] and the RLC MRO [Manning & Records Office] procedures for the selection of instructors.*
- o. *Review the instructor to soldier ratio and make recommendations to the S02 G2/G3, HQ RLC Training Group.*
- p. *Ensure that at least 20%-25% of instructors are female. One of the Troop Commanders should also be female.*
- q. *Increase the liaison with ATR Pirbright in order to identify trends and to reduce the number of PVRs [Premature Voluntary Release] on arrival at Deepcut.*
- r. *Maintain within the Squadron a register of minor punishments awarded by instructors.*¹⁸

7.10 The recommendations above that have been underlined by this Review reflect issues that, on the evidence summarised in this Chapter and the next, continued to affect the training regime at Deepcut for the next few years. The Review is aware that the Army did also respond to the deaths of Sean Benton and Cheryl James by commissioning studies into whether those at risk of self-harm could be identified at the screening, recruiting or Phase 1 training stages. These will be considered in Chapter 9.

¹⁸ See Appendix A11.009 ff.

(ii) Implementing the recommendations of the Evans Report

- 7.11 The Evans Report, and the other initiatives of the Army, proceeded on the assumption that risk of self-harm could be addressed by identifying those most likely to be at risk and managing their welfare needs accordingly. The difficulty in making such an appraisal the principal response to issues of self-harm, is that there is no certain ability to predict those who might be susceptible to it.¹⁹ Whilst Sean Benton's and Cheryl James's deaths indicated that improved contact and records of medical history direct from the GP to the recruiting office might have revealed childhood episodes of self-harm that could have prompted extra vigilance and concern, not every person who has harmed themselves in childhood will do so again, and it might be unfortunate if capable recruits with unhappy histories were to be prevented from embarking on a career in which they may very well succeed and overcome past problems. As for the monitoring of recruits and trainees as they progress in the Army, there was very little occasion in Cheryl James's career history, unlike in Sean Benton's, that would reasonably have given rise to a concern that she might misuse her weapon or injure herself.
- 7.12 Lieutenant Colonel Harding, like the other Commanding Officers who had or were to command the Training Regiment at Deepcut, did not receive any specific training concerned with the management of young people, or the welfare of vulnerable trainees generally. It seems, from the account given to this Review, that the opportunities for discussion and learning from his predecessor about problems or issues of concern were limited.²⁰ Documentary material would, therefore, have been that much more important. Lieutenant Colonel Harding explained to this Review that he implemented all the recommendations of the Evans Report that were within his power to give effect to.²¹ There is no reason to doubt that this was the case, although many of the matters required measures to be adopted by his junior commanders, whom he cannot now identify. It is known that the Squadrons were renamed.²² An officer of the Training Regiment, the Second-in-Command of 86 Squadron, was designated to have a particular interest in welfare matters and a formal welfare committee was established.²³ It also seems that Major M, the Officer Commanding 87 Squadron, had a personal interest in welfare issues in the Training Regiment²⁴. Indeed, before his appointment to 87 Squadron in January 1996, when employed in the School of Logistics at Deepcut, he had written a critical memo on the impact of guard duty and other matters on the training programme. Major M also comes into this Chapter later when the Review considers the events concerning one Leslie Skinner.
- 7.13 The Review has been informed that the welfare committee met regularly so that issues of concern about specific trainees could be ventilated outside the formal chain of command.²⁵ No minutes were kept and no record of actions taken have survived, so it has not been possible for this Review to ascertain what number of cases of concern arose in an average month and how they were addressed. It is apparent that there had been a similar informal system previously.²⁶ The Guard Commander on duty at any time was clearly

¹⁹ See House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Question 408 where Professor Keith Hawton says that screening recruits likely to engage in a suicidal act upon application would be "verging on impossible."

²⁰ See Appendix A4/6.004 A – B.

²¹ *Ibid*, E – G and A4/6.038 A – G.

²² The Squadrons were renamed 85, 86 and 87 Squadron following recommendation 34(b) of the Evans Report. The purpose of the renaming was to "help encourage corporate identity", see Appendix A11.010 and paragraph 7.9 above.

²³ See Appendix A11.011 paragraph 35 (e) and paragraph 7.9 above.

²⁴ See Appendix A4/6.015 D – 016 C for Lieutenant Colonel Harding's comments about Major M.

²⁵ See Appendix A4/6.016 F – 017 C.

²⁶ See footnote 13 of Chapter 5.

required to record incidents, including those of self-harm, in the guardroom daily occurrence logs. Members of the Review team have been able to abstract data relating to reports of self-harm from December 1996 from the surviving guardroom logs provided by the Army to Surrey Police in 2002 (see paragraph 9.48 ff below).

- 7.14 However, other matters remained beyond the effective control of the Training Regiment. Guard duty remained a burden for Phase 2 trainees on SATT (Soldier Awaiting Trade Training). That burden was not relieved by extra resources although, as the number of trainees arriving at Deepcut increased, the frequency with which guard duties were undertaken diminished from the peak of autumn 1995.²⁷ The number of supervisory staff did not increase, however, and poor supervisory ratios, particularly after normal working hours, remained a problem. From 1996 to 1998, Lieutenant Colonel Harding is clear that the numbers of trainees in 86 Squadron were rising rapidly and sometimes reached 1,600 at a time.²⁸ He is clear that he pressed Brigadier Dalby-Welsh for extra financial resources and personnel to address this problem but there were no resources available.²⁹ Brigadier Dalby-Welsh also told the Review that he pressed the case for more resources at ATRA level but with no positive results.³⁰ The issue of supervisory ratios was the subject of expressions of concern from Commandants at Deepcut to the ATRA Board, as well as being a source of concern for Commanding Officers. Some short-term juggling of numbers could be achieved by the use of staff from 85 Squadron or through the transfer of duties from other personnel posted to the Training Group, but there does not appear to have been any sense that disparities in supervisory ratios could be a source of risk.
- 7.15 Apart from a new Regimental Sergeant-Major, there is little evidence of an immediate improvement of the quality of the training staff since 1995, although it would be beyond the abilities of the Review to make an evaluation with the material now available to it. Lieutenant Colonel Harding pointed out to the Review that his efforts to improve the regime for trainees were reflected in the fact that no one died. This is, of course, the case, although reported incidents of self-harm continued. It may be that the frequency of guard duties declined with a rising number of trainees. However, Lieutenant Colonel Harding has pointed out that the rising number of trainees brought its own problems to the Training Regiment.

The female accommodation block

- 7.16 From the material it has seen, and from its extensive conversations with those in command at Deepcut, the Review is clear that out of bounds activity by both male and female trainees was a regular occurrence at Deepcut.³¹ Given the prevalence of this activity, as noted by the BOI into Cheryl James's death, it seems that the call for additional female NCOs and further resources to prevent male access to the female block were unsuccessful. The BOI into Cheryl James's death had met in January 1996.³² It had made a recommendation³³ for a security camera to be installed and linked to the guardroom. It appears that this recommendation was not to come into effect until after 2002. It may be that there are means of access to, and from, the female block other than by the front

²⁷ See paragraph 6.23 above.

²⁸ See Appendix A4/6.016 D – E.

²⁹ See Appendix A4/6.034 B – 035 F.

³⁰ See Appendix A4/2.024 A – D. See also paragraph 9.60 below and, for a comparison, the paragraphs thereafter. Note that the ITO became the Army Individual Training Organisation (AITO), which was then superseded by ATRA in April 1997.

³¹ See Appendix 5, entries 12, 71 and 77 from the 1995 Duty of Care Schedule, which relate to sexual assaults by males on female trainees whilst they were asleep in the female accommodation block.

³² See Appendix 10 to this Report for an edited version of the report of the Board of Inquiry into the death of Cheryl James.

³³ See Appendix A10.015, paragraph 41(e). See also paragraph 6.79 above.

door controlled by an entry phone, but video cameras placed at appropriate locations would have been able to cover four sides of the building. Monitoring in the guardroom, as well as taped capture of the nights' events, might well have deterred offences or led to the detection of offenders, where other means had proven inconclusive.

The role of the Commanding Officer in the complaints system

- 7.17 There are two problems for a Commanding Officer. First, how does he or she get to know about behaviour that is incompatible with the standards set for the Training Regiment? Secondly, when information comes to light, can anything be done about it and, if so, what? This was very much the theme of the conversation the Review had with Lieutenant Colonel Harding, who frankly recognised that the system may well have been too dependent on trainees making complaints when there might have been good reasons not to do so for fear of upsetting their NCOs.³⁴
- 7.18 There seems to have been continued tension between due process of law for those suspected of misbehaviour, on the one hand, and providing protection for trainees, on the other, that is to say running a regime that ensured that staff who had apparently failed to meet the standards expected of them, did not remain in post once the Commanding Officer was aware of a legitimate basis for concern. Captain Whattoff, who has been referred to in the previous Chapter, and who served as Adjutant under the command of both Lieutenant Colonel Josling and his successor, Lieutenant Colonel Harding, believed that Lieutenant Colonel Harding was more minded to deal with problems by the book.³⁵ By this he meant Lieutenant Colonel Harding would call in the RMP to investigate, and then decide on disciplinary or administrative action in the light of the results of the investigation. Such an approach has the benefit of ensuring that the available evidence acquired by the RMP is formally recorded and survives to this day. We have already noted, by contrast, that the evidence produced by the Regiment's own investigation into allegations regarding Regimental Sergeant-Major Z, which Captain Whattoff was tasked by Lieutenant Colonel Josling to conduct, has not been retained, meaning it is now impossible to assess whether there were credible reasons established for the concerns expressed. On the other hand, Colonel Josling is able to point to examples of his acting decisively to deal with staff who failed to adhere to the required standards.³⁶
- 7.19 Even where a decision is taken to call in investigators from outside the Regiment, a delay in doing so could prejudice that very investigation, as will be seen later in this Chapter.
- 7.20 This Review does not underestimate the difficulties for a Commanding Officer in making the right judgement as between fairness and safety on limited evidence. Simply relying on individuals to make a formal complaint may mean that behaviour causing risk to trainees goes unpunished. Similarly, once a complaint has been received, relying on an admission of guilt or convictions on adjudication, without further action, may mean that offenders remain in post for too long. The Review is conscious of the dangers that the benefit of hindsight can bring in making that judgement.

³⁴ See Appendix A4/6.031 A – C.

³⁵ See Appendix A4/16.008 B – D. See paragraphs 6.143–144 for an example of a Regimental investigation authorised by Colonel Josling.

³⁶ See Appendix A4/8.018 C – E.

Incidents of concern

7.21 With no deaths as the focus for a police investigation from 1996 until the death of Geoff Gray in September 2001, and, therefore, with limited reference to this period in the material collected by Surrey Police, the Review can only focus on a number of examples of unfortunate incidents that occurred during this period and have come to its attention. Where there is sufficient evidence available in the form of witness statements, these may throw light on the practical application of the standard of care of trainees and the Army's ability to deter abuse under the system then operating. However, the incidents discussed in detail below do, in the opinion of this Review, give rise to legitimate concern as to the efficacy of a supervisory regime designed to protect and promote the welfare of trainees.

(i) Indecent assault on 22nd July 1996

7.22 At approximately 01.15hrs on 22nd July 1996, the early hours of a Monday morning, Private(f) AT, a female trainee, awoke to find a male in her shared room, in the female accommodation block, who was indecently touching her. When she confronted him, the male replied that he thought this woman was another female trainee, a Private(f) AU, before he hurriedly left. Private(f) AT was extremely upset and, having woken a friend in a nearby room, was taken by the block senior and the friend to the guardroom shortly after the incident. It was apparent that a serious incident had occurred, although it took some time to get an account from the distressed trainee. From statements subsequently taken by the RMP, it appears that the initial investigation into this matter was conducted inside the Squadron, rather than being referred immediately to the RMP. The RMP only appear to have been informed on 26th August 1996, a delay of over a month since the incident occurred.³⁷

7.23 Once notified, the RMP took witness statements from 27th August 1996 and continued to do so through September until interviews under caution with a suspect were conducted. A final report was issued on 22nd October 1996, which was then referred to the legal branch for advice. Neither the guardroom daily occurrence log for July 1996, nor the subsequent legal advice in respect of the final report is now available for consideration by the Review. It appears that no criminal charges were brought.

(a) The delay in calling in the Royal Military Police

7.24 This is an incident that came to the attention of Surrey Police in the course of their re-investigations,³⁸ although the substantive information relating to it comes to the Review from the RMP and not Surrey Police. However, two points of interest were uncovered by Surrey Police. First, a friend of Private(f) AT asserted that following this incident, weekly meetings were held with Lieutenant(f) A, one of the Troop Commanders, and one of the few women in authority. At these meetings the female trainees voiced concerns regarding problems they were encountering at the camp, including the lack of security in the female block and the fact that NCOs attending courses at Deepcut were visiting the female block during their time there. The events described later in this Chapter would appear to show that this latter concern was still very much an issue in 1997.³⁹ Secondly, Surrey Police did note that one reason for the delay in the RMP investigating this incident was that the

³⁷ There is a suggestion that it was initially implied by the Squadron that Private(f) AT had dreamed the incident and that the RMP only became involved after Private(f) AT's parents applied pressure.

³⁸ See Appendix 5, entry 71 of the 1995 Duty of Care Schedule.

³⁹ See paragraph 7.89 below.

Officer Commanding 86 Squadron at the time, Major N,⁴⁰ and Squadron Sergeant-Major AR, who has been quoted from in the last Chapter, initially conducted their own investigation. This Review cannot confirm conclusively whether this is, indeed, the case. However, in her statement to the RMP, the complainant, Private(f) AT, described how Sergeant B, whom the Review has considered in previous Chapters, spoke to her about the incident and accompanied her around the camp to see if she could identify the male who indecently assaulted her. In his witness statement to the RMP, Sergeant B stated that, although Private(f) AT was not a member of his Troop, he had been tasked to accompany Private(f) AT on a search for the male by Lieutenant(f) A, his Troop Commander, whose conduct has also been considered in previous Chapters.⁴¹ It seems likely, therefore, that Major N decided to conduct an internal investigation first using his own staff.

- 7.25 Sergeant B was aware from information he had received from Private(f) AU, the female trainee that the male assailant had said he was looking for when Private(f) AT confronted him, that Lance Corporal AV was a possible suspect. It seems that Sergeant B and Private(f) AT passed Lance Corporal AV in the course of their tour of the camp and Private(f) AT informed Sergeant B that Lance Corporal AV had a similar build and voice to the male who had assaulted her. Sergeant B passed this information on to Major N.
- 7.26 It is quite possible that the combination of the delay in reporting the matter to the RMP and the Squadron's amateur attempt at identification frustrated the ability of the RMP to subsequently obtain sufficient evidence of the identity of the culprit to satisfy the criminal standard of proof.⁴² Private(f) AU told the RMP that Lance Corporal AV was looking at her inappropriately on 19th July, when she was booking out of camp in the guardroom, and that he spoke to her and a friend later that evening in the common room in the female accommodation block, presumably whilst he was on duty. That was the only time she had ever spoken to him. She also informed the RMP that the following day Lance Corporal AV had had a note with a sketched map delivered to her, via another trainee, whilst she was on guard duty, informing her that she should deliver a cup of coffee to him next morning in his room in the permanent staff accommodation block. She prudently ignored this instruction. In his subsequent interviews with the RMP under caution, Lance Corporal AV admitted that he sent the note but stated that he did not expect it to be acted on. This is somewhat redolent of how Regimental Sergeant-Major Z is alleged to have behaved towards a female trainee.⁴³ Although he denied the conduct in interview, Regimental Sergeant Major Z accepted that, if true, such an action would have been sufficient to have him removed from post.⁴⁴ Both the Sergeant on duty in the guardroom in the early hours of the morning of the incident on 22nd July, and the block senior who accompanied Private(f) AT to the guardroom, saw Lance Corporal AV in the vicinity of the female accommodation block, shortly after the incident had been reported.
- 7.27 There appears to have been no disciplinary or administrative action taken in respect of this incident against Lance Corporal AV. He was the only apparent suspect and it is presumed that the evidence was insufficient to bring a charge. No conclusion can now be drawn that

⁴⁰ It is unfortunate that this officer's period of command was cut short for unrelated personal conduct that undermined the Commanding Officer's confidence in his ability to command the training squadron, see Lieutenant Colonel Harding's comments in Appendix A4/6.010 F – 011 E.

⁴¹ This would appear to be a further example of Sergeant B's compassionate behaviour. See paragraph 5.104 ff above. For previous discussion of Lieutenant(f) A, see paragraphs 5.109 and 6.169 ff above.

⁴² It would appear that the recollections of the witnesses in relation to exact timings of events and descriptions of individuals were not as consistent as they might have been had they been interviewed immediately following the reporting of the incident to the guardroom rather than a month later. By way of example, while the incident is recalled to have occurred on a Monday morning, the witnesses' statements refer to different dates for the incident. Such inconsistencies on basic facts may have affected the prospects of a conviction and, therefore, the ultimate legal advice.

⁴³ See paragraph 6.151 above. See also paragraph 6.147 above.

⁴⁴ See paragraph 6.152 above.

he was the offender. Lance Corporal AV denied committing the offence when interviewed under caution by the RMP (Lieutenant C being present as an impartial observer).⁴⁵ He made similar denials to Surrey Police in 2002. He also made allegations against other NCOs. He acknowledged that he was working in the gym alongside Sergeant AQ. This unsatisfactory state of affairs is compounded by the following information giving rise to concern and, as will be seen later in this Chapter, was to reflect future events that were about to take place at Deepcut.

- 7.28 It seems that in October 1994, nearly two years prior to the incident in question, Lance Corporal AV had pleaded guilty in a civilian court to indecent exposure to a female in a public park, that had taken place the month before, and was duly fined. He was subsequently dealt with by Lieutenant Colonel Josling, the Commanding Officer at that time, for the consequent disciplinary offence of bringing discredit to the Army. He was reduced to the rank of Private under administrative procedures available to Lieutenant Colonel Josling.⁴⁶ It seems that witnesses who referred to him in the summer of 1996 then did so by reference to his former rank of Lance Corporal. In 1996, Lance Corporal AV was working as a Physical Training Instructor (PTI) in the Deepcut gym under the command of Sergeant AQ. Lance Corporal AV appears to have remained working in the gym until he voluntarily left the Army in January 1997. This is the same gym where Private (formerly a Warrant Officer) Leslie Skinner was assigned to work under Sergeant AQ when he arrived in Deepcut in about October 1996, following his Court Martial for indecent exposure to a male. The circumstances surrounding Leslie Skinner are considered later in this Chapter.
- 7.29 Further, Lance Corporal AV's personnel file shows that he was fined £100 on 19th July 1996, three days before the indecent assault on Private(f) AT, for allowing a girlfriend (unconnected to any of the above) to stay in his accommodation on 17th July when he knew that 'Standing Order 42' placed it out of bounds to females not on duty. It was the Officer Commanding, Major N, who dealt with this offence.
- 7.30 It was three days later that the same Officer Commanding, Major N, appears to have condoned an internal investigation into the indecent assault on 22nd July. As noted, this delayed the calling in of the RMP and, therefore, a professional and thorough contemporaneous investigation into this incident. The end result was that a Lance Corporal who had a civilian conviction for a sexual offence, who had recently breached standing orders with respect to out of bounds accommodation and who had admitted inviting a female trainee to visit him in the staff accommodation, in breach of instructions, remained in post at the gym.

(b) Major N

- 7.31 At some point in 1997, it seems that Major N, himself, was removed from post by Lieutenant Colonel Harding.⁴⁷ The circumstances of his removal were never subject to formal proceedings and may be disputed but appear to have concerned a domestic argument after an officers' social event which resulted in a period of detention by the civilian police. It seems Lieutenant Colonel Harding was sympathetic to the plight of this officer but the Brigadier was emphatic that he must go.⁴⁸ Major N had failed to set a good

⁴⁵ The Review notes that Lieutenant C had been promoted to the rank of Captain by this time.

⁴⁶ It appears that, by the time of the incident on 22nd July 1996, he had been promoted back to the rank of Lance Corporal. See paragraph 8.96 ff below for the difference between disciplinary and administrative action.

⁴⁷ See Appendix A4/6.009 C where this information was provided by Lieutenant Colonel Harding.

⁴⁸ See Appendix A4/6.011 A – B.

example to the trainees.⁴⁹ Equally it may be that what concerned the Brigadier was that Major N had contacted his Squadron Sergeant-Major, Squadron Sergeant-Major AR, to assist him, rather than contacting his Commanding Officer. He had, therefore, made his position untenable when rumours of his actions spread through junior ranks. Major N also makes an appearance in one of the incidents connected with Leslie Skinner,⁵⁰ to whom this Review now turns. He does not appear to have been an efficient Officer Commanding of B Squadron, effective in setting standards and protecting trainees from abuse.

(ii) Leslie Skinner

- 7.32 The unfortunate career of Leslie Skinner has caused embarrassment to his Commanding Officer, the RLC, the Army and the MOD. In the autumn of 2004, shortly before this Review was announced, the MOD acknowledged, at the highest level, that Skinner should never have been posted to Deepcut.⁵¹ In the opinion of this Review, it is very much in the public interest that the full account of Skinner's misdeeds is made known and the opportunities that did exist for a risk assessment to have been made in respect of him identified. Skinner was not at Deepcut at the time of any of the four trainees with whom this Review is primarily concerned, and neither was he employed by the Army to be a Military Training Instructor (MTI) for trade training or continuation training. However, the events leading up to his posting to Deepcut, the scrutiny that posting was subjected to and his ability to behave as he did, for as long as he did, without discovery, provide, in the opinion of this Review, an important source of information for any assessment of the regime at Deepcut and the discharge of its duty of care to trainees.
- 7.33 Skinner was employed in the gym at Deepcut from around late October 1996 until his conviction for indecent assault at a Court Martial in February 1998, that resulted in his imprisonment and discharge from the Army. As will become clear, that was not to be the end of matters. The RMP were responsible for the initial investigation leading to Skinner's conviction in February 1998, but the full extent of his activities at Deepcut was not discovered until a very thorough and professional investigation by Surrey Police that started in November 2002 and led to a criminal conviction in 2004. The Review has been provided with the full papers of the investigation and subsequent convictions of Skinner. In the account that follows, the names of his victims will remain anonymous, but the persistency and the scale of offending will be noted. From this, it appears that Skinner did abuse his authority in order to sexually assault trainees, and systems of risk assessment were either non-existent or seriously defective in their operation and application. In light of the findings of guilt made against him and his notoriety, Leslie Skinner's name has not been anonymised and he has not been approached by the Review. The events are reviewed to see what can be learnt about the dangers of a depot system⁵² in close proximity to a Training Regiment and the problems of inadequate risk assessments of individuals.
- 7.34 Leslie Skinner was a former Junior Leader in the Royal Corps of Transport. From September 1989 to May 1993 he was posted to Arnhem Barracks, Aldershot. In 2003, as part of their investigation, Surrey Police were able to interview two young males, who were in training at these Barracks and aged 17 and 21 at that time. The information they gave led to charges of indecent assault to which Skinner was to plead guilty in 2004. Their accounts suggest that they were groomed to agree to participate in sexual beatings. The methods

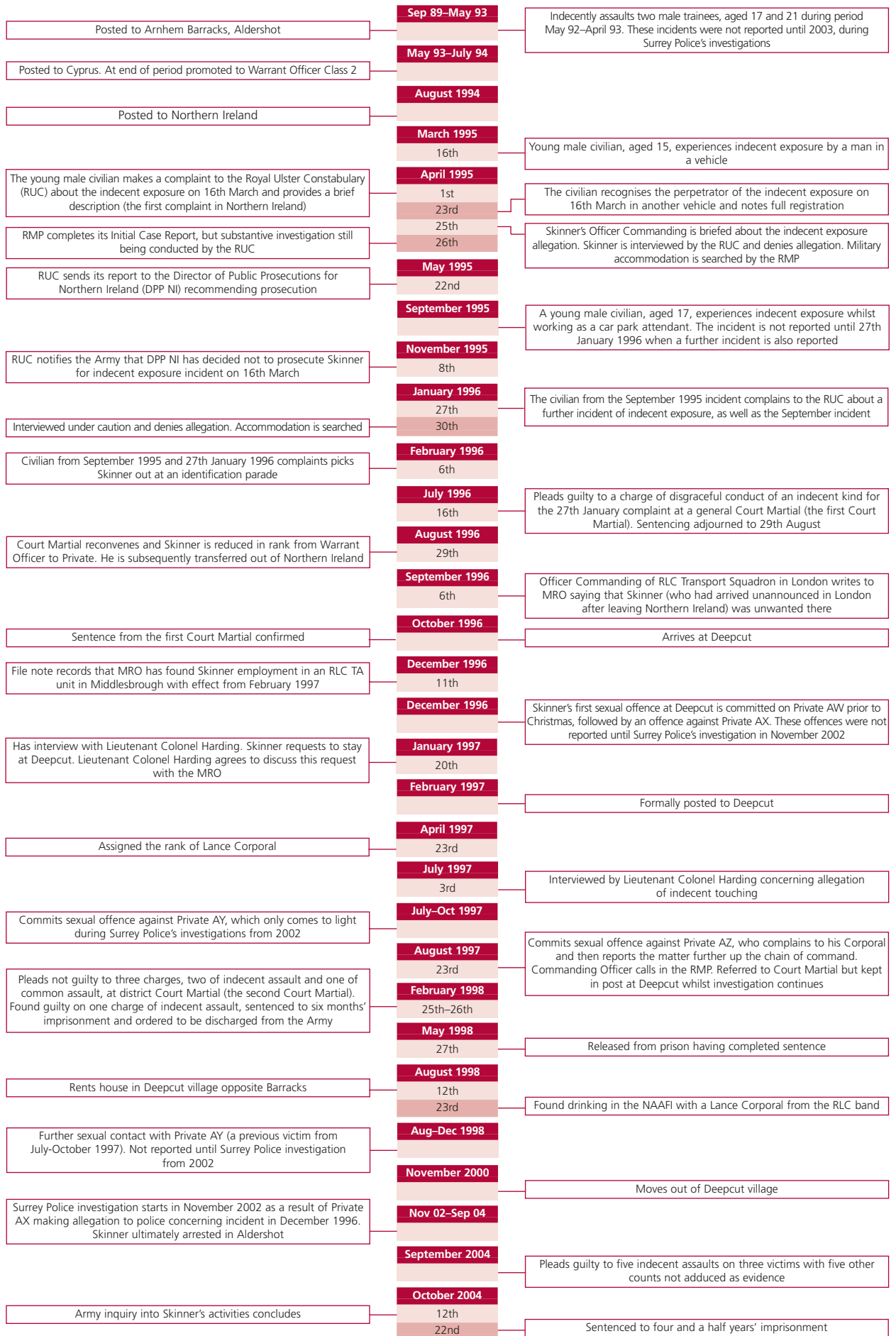
⁴⁹ See *ibid*, D – E, where Lieutenant Colonel Harding explained to this Review that Major N “was in charge of the ... meting out of discipline to a large number of youngsters ... all those things that you don't want to be advertising to the youngsters you've got this guy wrapped up in ...”

⁵⁰ See paragraph 7.64 below.

⁵¹ Commons Hansard 25 Oct 2004: Column 1140, reply by Under-Secretary of State for Defence Mr Ivor Caplin MP.

⁵² See paragraph 4.67 above.

Figure 7.1 Timeline of events concerning Leslie Skinner



of grooming or encouraging this conduct included offers made by Skinner of out of hours reporting to the gym. This was said to be as an alternative to formal sanctions for alleged disciplinary breaches by the victims. The matters were not reported at the time, partly because of the rank of the perpetrator but also because of the stigma of homosexuality that would be attached to this conduct, in the light of the Army's then policy on homosexual orientation and the very considerable prejudice that policy legitimated.

(a) The first complaint in Northern Ireland in April 1995

- 7.35 From May 1993 to July 1994, Skinner was posted to Cyprus. At the end of this period he was promoted to the rank of Warrant Officer Class 2 having received glowing confidential reports from his Commanding Officer. In August 1994, Skinner was posted to Northern Ireland with responsibility for transport matters. On 1st April 1995, a young male civilian aged 15 made a statement to the Royal Ulster Constabulary (RUC) complaining that a man in a motor vehicle, whose brief description he was able to provide, had indecently exposed himself to the complainant a fortnight before on 16th March 1995. There was contemporary support for the fact that the complainant had been the victim of an act of indecent exposure. On 23rd April, the complainant recognised the perpetrator in another vehicle whose particulars he noted in full. The details were sufficient to conclude that a military vehicle might be involved and so, on 24th April 1995, the RUC contacted the RMP SIB (Special Investigations Branch) who were able to confirm that the vehicle in question had been booked out to Skinner. They also were able to confirm that, on 16th March, a vehicle similar to that described by the young male had also been booked out to Skinner.
- 7.36 The SIB briefed Skinner's Officer Commanding about these events on 25th April 1995. Skinner was interviewed by the RUC, during which he denied the allegations, and his military accommodation searched by the SIB. The SIB report notes 26 videos and correspondence were seized, but there is no description of this material and they were not considered to be of evidential significance. The SIB completed their Initial Case Report on 26th April, but the substantive investigation was in the hands of the RUC, the civilian police, who, on 22nd May 1995, sent a report to the Director of Public Prosecutions for Northern Ireland (DPP NI) recommending prosecution. On 8th November 1995, the RUC notified the Army that "*on the basis of the facts and information available*" DPP NI had decided not to prosecute Skinner. The Review has been informed that DDP NI no longer retain the records relating to that decision. As a result, the justification for the decision not to prosecute cannot now be assessed. It seems that the decision not to prosecute was not revisited following subsequent events. It is sufficient to note that nothing undermining the credibility of the complainant has come to light.

(b) The second complaint in Northern Ireland in January 1996

- 7.37 On 27th January 1996, another young male civilian (aged 17) in Northern Ireland made a complaint to the RUC that he had been the victim of an offence of indecent exposure whilst working as a car park attendant. Once again, identification was via a car registration linked to the Army. The statement indicated that this was not the first time this complainant had been the victim of such an offence. An earlier incident in September 1995 was recounted and, from information given to others at the car park, a registration number for the earlier incident was recovered. Following further enquiries with the RUC, both vehicles were linked to the military unit in which Skinner worked, and the most recent vehicle was booked out to him shortly before the time of the alleged incident.

- 7.38 On 30th January 1996, Skinner was interviewed under caution and his accommodation searched. On this occasion 46 homosexual magazines, similar material such as contact magazines and some eight videos of homosexual pornography were found with titles such as 'Young Cadets', 'The Best of Europe's Boys' and the like being recorded in the RMP search logs. Also found in his possession were 45 live and 30 blank rounds of ammunition. In interview, Skinner said he had brought the ammunition back from his tour of duty in Cyprus. If this is right, then the Review understands that, not only was he in serious breach of military regulations by retaining ammunition he should have handed in, he was probably also in breach of regulations covering the conveyance of ammunition by air. Despite this, there is no record on his personnel file that he was charged for offences relating to ammunition, although the RMP report recommended such charges, and his Commanding Officer indicated that charges would be brought (see paragraph 7.41 below).
- 7.39 Skinner denied being homosexual, an admission of which would have resulted in his administrative dismissal from the Army under the policy then in force. He made no comment on whether the videos were his and whether he viewed them. He once again denied indecently exposing himself. On 6th February 1996, the complainant picked Skinner out on an identification parade. By this time it seems that the RMP had taken over the conduct of the investigation from the RUC. A second witness statement was taken from the victim saying that he could not now be sure that the man responsible for the first incident in September 1995 was the same man responsible for the flashing incident in January 1996 and, as he did not write down the vehicle registration number personally, he could not be 100 per cent sure that the number was correct. When the complainant was re-interviewed by Surrey Police in 2003, he said that he was responding to a suggestion from the investigating officer to withdraw the first complaint, relating to the incident in September 1995, and proceed solely on the more recent one in January 1996. In fact, the complainant told Surrey Police that the man had exposed himself on a number of different occasions and that this was the subject of ribald comment in the parking attendant's office. The Review cannot now make an assessment of this allegation. If it is accurate, it does, at the least, suggest that an opportunity was missed by the RMP to obtain a fuller picture of Skinner's proclivities. The RMP might have also decided to re-investigate the complaint from April 1995 by the first complainant, as Surrey Police subsequently did. It may be that better training in the investigation of sexual offences against young people might have enabled the RMP to have extended their investigation to good purpose.

(c) The first Court Martial in July 1996

- 7.40 In any event, on 16th July 1996, Skinner pleaded guilty to an offence of disgraceful conduct of an indecent kind for the 27th January 1996 incident at a General Court Martial. Sentencing was adjourned until 29th August. In the opinion of this Review, it is unfortunate that Skinner was charged with just one offence of indecent exposure when, at that time, there would appear to have been credible evidence to link him with at least the two known previous offences – the one from 16th March 1995 and the one in September 1995 – against two separate young boys aged under 18. At least such evidence might well have been admissible as evidence of 'similar fact'⁵³ to support the admitted incident of indecent exposure on 27th January 1996. It might also have been of assistance to the sentencing court to have been made aware of credible allegations of similar conduct.

⁵³ Although the common law is not a model of clarity on this issue, it did allow compelling evidence of a way of operating in respect of one allegation to be put before a tribunal of fact considering a second allegation. The matter is now governed by the Criminal Justice Act 2003, with effect from December 2004.

- 7.41 On 2nd February 1996, whilst Skinner was awaiting formal charge and the Court Martial, his Commanding Officer in HQ Northern Ireland (HQ NI) wrote to the RLC Manning & Records Office (MRO), Glasgow who were responsible for postings:

"WO2 Skinner was apparently questioned by the RUC early in 1995 in connection with an alleged incident of indecent exposure at children. The case was dropped by the DPP(NI) due to lack of evidence. You should note that we have only just been made aware of this previous incident.

"It is understood that WO2 Skinner will have disciplinary action taken against him for possessing ammunition and will be put before Bde Comd [Brigade Commander] 3 Inf Bde [Infantry Brigade] within the next 2 weeks."⁵⁴

- 7.42 As to the first paragraph, as noted at paragraph 7.36 above, this Review is unable to comment on why the DPP NI did not proceed in respect of the March 1995 incident and, in particular, whether that decision would have been revisited in light of the second complainant. There would appear to have been sufficient evidence to bring a charge as recommended by the RUC. However, HQ NI were wrong that they had only just been made aware of the March 1995 allegation, as the RMP file indicates that HQ NI were made aware of it at the time. It may be that HQ NI's misconception fed into an official Army review of Skinner's actions, conducted in 2004. As to whether Skinner did face disciplinary action by the Commander of 3 Infantry Brigade by the end of February 1996, again the Review is unable to say, but it was noted that no disciplinary sanction appears in his personnel file. Either no sanction was imposed for the ammunition offence, or it was imposed but was not formally recorded in his file.
- 7.43 It is not possible for the Review to reconstitute what facts were before the sentencing Court Martial that reconvened on 29th August 1996. It seems likely that the full picture of matters known to the Army by this date was not before it. It seems then, and now, that the RLC was surprised that Skinner was permitted to 'soldier on'.⁵⁵ A Warrant Officer who had pleaded guilty to one offence of indecent exposure, who had been linked to two other offences, who was in unlawful possession of live ammunition and in apparent possession of homosexual pornography, at a time when any manifestation of homosexual orientation would have led to administrative dismissal, could surely have no future in the Army for his remaining 18 months of service. However, the sentence was that Skinner be reduced in rank from Warrant Officer to Private.⁵⁶ Following sentence Skinner was transferred out of Northern Ireland forthwith.
- 7.44 This Review understands that, although administrative sanctions can be applied to dismiss someone from military service even where there has been no criminal prosecution or finding of fault, the 'double jeopardy' principle prevented the Army from administratively dismissing Skinner for the same conduct where that sanction could have been, but was not, imposed by the Court Martial.⁵⁷ There is an obvious rationale in principles of justice why a person should not be punished twice for the same conduct, but the rationale only works if the full extent of the conduct capable of being established is before the Court Martial or, if not, if the prosecution has a right of appeal on sentence. Failing this, a broader administrative assessment of suitability for continued future employment in the Army is surely required.

⁵⁴ 2nd February 1996.

⁵⁵ See Appendix A4/6.043 E – F for Lieutenant Colonel Harding's comments about this.

⁵⁶ *Ibid*, where Lieutenant Colonel Harding indicated to this Review that one of his objections to having Leslie Skinner posted to Deepcut was that he was now a "Private soldier who's used to being a Sergeant Major."

⁵⁷ See Appendix A4/15.012 B – E for the Brigadier Advisory's explanation of the Army's approach. See also paragraph 8.96 ff below.

- 7.45 The Review has noted that Surrey Police re-interviewed and took fresh statements from the two complainants from Northern Ireland in their investigations from 2002. It may be that, if Skinner had not pleaded guilty to these offences in 2004, Kingston Crown Court might have heard from these witnesses, whether as complainants to specific charges or on the 'similar fact' principle noted above.
- 7.46 For the Review, it is important to note that the RMP SIB does not merely take on the role of the civilian police force in investigating crime. They also have a specific function, as the Army police force, to maintain the high professional standards needed in the Army if someone is to exercise authority or be trusted with working as a member of a team with young people. The Review concludes that, for one reason or another, a chance to fully investigate and place before a court, or administrative authority, the full facts relating to Skinner's activities and suitability for continued employment was missed. The sentence of the Court Martial, and assumptions about why it was imposed, formed the basis of the assessments made about Skinner in the next part of the narrative of events. There is still some way to go before all the opportunities to prevent him coming to or removing him from Deepcut have been analysed.

(d) Administrative action following the first Court Martial

- 7.47 Undoubtedly, what happened next was not in accordance with Army procedure. First, Skinner's Commanding Officer at the time of the Court Martial should have considered whether there was a case for his administrative discharge from the Army under the Army General Administrative Instruction (AGAI) procedures for the conduct known about, in addition to the conduct forming the basis of the guilty plea. On the face of the file, this could at least have included consideration of whether the possession of the homosexual pornography (not itself the subject of the charge) was evidence of an orientation incompatible with military service at that time (see paragraph 4.88 above). Of course, this Review does not endorse the former policy whereby those with homosexual tendencies were liable to be denied access to, or debarred from continued service within, the Armed Forces. Indeed, as events in this narrative will show, the policy may have been counterproductive and rendered people unwilling to report matters to authority. If, however, the policy had any value at all, one might have thought that sexual offending by a Warrant Officer, in conjunction with related material of the sort briefly described above, would have been sufficient to contemplate its use. There is no evidence, however, that it was ever considered.
- 7.48 The second failure was that the MRO, Glasgow should have assigned Skinner a new posting if he was to remain in the Army. It may be that there was a period of time between the sentence imposed by the Court Martial on 29th August 1996 and the confirmation of the sentence on 4th October 1996, during which the file slipped between two authorities. In Skinner's personnel file there is a manuscript note relating to a telephone call on 16th September 1996, indicating that the MRO will "*examine the situation when the sentence is confirmed and the appeal heard.*" Skinner should have been assigned, in theory, to a new unit for employment purposes while this process was completed. Clearly, the Commanding Officer wanted him out of Northern Ireland as quickly as possible, but someone should have taken responsibility for where Skinner was to be placed. Such a decision should then have been recorded in his personnel file, along with the reasons justifying it.
- 7.49 In the event, there is some evidence that Skinner turned up unannounced at an RLC Transport Squadron in London where he had some contacts. The Officer Commanding of this Squadron wrote to the MRO on 6th September 1996 saying that Skinner was unwanted. Thereafter, Skinner spent some time at a servicemen's club in London at his

own expense, although, as a serving soldier, the Army were responsible for accommodating him. Then it seems, on a date unrecorded but probably some time in October 1996, Skinner turned up in Deepcut.

(e) Arrival at Deepcut in October 1996

- 7.50 It is likely that Skinner arrived at Deepcut because it was the depot for the RLC.⁵⁸ This meant that anyone who could not be placed elsewhere within the Corps was liable to be posted there. The depot function was the responsibility of 87 Squadron, formerly C Squadron, with Major M as the Officer Commanding. Major M has already been noted⁵⁹ as being personally concerned with the welfare of trainees. Now he had the difficult task of accommodating and supervising a man who was to turn out to pose a danger to those same trainees.
- 7.51 There is an undated note on Skinner's personnel file that appears to be in Major M's handwriting originating from around this time. It is worth reproducing because it is almost unique, amongst the documents seen in respect of Skinner's postings and career, in that it attempts to perform some kind of assessment of risk:

*"Was: 3 BDE TPT / MOV [Transport/Movement] Warrant Officer
A rising star / Para / In slot for Promotion, Commission*

...

Out of Character Offence ?

Waved willy at male car park attendant in Belfast – complaint

Said it wasn't me

Video showed his car leaving park.

'Room Search'

45 live rds .556 30 blank

46 Homosexual Porno mags/8 videos

*Allegation 1995 of Indecent exposure to children (RUC) was thrown out
'?Doubt' [...] (MRO (N)) suspects NI plant. DCM [District Court Martial]
might reflect this doubt?*

DCM Reduced to ranks 29 Aug

Petitioned – thrown out end Oct

*Where's he been? 3 BDE / [...] pushed him back to 20 Sqn / Union Jack
Club. Not well handled.*

*Future? None of the TPT / MOV Regts want him. Deputy very pleased we
have accepted him for the moment. Now asking PNR to accept him. MRO
(N) following up – Appreciate our concern. They will direct posting fairly
soon*

*'Way Ahead' interview, counsel, domestic circumstances, establish his
assessment of career in view of failure of petition, assess risk to our own
people, Accept high level of interest records / deputy, Discuss with
MRO(N), [...] wants to speak to him, Employ or send on leave*

*discharge – resignation, PVR [Premature Voluntary Release], Pension
aspects*

Retention? hasten posting"

⁵⁸ See paragraph 4.67 above. See also Appendix A4/6.043 A – D for Lieutenant Colonel Harding's understanding of his position.

⁵⁹ At paragraph 7.12 above.

- 7.52 Unfortunately, for all those concerned and affected by the case, although the headings to the note represented pertinent questions to pose, the proposed answers, just like the decision on sentencing in August 1996, were based on incomplete data. In light of the history, as recounted to date, it can be seen that the indecent exposure by Skinner was unlikely to have been a one-off incident out of character; nor was the 1995 allegation “*thrown out*”. Whatever else may have prompted the Court Martial to impose the sentence it did, it can hardly have been the belief that Skinner was the victim of a malicious allegation in the context of the military presence in Northern Ireland. Furthermore, it is difficult to see how a risk assessment “*to our own people*” could have resulted in Skinner’s placement in the gym as a PTI if the nature of the pornography had alerted Major M to an unhealthy sexual interest in young male trainees. Whilst working in the gym, Skinner would have had regular contact with Phase 2 trainees whose physical fitness had to be maintained or who were on rehabilitation training.
- 7.53 The issue of Skinner’s employment in the Training Regiment has been discussed with Lieutenant Colonel Harding in conversation, and in subsequent correspondence when further information became available to the Review. The Review is grateful to Lieutenant Colonel Harding for his assistance and recognises that it has been difficult for him to remember details in response to some of the enquiries made. He recalls interviewing Skinner when he first arrived at Deepcut, although the Commanding Officer’s interview book makes no reference to it. Lieutenant Colonel Harding has indicated that the gym was thought to be a place where Skinner would be supervised during the day by Sergeant AQ and the civilian PTI.⁶⁰ This was one of the few places in the camp where there would be constant daytime supervision.
- 7.54 The reality is that there was probably little alternative but for the depot to accept back a disgraced and unwanted soldier who had 18 months of service left before retirement. If so, this was not a mistake in his posting there, but the inevitable consequence of the system in place at the time. Lieutenant Colonel Harding emphasised to this Review that he had no alternative but to accept Skinner, although he protested the appointment as ‘unsuitable’.⁶¹ There is some uncertainty as to whether he protested his concerns to the Brigadier, who has no recollection of this.⁶² Lieutenant Colonel Harding’s account was that, even if he had further information and had concluded that Skinner was a danger to his trainees, he could have done nothing to prevent his posting. Given the posting, he was ambivalent as to whether the gym was the best place for him to be.⁶³
- 7.55 For his part, Major M has explained the problem that he faced in a statement given to Surrey Police in 2003:

“We had no choice on this matter as he was a single man. My accommodation was adjacent to the Phase 2 training accommodation. These ghastly Poulson-built buildings comprised mixed but segregated male/female floors which were a veritable maze. These were impossible to police and monitoring of nocturnal activities was practically impossible.”⁶⁴

⁶⁰ Who was a former Army Warrant Officer.

⁶¹ See Appendix A4/6.043 B, where Lieutenant Colonel Harding informed this Review that “*somebody told me I had to have him*”.

⁶² See Appendix A4/2.031 B – C.

⁶³ See Appendix A4/6.050 D – 052 F. Towards the end of his meeting with this Review, Lieutenant Colonel Harding conceded that “*the gym was the wrong place to put him, I put him there, subsequently in hindsight, perhaps I put him in the wrong place*”, A4/6.052 E – F.

⁶⁴ 8th July 2003.

- 7.56 Major M explained that he raised his concerns with Lieutenant Colonel Harding. Skinner had no other accommodation to go to and was not eligible for offsite residence in married quarters, so there was no alternative to his being housed in the staff accommodation at Deepcut. Skinner had some expertise in physical training and it was considered that his skills in this regard would make him useful in the gym, where he would be properly supervised by Sergeant AQ.⁶⁵
- 7.57 It would appear that the staff assigned to work in, or supervise, the gym had a somewhat unfortunate record when it came to setting standards in respect of sexual activity. Some evidence has emerged from Lieutenant Colonel Josling's interview book for 1995.⁶⁶ It has already been noted earlier in this Chapter,⁶⁷ in relation to the incident on 22nd July 1996, that amongst the members of permanent staff who were working in the gym in 1996 there was Lance Corporal AV who, like Skinner, had a conviction for indecent exposure. Major M has stressed that Skinner was warned, in the presence of Lieutenant Colonel Harding, as to his future conduct when assigned to the gym.
- 7.58 It is fair to state that, given what happens next, there is no evidence that Skinner abused trainees in the gym during working hours. Rather, he appears to have abused the position of authority that his employment in the gym gave him to sexually proposition young trainees whom he had met in the gym or elsewhere.
- 7.59 Major M's manuscript note, referred to earlier at paragraph 7.51, suggests that Skinner's employment at Deepcut was to be temporary until the MRO could find another appointment. From Skinner's personnel file, it appears that there was an opportunity to move him on. There is an undated manuscript note referring to a telephone conversation between Major M and MRO on 11th December 1996, in which it is stated that the MRO had found him employment in an RLC Territorial Army unit in Middlesbrough with effect from February 1997. Skinner, however, had by this time decided he wanted to serve his final 18 months of his 22 years service at Deepcut. There is an entry in Lieutenant Colonel Harding's interview book for 20th January 1997 to the effect that Skinner had requested to stay at Deepcut and that Lieutenant Colonel Harding had agreed to discuss this with MRO.
- 7.60 Following his meeting with the Review, some follow-up questions were asked of Lieutenant Colonel Harding in correspondence, including a request for any comment on this entry in his interview book. In his response, Lieutenant Colonel Harding disagreed with the suggestion that Skinner stayed at Deepcut thereafter because he supported his request. He told the Review that, as far as he could recall, there was no evidence that Skinner was misbehaving himself or giving additional cause for concern. He thought that fairness required that the soldier's request be forwarded to MRO and his wishes noted. With respect to Lieutenant Colonel Harding, the fact that Skinner wanted to stay did not require him to support that request, particularly if he thought that this was the wrong posting in the first place. In any event, Skinner remained at Deepcut. It seems to the Review that this was a lost opportunity to remove Skinner from the unsuitable environment of the Training Regiment.

⁶⁵ See Appendix A4/6.050 E – F.

⁶⁶ A Warrant Officer was the superior to Sergeant AQ in the gym. The Warrant Officer was dismissed from post by Lieutenant Colonel Josling for failing to report inappropriate sexual behaviour on a staff coach trip, see Appendix A4/9.054 C – G and paragraph 6.135 above. At about the same time Sergeant AQ was warned for inappropriate familiarity with a female trainee.

⁶⁷ See paragraph 7.28 above.

(f) Offences at Deepcut

7.61 By January 1997, the same month that he was requesting to stay on at Deepcut, Skinner had already embarked on a sequence of serious sexual assaults on trainees. However, as will be seen, these offences were not uncovered during a subsequent RMP investigation in August 1997 and only came to light as a result of Surrey Police's investigation that started in November 2002. The evidence subsequently revealed, again, throws light on the lot of a Phase 2 trainee at Deepcut at the time. Of course none of this would have then been known to Lieutenant Colonel Harding or Major M.

7.62 The first offence was committed shortly before Christmas on a Private AW, recently arrived at Deepcut, who became friendly with the gym staff:

*"Skinner was like one of the lads but seemed as though he was sort of above the rest of us and outranked us. I think this was due to his previous rank and us being new in the army. He had been in the army a while and acted in the way an NCO would."*⁶⁸

Using this influence, Skinner invited Private AW to his room where he got him drunk and sexually assaulted him:

*"I have never told anyone what happened that night, as I was frightened that I would not be believed and everybody would think that I encouraged what happened. I thought everybody's opinion of me would change and I would be branded as gay or something like that."*⁶⁹

7.63 The next assault was on a younger trainee a short time after. Private AX was an 18 year old trainee at Deepcut at the time. He had arrived for Phase 2 training in about June 1996 but had missed the trade training course assigned to him and, rather than wait months for another chance, switched trades and was due to begin another course in January 1997. He was, thus, yet another example of someone held back at Deepcut because of the SATT phenomenon. In the meantime, he was assigned to temporary employment in the gym because of some previous physical training experience. He met Skinner there and understood that he held a senior rank and had over 20 years' experience.

7.64 Private AX was vulnerable to Skinner's approaches because that Christmas Private AX had been disciplined by Major N, the Officer Commanding 86 Squadron, for allegedly inappropriate behaviour towards an officer's wife. As a result of this, Private AX was summoned to appear before Major N and informed that he would be taken out of the gym, that his Christmas leave was cancelled and that he was to perform Christmas duties at the Barracks, including guard duty over the Christmas break, two hours on, two hours off. It seems that Sergeant AQ was concerned about the severity of this response. Lieutenant Colonel Harding has informed the Review that this would have been a sanction dealt with at Squadron level and, therefore, he had no connection with it. As everyone else in his room had left for the Christmas period, Private AX was alone when Skinner entered his room late at night and sexually abused him. It, thus, appears that Private AX became the victim of sexual abuse from a more senior member of staff because of SATT and the administering of informal disciplinary sanction, by an officer, of cancellation of Christmas leave and additional guard duty. It would appear from the statement that there was some acquiescence in Skinner's unwanted sexual attentions, but Private AX told the Surrey Police:

⁶⁸ 4th July 2003.

⁶⁹ *Ibid.*

*"I was shaking at this point, he was a senior rank to me and he told me 'Your career will be over, before it's even started'. I didn't know what was happening to me. He said 'Don't worry I'm not going to hurt you, we're going to my room because it's a lot more private and we won't get caught'."*⁷⁰

As Skinner was ultimately to plead guilty to other charges of indecent assault, the evidence from these two Privates was not tested in court, but from press reporting of the court proceedings, the case was opened by the Crown as one of abuse of apparent authority that took place on a number of occasions.

- 7.65 Private AX was the reason why Surrey Police re-investigated Skinner from 2002 to 2004. Following a television programme about sexual abuse of young men, Private AX approached the police with details of his experiences and the unhappy consequences it had had for his personal life. Surrey Police, using their experience of sexual offenders, then carried out further enquiries with Private AX's colleagues resulting in Private AW, and a further trainee, coming to light. Then, when Skinner was arrested in 2003, amongst items of interest taken were some photographs of sado-masochistic sessions with other young men and the earlier offences in Aldershot came to light.⁷¹ It is unfortunate that these photographs had not been discovered earlier and that, on the occasion of the two previous RMP prosecutions of Skinner (the second of which is discussed below at paragraph 7.71), the bigger picture of sexual abuse had not been brought to light.
- 7.66 Following his interview with Lieutenant Colonel Harding in January 1997, Skinner was able to conclude his military service at Deepcut. It seems his formal posting only came through in February 1997, although he had been there for some four months by then. Some consideration was given to his rank. He was assigned the local rank of Lance Corporal on Brigadier Dalby-Welsh's authority on 23rd April 1997 to attend a PTI course.⁷² He seems to have retained this rank thereafter. He may also have been permitted to use this rank prior to Brigadier Dalby-Welsh giving his authority. Lieutenant Colonel Harding's recollections of these matters were unclear.
- 7.67 On 3rd July 1997, Lieutenant Colonel Harding interviewed Skinner but the records do not reveal what the interview concerned. Lieutenant Colonel Harding recalls that there was a sexual allegation of indecent touching made, but that there was no supporting evidence.⁷³ It is unclear who, if anybody, investigated this matter.
- 7.68 The subsequent Surrey Police re-investigation brought to light a further offence against Private AY, an 18 year old Phase 2 trainee, at some point between July and October 1997. His statement described how he was groomed by Skinner for sado-masochistic activity. This involved use of the gym after hours, the key to which Skinner had access. Once in the gym, activities were conducted resulting in indecent assault. Private AY had a vulnerable background and believes that was a reason why he was selected for attention by Skinner. Although no longer holding the rank of Warrant Officer, Skinner was still able to convey his authority. Private AY's witness statement contains two relevant passages:

⁷⁰ 27th November 2002.

⁷¹ See paragraph 7.34 above.

⁷² See Appendix A4/2.032 B – F.

⁷³ See Appendix A4/6.047 F – 048 C.

"I just kept thinking you don't say no in the Army. I know what discipline is like, I have been doing it for seventeen years. When the pressure is on, it's a lot easier to say yes and put yourself through the consequences later. My whole life, I have been told what to do and to survive, I have done what I am told. I just saw it as another of those situations. I wanted to go so badly but I just got [on] with it, hoping and hoping it would be over soon.

"When I first met Les, he was in his forties and had been in the Army for a long time. He was a bit of a powerful guy. Powerful both physically and mentally. He got things done. He got everything done and everybody respected him. Nobody took the micky out of him and nobody slagged him off behind his back. All the recruits did as they were told with him. I think he said he had been a Para. I wish to make a formal allegation of indecent assault against Leslie Skinner.

"I have tried to forget the incident and move on but now I have been approached by Surrey Police and I have had to relive the incident, I am able to see that Les picked on me and used his rank to do things to me. He knew he would get what he wanted due to his rank and he also bought me drinks so that I wouldn't care what was going on. I have never encouraged Les in any way to touch me."⁷⁴

- 7.69 These statements are quoted because it is important that those who take decisions on Army discipline and welfare policy should be aware of how abuse is perpetrated in a disciplined environment, whether on young men or women, and why the victims may be reluctant to instigate formal complaints. All of Skinner's victims at Deepcut had either worked in the gym as an assistant or received training assistance from Skinner there.
- 7.70 Time was running out for Skinner when on 23rd August 1997 he entered the room of a 19 year old trainee, Private AZ, and indecently assaulted him by touching him whilst asleep. On this occasion he had encountered someone who was prepared to make a prompt complaint to his Corporal who told him he should report it up the chain of command. The RMP were called in under the authority of the Commanding Officer. When he was questioned, Skinner admitted his presence in the trainee's block, where he had no business being, but denied the allegation of indecent assault. He was not, however, suspended or removed from post, or moved out of Deepcut while the investigation continued, even after the Commanding Officer referred the case to higher authority for Court Martial in the autumn of 1997.

(g) The second Court Martial in February 1998

- 7.71 At a two day district Court Martial starting on 25th February 1998, Skinner pleaded not guilty to three charges, two counts of indecent assault and one of common assault. He was found guilty on one count of indecent assault. On 26th February 1998, he was sentenced to six months' imprisonment and ordered to be dismissed from the Army. He was two months short of his 22 years' service, which meant that his accrued pension could not be drawn until he was aged 60.⁷⁵ His personnel file retains a report by Major M in mitigation of sentence. It notes:

⁷⁴ 14th August 2003.

⁷⁵ On completion of 22 years service, soldiers are able to draw an immediate pension.

"The background and reasons for his posting remained privy to but a few and it was decided that he might best be employed in the Gymnasium.

"A high level of trust was placed in him as a member of the Gymnasium staff and his performance was kept under constant review throughout. His continued employment up to the end of last week notwithstanding the investigation of the then alleged offences from August 1997 was a deliberate decision by the Commanding officer."⁷⁶

- 7.72 The Review has tried to ascertain why Skinner did remain in post in light of the history known to Lieutenant Colonel Harding and Major M. The Review discussed this matter with Lieutenant Colonel Harding.⁷⁷ The fact that Skinner disputed his guilt until late in the proceedings does not disable the Commanding Officer from exercising a judgement as to continuation of employment or transfer out of the Training Regiment.
- 7.73 In response to questions posed by the Review, Lieutenant Colonel Harding refers to legal advice he received but cannot assist with more details. He cannot recall the reasons why Skinner was not removed pending trial. As far as this Review can now reflect, what was, or should have been, known to the Commanding Officer were the following: the details of Skinner's history in Northern Ireland, the fact that Skinner admitted being in a trainee's block where he knew he should not have been, and the fact there was sufficient evidence to justify a Court Martial. It may be that the nature of the unsubstantiated incident in July 1997 could also have been taken into account in a risk assessment.
- 7.74 It is difficult to understand why, if Lieutenant Colonel Harding was so opposed to Skinner's presence twelve months previously, he would not have sought to have had him removed from the Training Regiment at the first opportunity once a formal complaint had been received, evidence obtained and formal proceedings instigated in pursuit of it.

(h) Conclusions on Skinner's prolonged stay at Deepcut

- 7.75 The Review is aware, from other cases of suspected abuse that will be considered in the next Chapter, that a Commanding Officer can, indeed, secure removal out of the Training Regiment at short notice by transfer out. If it was the depot function that inhibited or prevented such action in the case of a virtually unemployable senior soldier who was single and had no family, then this system posed a direct threat to the welfare of trainees at the time. The Review understands that it has now been reviewed. The depot function has been considerably reduced and those awaiting Court Martial, sentencing or dismissal following sentencing will remain with their unit, unless they can be transferred elsewhere other than Deepcut.⁷⁸ It may be that this has merely relocated the place of risk rather than controlled it. Although the Army may have a responsibility for housing its staff, this should not prevent it from being able to remove a person who is considered to be a risk to others, pending the outcome of disciplinary proceedings.
- 7.76 This Review recommends that consideration is given to where people who are reasonably suspected of being a risk to the welfare of trainees or others should be located pending decisions being taken on their future. Apart from the risk of re-offending, there is the risk that witnesses will be intimidated or discouraged, if suspects are not removed from the scene of the offence.⁷⁹

⁷⁶ 26th February 1998.

⁷⁷ See Appendix A4/6.046 A – C.

⁷⁸ See paragraph 4.67 above. See also Appendix A4/9.026 E – F.

⁷⁹ See Chapter 12 at paragraphs 12.83, 12.85 and Recommendation 21 (ii).

7.77 When he was interviewed by Surrey Police in 2003, Major M was insistent that the risk of Skinner's presence was not ignored but that it was thought that a warning as to his conduct and intense supervision in the gym, together with a belief that he was a reasonable man who would not let his officers down, were sufficient. He explained:

*"The risks that the system was taking on his behalf gave credence to his not guilty protestation. The Court found otherwise and our trust in his hoped for performance was betrayed."*⁸⁰

7.78 If, despite the concerns noted and the measures taken with regard to someone who was regarded as a potential risk to the Regiment, Skinner was able to offend so often there from shortly after his arrival, in the opinion of the Review, there was something very wrong with the system for protecting the welfare of trainees or the way in which it was implemented. It seems that the discharge of the duty of care was primarily dependent on the victims of abuse, with their varying vulnerabilities, making complaints and proving them to the criminal standard. That is not an effective strategy for prevention. The events described above explain why genuine victims may not complain against staff or their superiors.

7.79 It may well be that the depot function, as it then was, caused Skinner to be placed at Deepcut for some months. It seems difficult to imagine that a full assessment of the risks he presented was undertaken or the reasons for concern were adequately explained or recorded. The decision to allow Skinner to remain at Deepcut when an alternative posting had been found does not square easily with continued opposition to his presence. The decision not to call for his transfer out of the Training Regiment pending his Court Martial in February 1998 also seems inexplicable in the light of what was, or should have been, known. If fairness to Skinner's desire to stay at the Training Regiment required the Commanding Officer to suppress his concerns, that fairness needs to be more keenly balanced with a duty of care to young people, male and female, who were trainees and, therefore, all the more susceptible to abuse from those in authority.

(i) The return to Deepcut in August 1998

7.80 The failure to suspend Skinner and remove him from post before his Court Martial may have had consequences even after his sentence. Deepcut was not quite rid of him yet. On 27th May 1998, Skinner was released from prison having completed his sentence.⁸¹ It seems from the subsequent Surrey Police investigation that, on 12th August 1998, he rented a property in the Deepcut village opposite the Barracks. On 23rd August, Skinner was found drinking in the NAAFI in the company of a Lance Corporal in the RLC band, whom it was presumed had signed him onto the camp as his guest. The guard who discovered Skinner urged him to leave and made enquiries as to whether he was formally barred from entering the camp, including as a guest. The entry in guardroom daily occurrence log reads:

"... it appears that he is banned. If this is the case, then some action should be taken to prevent a recurrence."

⁸⁰ 24th July 2003.

⁸¹ Since Private AZ, Skinner's victim, was over 18 and the sentence was only 6 months' imprisonment, Skinner was not placed on the sex offenders' register.

- 7.81 Surrey Police discovered a final sexual contact by Skinner and a trainee between August and December 1998. This was between Skinner and Private AY, one of the undiscovered victims of the 1997 period, who has been quoted from at paragraph 7.68 above. There was a drinking session resulting in the Private being too late or too drunk to return to camp one night.

(j) The Surrey Police investigation in 2002 and the conviction

- 7.82 Skinner moved out of Deepcut in November 2000. He was living in Aldershot when he was arrested by Surrey Police, who, having been approached by Private AX,⁸² had decided to make enquiries of the friends of the known victims to understand the scale of the abuse. When photographs of the young trainees were discovered,⁸³ enquiries were re-opened into events from 1993, as well as into his activities at Deepcut. In September 2004, Skinner pleaded guilty to five indecent assaults on three soldiers. Five other counts were left on the court's files without adjudication. He was subsequently sentenced to four and half years' imprisonment on 22nd October 2004.

(k) The Army's internal inquiry

- 7.83 There are some postscripts to these events. First, the Army held an internal inquiry into these events in anticipation, no doubt, of unfavourable press reporting when the facts were known. The inquiry was concluded on 12th October 2004. It noted that the first Court Martial decision in 1996 had been referred to a military personnel officer in the MRO for risk assessment and re-evaluation of vetting, ensuring that sufficient information was available concerning Skinner's background to allow an informed decision to be made, but that insufficient consideration was given to the risk of attaching Skinner to 87 Squadron in the Training Regiment at Deepcut.

- 7.84 Despite this, it made a curious observation:

"... there was no failure in process that resulted in Skinner being posted to Depot & Trg Regt, RLC in Deepcut."

And concluded that:

"Skinner's attachment to the Depot and Trg Regt RLC was taken in adherence to recognised posting procedures."⁸⁴

The Review has not seen any evidence of an MRO risk assessment, only Major M's manuscript note, quoted above at paragraph 7.51. The Review cannot now be sure what input the Commanding Officer made into the process and what weight was attached to his concerns. There seems to have been no process adopted before Skinner arrived at Deepcut, and the conclusions that he could be best located in the gym seem remarkable. If the recognised procedures simply meant that problem cases went to the depot, then this hardly suggests an informed judgement was made. Either way, the conclusions are hardly reassuring.

⁸² See paragraph 7.65 above.

⁸³ *Ibid.*

⁸⁴ 12th October 1994.

- 7.85 The internal inquiry could not resolve who decided to post Skinner to Deepcut and whether this decision was taken with full recognition of the environment into which he was to be posted. It may be that the Army will want to review this conclusion in the light of Lieutenant Colonel Harding's and Brigadier Dalby-Welsh's accounts to this Review.⁸⁵ According to them, it was a decision forced on them by the MRO, despite the concerns expressed, due to the very nature of the depot function at Deepcut. Major M, at least, was aware of the substantive details of the potential risk.
- 7.86 The inquiry recognised that Skinner could have posed a risk regardless of where he was posted. That may be true, in which case he should have been administratively discharged after the 1996 Court Martial, and not left to drift into the depot. Although the inquiry thought that poor judgement was shown in assigning him to the gymnasium, it added the comforting conclusion:

*"Soon after arriving at Deepcut ex-Pte Skinner was employed in the gymnasium where he routinely came in contact with recruits. There is no suggestion that he acted inappropriately towards soldiers he came in contact with through his work in the gymnasium."*⁸⁶

This is not the case, as the extracts from the Surrey Police witness statements above show. Trainees were selected for sexual attention precisely because they worked or trained in the gym and had contact with Skinner. It may be that the inquiry was unaware of the full details taken by the civilian police. If it had been, it would have noted the additional information provided by Private AZ, the victim from 23rd August 1997 who reported Skinner to the chain of command, when re-interviewed by Surrey Police.

- 7.87 Private AZ stated that, after he reported Skinner to the RMP, there was a parade where the Sergeant-Major:

*"... announced to all that I was a fucking nut and deserved what had happened regarding the indecent assault. He said I was gay ... I went to his office after the parade and tried to obtain an apology from him. This was not forthcoming and I went to see the OC [Officer Commanding]. He said he would deal with it and not long after I got a posting order to go to Germany."*⁸⁷

If this is accurate, and there appears to be no reason why Private AZ's account should not be credible, it suggests that there was still some resistance to the proposition that Skinner was guilty of these offences. It should be noted that the Officer Commanding at this time was probably Major BA, who will feature in the next Chapter. Private AZ also adds a telling picture of the disciplinary regime at Deepcut at the time, that may be informative of the regime and needs to be considered alongside the evidence reviewed in the two previous Chapters:

*"At Deepcut as a Private you were treated as the lowest of the low and had to do as you were told. The Lance Corporals and Corporals were treated like God by the recruits. If they told you to do something you did it without asking questions."*⁸⁸

⁸⁵ As reproduced in Appendices 4/6 and 4/2, respectively.

⁸⁶ 12th October 1994.

⁸⁷ 12th May 2004.

⁸⁸ *Ibid.*

On the subject of punishments, Private AZ added:

*"Punishments were given thick and fast for any reason. This could range from having a crease in the wrong place of your shirt or not having your boots cleaned correctly. The punishments were not always justified and were sometimes given for the most petty of reasons. The punishments ranged from being frog marched around the drill square, extra guard duties, restrictions of privileges, fines and jail. The army say the punishments are character building and encourage discipline within the ranks. Because of these punishments, the recruits did as they were told without question."*⁸⁹

- 7.88 All this suggests that the reforms proposed in the Evans Report in December 1995⁹⁰ had either not been fully understood, or brought into effect, or were otherwise not being applied in practice. The events of the next Chapter will assist in this evaluation.

(iii) 'Out of bounds' activities in 1997

- 7.89 As has been seen from Chapter 6, as well as from the incident described earlier in this Chapter,⁹¹ trainees being found in out of bounds accommodation was a fairly regular occurrence at Deepcut. The guardroom daily occurrence logs during this period suggest that the issue of being 'out of bounds' – caught in the male or female blocks – was not always, in practice, considered one that merited serious punishment. Extracts taken from the daily occurrence log from the guardroom, identified by the Review team, for two dates in 1997, illustrate this point. The first, dated 21st March 1997 at 01.00hrs, states:

"Sir, at the time and date stated, a [Private(f) ...] of 86 Squadron came to the guardroom with a civilian female, [Private(f) ...]'s cousin, to say that three soldiers, male, who she did not recognise were trying to gain access to the female accommodation. After hearing what [Private(f) ...] said, I went over to where the accommodation was and found three male soldiers near the small annexe by the female accommodation. I immediately told them they should not be there and told them to go to bed, which they did. The three soldiers concerned were on a basic Storeman's course. Prior to this [Private(f) ...] asked the soldiers what they were doing near the female accommodation. She was given verbal abuse as was her friend, who is a civilian. I told [Private(f) ...] that if she wished to make a complaint to come to the guardroom and speak to the Provo Sergeant. On looking at the course personnel, I looked through the list and found the three soldiers from the description given by [Private(f) ...] and what I saw, they are [Corporal ...], [Lance Corporal ...], [Rifleman ...]..."

The Review would point out that, while it was appropriate to ask the female Private whether she wanted to make a complaint about abuse, the males were, in any event, attempting to commit an offence by entering the female accommodation in the early hours and that offence should have been pursued, regardless of the view taken regarding the alleged verbal abuse. The threat to female trainees by males in the female block need

⁸⁹ *Ibid.*

⁹⁰ As reproduced in Appendix 11 to this Report.

⁹¹ See paragraph 7.22 above. See also paragraphs 4.89–92, 6.9, 6.129 and 7.16 above.

hardly be emphasised here in the light of the events described earlier in this Chapter. This entry also appears to confirm that the visiting of the female block by NCOs attending courses at Deepcut was an issue of concern.⁹²

- 7.90 The second date of interest is 3rd May 1997. The events are described in three entries in the guardroom daily occurrence log. The first entry, timed at 03.45hrs, states:

"Sir, at the time and date stated myself and [Staff Sergeant 1] found four males in the female block (16A) TV Room. [Corporal 2] was one of these males.

Action taken – Male personnel told to leave female block and females told to go to bed."

The next entry, at 04.00hrs, states:

"Sir, at the time and date stated, 04.00hrs, after seeing males enter block (16A) myself, [Staff Sergeant 1] and [Private(f) 3] made a thorough search of block (16A) but found no male personnel present.

Action taken – NFTR [Nothing Further to Report]."

The third entry, at 04.25hrs, states:

"Sir, at the time and date stated 04.25hrs, myself and [Staff Sergeant 1] started to make a search of the male accommodation. On entering the second floor of block (11C) we heard noises that were definitely compatible with that of sexual activity in [Corporal 2]'s bunk.

Action taken:

1. *[Staff Sergeant 1] made his presence known and ordered the occupants to leave the room*
2. *Female occupant of the room was [Private(f) 4] of St.Omer Barracks, Aldershot. The male occupant of the room was [Corporal 2], 86 Sqn, RLC.*
3. *St.Omer Barracks informed that [Staff Sergeant 1] was returning [Private(f) 4] to their unit."*

- 7.91 These entries were the subject of discussion with Lieutenant Colonel Harding when it was pointed out that there was no evidence of a follow-up interview in his discipline book with the Corporal concerned.⁹³ It may well be that the matter was dealt with by the Officer Commanding, whose interview book is understood to have been disposed of in accordance with document retention policies. If so, this suggests that out of bounds activities by a Corporal was being dealt with at Officer Commanding level rather than by the Commanding Officer, and thus engaged a lower level of sanction.

⁹² See paragraph 7.24 above.

⁹³ See Appendix A4/6.022 B – D.

The assessment of Lieutenant C

7.92 The Review's concerns about how the Army selects and promotes its officers and NCOs for Training Regiments are reflected in events dealing with the career of Lieutenant C, one of the Troop Commanders at Deepcut in 1995. His connection with the circumstances surrounding the death of Sean Benton and his alleged fraternisation with female trainees have already been the subject of discussion in Chapters 5 and 6, respectively.⁹⁴ In interview with this Review, Lieutenant Colonel Harding also gave a frank and unfavourable assessment of this officer and his alleged dealings with female trainees.⁹⁵ From what follows, it is apparent that, notwithstanding his comments in interview with this Review, any concerns Lieutenant Colonel Harding may have had at the time could not have been foremost in his mind. At the time of the meeting, Lieutenant C's personnel file had not been seen by the Review. When it was subsequently examined, it revealed a striking contrast in the assessments of his performance. Lieutenant C was a short service commission officer whose Army service was due to end in August 1996 unless a senior officer recommended an extension.

7.93 After modest confidential reports from his original Commanding Officer, Lieutenant Colonel Josling, and his Commander, Brigadier Evans, Lieutenant C was the subject of a very frank assessment by Brigadier Evans in October 1995. This was shortly after the events leading to the departure of Regimental Sergeant-Major Z. Brigadier Evans wrote:

*"I no longer have any trust or confidence in this officer and I recommend he leaves the Army in August 1996."*⁹⁶

7.94 The MRO subsequently wrote to Lieutenant Colonel Harding on 23rd April 1996 indicating that a second request for a three-year extension to Lieutenant C's short service commission could be made but would be likely to fail in light of the previous comments made by Brigadier Evans, unless Lieutenant Colonel Harding could demonstrate a marked improvement in Lieutenant C's performance which would have to be strongly supported by Brigadier Dalby-Welsh. The letter also stated that the Brigadier would also need to be made aware of the background to Lieutenant C's case. Lieutenant Colonel Harding and Brigadier Dalby-Welsh did, indeed, write in sufficiently strong terms, expressing surprise that Lieutenant C's service had not been extended and how his services were valued in the unit. Lieutenant Colonel Harding wrote the following:

"Lt [C] has been under my command for 6 months. I have had the opportunity to watch his work closely as a stand in for my Adjutant. I find him mature and responsible able to handle many of the complex issues thrown at him both professionally and sensitively."

*"As a Troop Commander he is a sensitive but firm leader who readily accepts advice and guidance. A pleasant personality who takes a full and active part in all his Squadron and Regimental activities. Lt [C] is a contributor and an asset to the Regiment. I would gladly retain his services. I am surprised that he has been unable to achieve an extension of his commission to date and thoroughly endorse his wish to do so."*⁹⁷

⁹⁴ See paragraphs 5.63 and 6.160 ff above.

⁹⁵ See Appendix A4/6.025 E – 027 A.

⁹⁶ 11th October 1995.

⁹⁷ 24th May 1996.

- 7.95 The commission was duly extended and, in December 1996, Lieutenant C left Deepcut for service in another Regiment. He was clearly not a success. His personnel file contains an assessment of his performance by his new Commanding Officer which, in a world of carefully crafted assessments, is brutally frank. Having outlined Lieutenant C's apparent inefficient and general poor performance, he concludes as follows:

*"My greatest concern though is his stating falsehoods. This habit attempts to mask failures to comply with instructions or routine and fundamentally undermines my trust in his actions and judgement. His practical performance is well below that required. He demonstrates crass management and I detect an arrogant and cavalier behaviour towards soldiers. Furthermore he appears to consider himself above the norms and behaviours expected from commissioned officers."*⁹⁸

*"Throughout the period he has been given counselling and a record of those recommendations and his actions has been made. Notwithstanding his warning and fresh start, his performance has not improved. Through a combination of inefficiency and falsehoods he has lost my trust, and more importantly, that of the soldiers. Although to his credit he has recently admitted to stating a falsehood, I have no confidence that this character defect will not be repeated at some time in the future. I consider him to be over-faced as a field force squadron Second in Command/Administrative Officer and I am not prepared to take him on the Regiment's forthcoming deployment. Additionally, I recommend that he should not be employed further!"*⁹⁹

- 7.96 This material prompts two reflections. First, the Review asked Lieutenant Colonel Harding why he supported the extension of a short service commission in the light of his unfavourable opinion, stated in interview with the Review, of this officer. He replied that while he opposed a transfer to a regular commission he did not think he could oppose an extension to Lieutenant C's short service commission.¹⁰⁰ He had no recollection of seeing Brigadier Evans's previous comments or raising them either with Evans or his own Brigadier before compiling his report. From the letter from the MRO to Lieutenant Colonel Harding, discussed at paragraph 7.94 above, the Review is satisfied that they must have been brought to his attention. This suggests that the process of reporting on officers may not ensure a rounded assessment is delivered. A culture of euphemism and disguising genuinely held views by the platitudes of confidential assessments may not be the most effective means of identifying quality in NCOs and young officers alike. As noted at paragraph 6.168 in the last Chapter, in correspondence with the Review, Lieutenant C has been frank in his assessment of his own suitability for posting to a Training Regiment. He has also pointed out that he was promoted to the rank of Captain and has queried whether the issue really is as fundamental as: *"Is the system making a huge mistake ...?"*
- 7.97 Secondly, taking all that the Review has seen or heard about Lieutenant C alongside the observations made earlier about Lieutenant(f) A,¹⁰¹ it suggests that in 1995, in all probability, B Squadron of the Training Regiment at Deepcut did not benefit from the most effective Troop Commanders at a time and place where good quality commanders were probably very important to redress the risks that the system was generating.

⁹⁸ 25th August 1997.

⁹⁹ 13th June 1997.

¹⁰⁰ See Appendix A4/6.025 F – G.

¹⁰¹ See paragraphs 6.169 – 174 above.

8 Deepcut from 1998 to 2000

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Change of command

- 8.1 Lieutenant Colonel Harding's tour of duty as Commanding Officer of the RLC Training Regiment and Depot (the Training Regiment) ended in October 1998 and he handed over command to Lieutenant Colonel Govan, who was Commanding Officer until June 2001. In January 1999, there was a change of Commander when Brigadier Brown took over from Brigadier Dalby-Welsh. The Review has benefited from conversations with all the above and this Chapter of the Report drawn in part from those conversations.¹
- 8.2 In 1998, ATRA's 'Code of Practice for Instructors'² was published that spelt out the standard of conduct to be expected from instructors. In preparation for the Review's meeting with Lieutenant Colonel Govan, the case of a Sergeant BB first came to light. Subsequent papers provided by the Royal Military Police (RMP) and the Army Legal Services have enabled the Review to reconstruct allegations, investigations and actions taken in respect of Sergeant BB that provide an informative account of the treatment of trainees and practical aspects of the discharge of the duty of care. The case of Major BA also formed the subject of discussion with Lieutenant Colonel Govan³ and some RMP papers in respect of Major BA have been helpful in obtaining an overall picture.

Issues of concern

- 8.3 In the opinion of this Review, there are five issues that emerge from this material:
- (i) the continuing manpower shortages to effect a supervisory regime at Deepcut and the Army's response to these concerns;
 - (ii) the selection and training of officers and NCOs concerned with the training, supervision and welfare of trainees at Deepcut;
 - (iii) the use of informal punishments by NCOs;
 - (iv) the definition of unacceptable conduct by soldiers and the means to deter it; and
 - (v) the efficacy of investigations into allegations of abuse and misconduct, and decisions taken in respect of them.
- 8.4 The material relating to the first issue will be discussed further in the next Chapter. Examples of events between 1998 and 1999 informing the Review as to the other four issues will be considered in this Chapter. Pursuant to its policy explained in Chapter 1, all parties to these events will remain anonymous.
- 8.5 Unlike the vast majority of the allegations contained in Surrey Police's Duty of Care Schedules,⁴ these matters were the subject of a contemporaneous investigation and determination by relevant agencies. No one was successfully prosecuted. Notwithstanding this, the Review considers that there is a considerable public interest in noting this material and commenting upon it to achieve a fuller understanding of the experience of some trainees of the Phase 2 regime at Deepcut during the period in question and the problems in safeguarding their welfare.

¹ The transcripts of the conversations this Review had with them are reproduced in Appendix 4 to this Report.

² Published as Annex A to Serial 1 ('ATRA Employment Charter') of the ATRA Handbook, July 1998. ATRA's Code of Practice for Instructors superseded the Army Individual Training Organisation's (AITO) Code of Practice.

³ See Appendix A4/5.015 D 016 F.

⁴ See Appendices A5 and A6.

Major BA

8.6 In 1997, Major BA was appointed as the new Officer Commanding 86 Squadron to replace Major N, who, as described in the previous Chapter, was prematurely removed from post having lost the confidence of his Commanding Officer. Major BA was also to leave his appointment early as a result of his handling of an incident in December 1998, the circumstances of which are described below. Major BA's Commanding Officer, Lieutenant Colonel Govan, told the Review that, on taking up his command, concerns had been expressed to him by Lieutenant Colonel Harding about the efficiency of this officer, who was crucial to the welfare of Phase 2 trainees.⁵ It was not long before those concerns were to manifest themselves.

(i) Indecent assaults on 10th December 1998

8.7 On 9th December 1998, there was a Christmas social function at Deepcut. There was a dance and alcohol was consumed. After midnight there was a sequence of events in the women's accommodation that further illustrate the Review's concerns for the physical safety of female trainees at the time. Given the accounts described in the previous Chapter, male access to the female block was doubtless highly predictable. The guardroom daily occurrence logs for 1998 contain numerous entries of reports of out of bounds activities in the male and female trainees' accommodation blocks. It would appear that little had changed from 1996.⁶ With the limited resources available, all that could be done was occasional patrols by the Regimental Provost (RP) staff.

8.8 In the early hours of 10th December 1998, Major BA and the RP staff conducted an inspection of the female accommodation block. The ease with which such inspections could be evaded is demonstrated by the material subsequently recorded. A Private BC obtained access to the female block to visit his girlfriend but was warned by her that he should return later as Major BA and his team were patrolling. Private BC subsequently returned later to spend the night there. When Private BC entered the premises through the front door he noticed an unidentified soldier in a blue checked shirt following him into the female accommodation and subsequently hanging around.

(ii) The reporting of the indecent assaults by the complainants

8.9 The following morning, four separate female trainees were to complain to their NCOs about a series of indecent assaults committed in the early hours when a man entered their separate bedrooms and put his hand under their bedclothes and indecently touched them while they slept. When challenged, the man claimed to be looking for a woman he identified by a first name and said that he had made a mistake with the room. These events happened in the dark and none of the women were able to give a complete description of the assailant. There was, however, a strong inference that there was one assailant using the same story to explain his presence when challenged. The names of the woman supposedly being sought, and the actions in touching each woman's body without checking who she was, were similar in each case. It will be noted that this incident is strikingly similar to the incident of 22nd July 1996 discussed in the previous Chapter.⁷

⁵ See Appendix A4/5.015 E.

⁶ See paragraphs 7.16 and 7.89 ff above.

⁷ It should be noted that the suspect in that incident, Lance Corporal AV, left the Army voluntarily in January 1997.

- 8.10 In the morning, one of these female trainees, Private(f) BD, and one of her roommates found the military ID card belonging to a male soldier, Private BE, in their bedroom. Private(f) BD handed the ID card to a Corporal at about 08.30hrs that morning. She states she mentioned the assault at the same time. The Corporal understood that the complaint was merely about an unauthorised intruder and not that she had been indecently assaulted. The Corporal in turn handed the ID card to his Sergeant.
- 8.11 Meanwhile, early the same morning, Private BE, who had been wearing a checked shirt the previous evening, was seen outside the female accommodation block asking for help from a female trainee in retrieving his ID card that had been left in the female's block. He had some difficulty identifying which room he had visited. Private BE then made his way to the Squadron office. Major BA was there and asked him whether he had been in the female accommodation. He replied 'no' but that his girlfriend had left the ID card in her room. At that time, Major BA had now heard of at least one complaint but thought that it related to an 'out of bounds' incident, rather than a sexual assault, and ordered the ID card to be handed back to Private BE.
- 8.12 Between 09.00 and 10.00hrs, all four female trainees assaulted the previous night made complaints to their NCOs. At this point in the narrative, there is a sharp divergence of accounts. Two of the complainants state that they approached Major BA out on his rounds and complained of an assault. Major BA asked if the female trainees could identify the assailant. They allege that Major BA pulled a male trainee, Private BE, out of a line and asked whether he was the man from the night before. When they could not make a positive identification, he then said that there was nothing more he could do. Private(f) BF, a roommate of Private(f) BD, who was aware of the finding of the ID card, states she overheard a conversation between two female trainees and Major BA about the identity of an assailant and attempted to intervene with the information she could add about the identification card. She says that Major BA was dismissive of her information.
- 8.13 When interviewed, Major BA stated that the women never complained to him of assault. He stated he was aware of the allegation of a male intruder and that the third woman, Private(f) BF, intervened in an insubordinate way and so he sent her to her Troop Sergeant to be disciplined for insubordination. Corporal(f) BG's recollection is inconsistent with Major BA's account. She saw Private(f) BF walk away from Major BA and recounts the following:

"I clearly heard [Major BA] shout at her, 'Don't give me your attitude, don't walk away from me' and whilst doing so, he was pointing at her and was visibly angry and red faced. As [Private(f) BF] turned to face him, I saw that she was crying. I saw her mouth, 'I'm sorry Sir.' I walked out of the office to intervene at which point I heard [Major BA] shout, 'Get upstairs,' I took this to mean for her to report to 1 Tp offices.

"I returned to the office, as [Major BA], still visibly irate, entered the office, followed by [Private(f) BF] who was still crying.

"[Major BA] then said, '[Corporal(f) BG], fucking deal with her.' I asked what she had done, to which he replied, 'She walked away as I was telling her that they couldn't fucking identify him.' [Major BA] then left the office. I was left bemused by what had happened."⁸

⁸ 11th December 1999.

(iii) The delay in calling in the Royal Military Police

8.14 There is a further difference of recollection between Major BA and the Troop Sergeants, who both state they informed Major BA that the incident was serious and that the RMP needed to be called. Their account was that Major BA responded that this should wait until he got changed and returned to the office. The NCOs nevertheless reported the matter to the then Regimental Sergeant-Major⁹ who briefly spoke to the complainants and promptly called in the RMP. Major BA was unhappy about this but the Regimental Sergeant-Major explained the need to act swiftly. Major BA said, in his subsequent RMP Special Investigations Branch (SIB) interview, that it was only when he spoke to the Regimental Sergeant-Major that the seriousness of the incident became apparent. He denied he had arranged a confrontation with a suspect.

(iv) The Royal Military Police investigation and actions of Major BA

8.15 As a result of the RMP SIB's concerns at the way Major BA had acted in response to this incident, he was suspended from duty on 18th December 1998 by his Commanding Officer and transferred out of the Training Regiment. At the end of the SIB investigation, the legal branch recommended that no disciplinary charges of conspiracy to pervert the course of justice, or neglect of duty, or disobedience to unit standing orders should be brought against Major BA. There was no evidence of conspiracy to pervert the course of justice but, in the opinion of this Review, a *prima facie* case of neglect of duty. The reason for the recommendation at the time was that there was room for confusion as to what Major BA understood was the essence of the female trainee's complaints, the time at which he first understood that an indecent assault allegation was being made and the fact that the evidence might reveal that he merely delayed, as opposed to refused, to call in the RMP. Instead, Major BA received an informal rebuke.

8.16 The RMP subsequently conducted an identification parade where three of the four female trainees and Private BC, the boyfriend in the accommodation block on the night in question, failed to make an identification of Private BE. One complainant did identify Private BE but, on her account, she had been party to the confrontation of a suspect arranged by Major BA when he had pulled a male trainee out of a line. It seems that the RMP concluded that the subsequent identification by this assaulted trainee of Private BE at an identification parade could not be relied on and he was never prosecuted for any of these assaults. This is a highly unsatisfactory outcome for what looks like both a sequence of extremely unpleasant sexual assaults by touching and a failure by the Officer Commanding of the Squadron, Major BA, to obtain a coherent account of the complaint and then take the necessary action of calling in professional investigators. It is difficult to see how the identification of Private BE by one of the complainants could be considered tainted by Major BA's attempted confrontation, and yet, at the same time, there be insufficient evidence to contradict Major BA's account to the RMP that he had not arranged a confrontation.

(v) Conclusions on Major BA

8.17 For this Review, this incident raises persistent questions as to the way the Training Regiment delivered on its duty to take reasonable measures to protect trainees generally, and female trainees in particular, from sexual assault and harassment.

⁹ The Regimental Sergeant-Major at the time is not one of those previously discussed in this Report.

- 8.18 The Review is concerned as to the efficacy of the practical measures to give effect to discharge this duty. The continued absence of video camera monitoring of the female block – three years after the recommendations of Board of Inquiry (BOI) convened into Cheryl James’s death,¹⁰ two and a half years after the indecent assault of Private(f) AT, noted in the previous Chapter,¹¹ and after innumerable incidents of ‘out of bounds’ activities were reported in the interim – is a matter of regret. On the striking facts of the allegation briefly summarised above, where the investigators had the good fortune of the finding of the ID card of the suspect in the bedroom of one of the victims of the assaults, one would have thought that the prospects of successfully bringing charges for all four assaults were rather strong, and the public interest in doing so overwhelming.
- 8.19 Once again, as was alleged with Major N and the investigation of the indecent assault of Private(f) AT in the previous Chapter, an amateur investigation by the Officer Commanding 86 Squadron, in this case Major BA, delayed the calling in of the RMP, appears to have contaminated valuable evidence and damaged the prospects of a disciplinary conviction, and, thus, failed to provide a deterrent to future offenders. Moreover, it is a matter of concern that, had not the RMP raised such concerns as to Major BA’s judgement that he was removed from post, Private(f) BF might have been subject to disciplinary sanction for insubordination in trying to point out to Major BA that there was cogent evidence of identification, irrespective of the inability of the complainants to see in the dark.
- 8.20 For this Review, the conduct displayed by Major BA throws doubt both on the quality of training or guidance he may have received to take on this challenging post and his personal competence to undertake it. It is not unreasonable to have hoped that by 1998, with the deaths of two trainees, the Evans Report and the other matters noted previously, that the authorities in the Royal Logistic Corps (RLC) and the Manning and Records Office (MRO) would have been particularly astute to find officers and NCOs of high calibre to undertake this demanding function. This did not appear to have been the case with the selection of this officer as Officer Commanding.

(vi) The Duty of Care in practice

- 8.21 In his RMP SIB interview, Major BA acknowledged the duty of care owed:

“I have a duty of care and especially to under 18s of which I have got quite a few ... if anything goes wrong, I must inform their parents.”¹²

The interview also reveals the practical situation on the ground at the time in relation to other aspects of the duty of care, such as alcohol abuse and the need for supervisory manpower. It does, again, suggest that little had changed since the recommendations of the Evans Report in December 1995, and, indeed, the pressure of increased numbers of trainees had aggravated matters, although Major BA believed incidents of self-harm had gone down *pro-rata*:

“... my one concern with so many – and I need to make this clear – when I first took over the Squadron and, and again the SIB were called or RMP were called in, I had up to four, I wouldn’t call it – ‘suicide’ is a terrible word – ‘cries for help’ a week, a week subsequently and that was with 350 soldiers I now have 1,200 and it’s gone down to one or two and I am

¹⁰ See Appendix A10.015. See paragraph 41(e). See also paragraph 6.79 above.

¹¹ See paragraph 7.22 above.

¹² 2nd March 1999.

*continuously on the ground. I, I leave my office, my 2 IIC deals with the computer side of the course of trades. Everyday when I get into work I look at the sick parade and I ask them how they're feeling. I then go down to the Med Centre, to the NAAFI. I continued to wander up into the Troop Offices. I get the kids on the ground, sorry, the soldiers on the ground – that's a bad habit of mine – I speak to them, they then say to me, 'Sir this happened last night, that happened last night.' 'This girl you'll have to watch may have taken some pills last night'."*¹³

8.22 As to alcohol, Major BA disclosed the following:

"Alcohol is a bad problem within my Squadron. We have a club, a fantastic club, however, with the numbers and the availability of the club, when there's, it's difficult, there's not much for them to do on night times but gather in the NAAFI or Route 66 ... and they do drink quite a lot, and I have, although that it has been open until 11 o'clock, I get my staff, my Sergeant Major, to ensure at 10 o'clock on most occasions, we kick them out during the week. At the weekend they are at liberty because I can't contain their liberty but that's my decision, 10 o'clock."

8.23 When asked how he is able to monitor which trainees are over 18 and therefore allowed to drink, and which are not, Major BA replied:

*"That is, it's a problem I've been trying to solve over the, the period I've been here. Either the NAAFI staff who have a responsibility as well to look at somebody who's young and say have you got an ID card. I've been trying to work out some form of system where they have to have a colour card or something to say that ... but it's extremely difficult to do because if they don't, sadly it, it's easier to keep them on camp in the NAAFI because there is some form of control because I have a Duty NCO in there, than let them run say footloose in Camberley or Frimley and then, then they do ... cause hassles."*¹⁴

These comments reflect the picture of Deepcut described in the Evans Report in 1995 and elsewhere in this Report: young people, self-harm, abuse of alcohol, insufficient facilities to stimulate them and inadequate staff numbers to supervise them

Sergeant BB¹⁵

(i) Arrival at Deepcut in January 1998

8.24 Sergeant BB was posted as a training Sergeant to Deepcut on 19th January 1998 for a three-year tour. He was clearly an able soldier who demanded the highest standards, although whether he was the most appropriate choice for the sensitivities of a Phase 2 Training Regiment may be open to doubt in the light of the assessment of his previous Commander on his last confidential report, written nine days before Sergeant BB arrived at Deepcut. Having stated that Sergeant BB was motivated and kept high standards, the assessment continued:

¹³ *Ibid.*

¹⁴ 22nd March 1999.

¹⁵ This is not the same person as Sergeant B described in Chapters 5 and 6. He had left Deepcut long before the events to be described.

"That said, his confidence is often unjustified and he is intolerant of opinions which differ from his own. This has led to clashes which are not limited to his subordinates. As a result his actions and manner are not always an asset.

"[Sergeant BB] shows great loyalty to those he considers worthy of such but is begrudging of his support to those he considers unworthy. This has manifested itself in 'writing off' subordinates and actions bordering on insubordination to officers."¹⁶

- 8.25 The Review is aware that, not infrequently, a candidate is assessed for a posting without the benefit of the most recent, or updated, confidential report.¹⁷ In fairness to Sergeant BB and the MRO, it should be pointed out that Major BA held a high opinion of him. In Sergeant BB's first, and only, confidential report from Deepcut, Major BA wrote, on 21st October 1998:

"He has up to 300 Phase II in his Tp at any one time. His responsibilities include the welfare, discipline, training and administration of this large number of both male and female soldiers. He has carried out all his responsibilities with outstanding success ... robust character who approaches his work in a positive and dynamic manner ... has had an exceptional year. I rate him as the best SNCO in my Sqn."¹⁸

Lieutenant Colonel Harding countersigned this assessment with a favourable report, noting that Sergeant BB's:

"... leadership style is robust yet fair and considerate and has therefore gained the confidence and respect from the trainees in his charge. His appearance and bearing are first class and he is a first class example to the junior soldiers."¹⁹

- 8.26 From the subsequent RMP investigation that was to occur, it would appear that it was at about this time that the first evidence of overly robust behaviour by Sergeant BB began to emerge. This Review will present the material in chronological order,²⁰ although the statements supporting it came to light later and in a different sequence.

(ii) Private(f) BH

- 8.27 Private(f) BH was a female soldier attached to 1 Troop of 86 Squadron in 1998. She made a statement to the RMP in August 1999. Private(f) BH described her first encounter with Sergeant BB in November 1998 as follows. For no apparent reason he came up to her and said:

"So you think you are hard,' I did not respond he then said, 'You think you are special, well I'll knock your fucking head off!"

¹⁶ 10th February 1998.

¹⁷ This has been noted in relation to Regimental Sergeant-Major Z in Chapter 6, see paragraph 6.133 above.

¹⁸ 21st October 1998.

¹⁹ 21st October 1998.

²⁰ From November 1998 onwards, although one complainant's account reaches back to May 1998, see paragraph 8.35 below.

"I then said, 'You've just threatened me, you can't threaten me. I'll make a complaint against you.'

"He responded by ordering me to put my heels together when I spoke to him and told me that we could go to the guardroom and then the OC's [Officer Commanding] Office if I wished to make a complaint. He then told me to get lost."²¹

- 8.28 Private(f) BH then went to see her Troop Sergeant, who subsequently went away. She recounted what he said on his return:

"He told me that he had spoken to [Sergeant BB] and that if I still wished to make a complaint against him, I should know it would affect my career. He said that the RLC was like a close-knit family and I could become known as the one who got a Sergeant sacked.

"Despite this, I persisted with my complaint and I got an interview with the 1 Troop Comd, ...

"[She] said she would make a note of the incident, but persuaded me not to make an issue of it. I was satisfied with that at the time."²²

- 8.29 A little later that day, Private(f) BH was told to parade in the office for briefing about participation in the RLC contribution to the Lord Mayor's Show. She was apprehensive about this, as she was aware that Sergeant BB was in charge of the group. Her statement continues:

"I entered the office and tried to stay at the back out of [Sergeant BB]'s way. However, he saw me and called me out to the front saying not to be so 'pathetic'. I felt myself start to cry, so I turned to walk out of the office. I did not ask permission and I heard [Sergeant BB] shouting.

"I did not look back, but as I reached the door, I heard and saw a white mug smash against the wall next the door. It smashed at shoulder height, just about one foot to my left. The mug still had tea in it as it hit the wall and I realised that the mug had been thrown at me. I did not see the person who threw the mug but I know [Sergeant BB] had been drinking from a similar mug just seconds earlier. Again I was frightened and I began to run. When I got down the first flight of stairs, I realised I was being pursued.

"I saw [Sergeant BB] being pushed up against the wall by [Lieutenant BI]. They almost barged into me on doing this. I could see [Sergeant BB] was angry from his expression and that he was struggling to free himself from [Lieutenant BI]. He shouted something like 'Don't ever fucking walk away from me'. "²³

- 8.30 The Review has seen subsequent witness statements from Lieutenant BI and a number of others present in the office on this occasion, all of whom confirm that Sergeant BB threw a mug at the retreating Private(f) BH, and that he was very angry and had to be physically restrained. Private(f) BH's statement continued that Sergeant BB then came into the office where she was speaking to her Corporal and started up again:

²¹ 11th August 1999.

²² *Ibid.*

²³ *Ibid.*

*"[Sergeant BB] said words to the effect of, 'Your tears don't, wash with me, you are pathetic.' This was interrupted though by the entrance of [Lieutenant BI]. [Sergeant BB] left the office, and then [Lieutenant BI] began to sing his praises. The officer did not mention the incident with the cup, but rather the earlier incident. He said, '[Sergeant BB] did not mean it, when he said he would knock your head off, it's just like something I would say to get you to run up a hill.' He finished this interview by saying 'that's enough of that incident, on your way'."*²⁴

- 8.31 Lieutenant BI was interviewed in due course and, having confirmed he witnessed the cup being thrown, said as follows:

"I followed quickly and found them on a half landing close by. [Sergeant BB] was stood very close to [Private(f) BH], shouting at her about what she had just done. He was speaking again about her being a soldier and how she had to follow orders. Although I agreed with his sentiments I was very much aware that the SNCO [Senior NCO] was angry and perhaps overbearing in this case. I stepped between [Private(f) BH] and [Sergeant BB] in order to calm things down. I ordered [Private(f) BH] to go to Sqn HQ, and [Sergeant BB] to return to the Troop office.

*"I subsequently spoke to both individuals about their conduct, although not in a formal capacity. I reminded [Sergeant BB] that [Private(f) BH] was not a member of 2 Troop and therefore disciplinary action should be initiated through her chain of command. I also cautioned him as to his temper and aggression, which he had just demonstrated. I told him I would not support or tolerate any future displays from him. I believe I briefed Lt [...], 1 Troop Comd, about this incident. I took no further action though as I did not believe it was warranted."*²⁵

- 8.32 It would, thus, appear that none of these matters were brought to the attention of the Officer Commanding the Squadron or the Commanding Officer of the Training Regiment. No formal sanction or rebuke was issued to Sergeant BB for his verbal abuse, his intimidating manner and behaviour towards a female trainee on three occasions on the same day. This was so although there was clear evidence of his violent acts, his loss of temper and conduct undermining the complaint system.

- 8.33 Of further relevance to the overall themes of this Review is Lieutenant BI's response when asked about the discipline system at Deepcut at the time:

"I have to say that due to the large number of trainees and limited staff that [Sergeant BB] and the JNCOs under him ... had a good deal of autonomy where punishments and disciplinary action was concerned. To my knowledge [Sergeant BB] used the following methods to maintain discipline: extra duties, show parades, in-nights and physical punishments.

"At the time within 86 Sqn RLC both Troops had a responsibility to provide manpower for guard duties on a constant basis. The lists of those for guard would therefore be a routine administration task conducted by the Troop Admin NCO and I know that individuals would often be added to these lists at the whim of the Instructors. It was normally the case that excused from guard was a reward for hard work and that selection for

²⁴ *Ibid.*

²⁵ 10th August 1999.

*guard was a punishment for a minor offence which was not serious enough to warrant an interview with myself or 'OC's' orders. I considered this to be a fair method and I did not feel it necessary to endorse or question this policy."*²⁶

This account of what a Troop Commander in 1999 considered acceptable conduct by a training sergeant, may throw some light on similar complaints reviewed in Chapter 5 as to the use of guard duty as a punishment. It suggests that that both in 1995 and 1999 training Sergeants had very considerable discretion, unsupervised by Troop Commanders, as to informal sanctions and the way they treated soldiers under their command. It would appear that little had changed since 1995, despite reports, reviews and the ATRA Code of Practice for Instructors.²⁷

(iii) Private(f) BJ

8.34 In December 1998 another female trainee, Private(f) BJ, sought to make use of the official welfare system to voice her concerns at the way she had been treated and first spoke to a Sergeant in the Army Welfare Services (AWS) about abuse she had suffered at the hands of a, then, unnamed Sergeant. There were three subsequent meetings and calls to the AWS in December 1998 and January 1999, when she was reluctant to make a formal complaint. Private(f) BJ was joined in some of these meetings by a male trainee, Private BK, who had allegations of his own to make that were causing him concern. Private(f) BJ only had the confidence to make a formal complaint in February 1999, by which time a third trainee, Private BL, had joined the pair in approaching the AWS.

8.35 When it eventually emerged in her witness statement, Private(f) BJ's complaints against Sergeant BB were as follows. Until May 1998, Private(f) BJ had been impressed with Sergeant BB as a good and helpful Sergeant. In that month she was called to his office alone where the following occurred:

"Once alone, [Sergeant BB] surprised me by saying words to the effect of 'I fucking hate you [Private(f) BJ], head or guard?'"

"No words had been spoken prior to this and so I was shocked by his words. I did not have a clue why he said what he said. At the time I did not understand what [Sergeant BB] meant by 'head or guard'. I was stood approximately 1½ metres directly to the front of [Sergeant BB] and replied 'Pardon?' as I was unsure of the conversation."

"At this, [Sergeant BB] took a step forward, closer to me, within arm's length. I watched as [Sergeant BB] raised and pulled back his left arm, his left fist was clenched, his arm then moved towards my face and his clenched fist struck the right side of my face, in the area of my lower jaw."

"The impact hurt the right side of my lower face and jaw, and the result of the impact caused me to stumble backwards and fall onto the ground. I fell backwards and landed on the floor, sitting on my bottom. I was still facing [Sergeant BB]. At this point I was scared of the SNCO, I thought he might hit me again. I did not say anything whatsoever to [Sergeant BB], however, I stood up and moved backwards out of arm's reach. [Sergeant BB] then said words to the effect of 'Get the fuck out of my office'."

²⁶ *Ibid.*

²⁷ See paragraph 8.70 below.

*"I immediately left his office. I did not have a clue why the SNCO had hit me and I am still unaware as to his reasons. [Sergeant BB] never explained at the time and has not done since."*²⁸

- 8.36 In light of subsequent evidence that emerges about Sergeant BB's idiosyncratic methods of administering discipline, there may be room for confusion as to whether he was offering Private(f) BJ a choice of location for the punch between head or 'gut' or a choice between a punch and extra guard duty. Other informants suggest that both choices were regularly offered.²⁹
- 8.37 In any event, Private(f) BJ's statement suggests that this incident was the start of a campaign of abuse of the most unpleasant variety. She continued:

"After this incident with [Sergeant BB], the name-calling started, it was not on a daily basis, but usually every time I saw him. Due to being on different courses I did not have to see the SNCO every day, however, on occasions we did meet, he would say nasty comments regarding my weight and hair. I have ginger coloured hair. [Sergeant BB] would say things like, 'You fat git, you shouldn't eat for about a month, you've got enough fat on you.' 'Get your hair dyed, you shouldn't be in the Army with ginger hair.' 'You stink of piss.'

"These remarks and similar ones have continued to date. I cannot recall any particular, place, date or time any of these comments were made. They were on such a frequent basis it is hard to separate one from the other.

*"I have reported these remarks to [Sergeant BM] who works with the injured in 86 Sqn. I cannot recall when, but I have reported it to him on numerous occasions. Each time [Sergeant BM] said he would speak with [Sergeant BB]."*³⁰

- 8.38 When interviewed by the RMP, Sergeant BM recalled various trainees complaining to him about Sergeant BB but not the details of the complaints or his response to them. He did indicate that he received a phone call from Sergeant BB in April 1999 to the effect:

*"Most of what's happening to me is your fault, so watch your back."*³¹

As will be seen below, such a call would have been at a time when Sergeant BB had been transferred out of the Training Regiment pending the outcome of an RMP investigation.³²

- 8.39 In November 1998, Private(f) BJ was assigned to an induction Troop outside of Sergeant BB's line of command, but he came into an office where she was alone working and inquired after Sergeant BM:

"I was not happy about being in the presence of [Sergeant BB] alone, I now did not like the man, and I believed he did not like me. He remained in the office and began commenting about my weight again. I cannot recall his exact words, but it was degrading and nasty referring to my weight.

²⁸ 10th February 1999.

²⁹ See paragraphs 8.53, 8.58 and 8.65 below.

³⁰ 10th February 1999.

³¹ 13th May 1999.

³² See paragraph 8.51 below.

"I did not wish to be in the same room as him so I stood up and began walking towards the door. I'd had enough of his comments and did not know how long I could carry on without answering him back, so I thought it better just to leave the office.

"[Sergeant BB] was stood just to the right of the door and I had to walk past him to go through. Whilst walking past him, he grabbed my right arm, with one of his hands, I am unable to recall which one. He had more of a hold of the combat jacket I was wearing than my arm and, therefore, was not causing me any pain. But his hold was strong enough to prevent me from walking any further.

"Before I had time to do anything, [Sergeant BB] raised one of his knees, which connected with my right thigh. I cannot recall which knee he raised. His knee struck my right thigh, on the outer side of my thigh, just above the knee, which had the effect of giving me a 'dead leg', my leg went numb with a tingling sensation.

"Once he had struck me with his knee, he let go of the grip on my combat jacket and walked out of the office without saying a word. I was feeling upset about the situation now, I did not know what to do."³³

- 8.40 Shortly after this, Private(f) BJ spoke to someone else from AWS and explained why she did not make a formal complaint:

"I just needed to speak to someone about it. [...] asked me if I wished to complain, but I declined, because I thought I'd get into trouble. [Sergeant BB] was a SNCO and I just a Private, I thought he would be believed over me and that he would somehow make my life worse than what it already was, i.e. making me do extra duties etc."³⁴

- 8.41 Later that November, Sergeant BB was enquiring as to why Private(f) BJ was not doing physical training and it was pointed out she was unfit. Sometime thereafter, she was on a parade for Physical Training (PT):

"[Sergeant BB] approached me and said words to the effect, 'So you're finally doing PT, you need to lose a bit of weight.' He then sighed and raised his right clenched fist, however, he never moved it towards me, but I initially took it as a threatening gesture. However, I do not believe he would have struck me with so many other people present. The SNCO then walked away."³⁵

- 8.42 Private(f) BJ informed the RMP that she had witnessed no other violent acts by Sergeant BB and, in particular, had not witnessed the incidents that she subsequently knew would form the complaint by Private BK. On the face it, Private(f) BJ's account is a careful and credible narrative of a very reluctant informant, with no apparent motivation to make malicious allegations against Sergeant BB, who has carefully distinguished between what she herself saw and heard, and what she had heard happened to others. The use of insulting words was to be well supported by other informants, as was Sergeant BB's apparent obsession with, and dislike of, those he considered overweight. Private(f) BJ did give an account that another female trainee had told her she had had sexual relations with

³³ 10th February 1999.

³⁴ *Ibid.*

³⁵ *Ibid.*

Sergeant BB, that was not supported by the female concerned, but in the opinion of this Review that does not undermine Private(f) BJ's credibility. Indeed, the question of Sergeant BB's relations with female Privates is a further matter of concern.

(iv) Private BK

- 8.43 Private BK's own problems with Sergeant BB started in November 1998, when Sergeant BB appeared to query compassionate leave granted to Private BK to attend to medical problems of his fiancée. On his return, Private BK may have incurred further hostility when he assisted a female trainee who had fainted on parade and, according to Private BK, Sergeant BB had responded with *"Get up you stupid bitch."*³⁶ Matters deteriorated when Private BK was on the dance floor at the Troop Christmas function in December 1998 and saw Sergeant BB dancing with a female trainee he knew only by her nickname. Private BK stated that Sergeant BB deliberately struck him very hard in the back. Nothing was said. In January 1999, Sergeant BB had occasion to pass Private BK and told him to get a haircut and then said:

*"'Did you hear me', or words to this effect, as I had not answered him, then again I felt a blow as if by an elbow to the small of my back. This did not cause me a great deal of pain but did cause discomfort. He was the only person behind me at the time and therefore must have been responsible. Following the parade nobody else on the parade remarked on the fact that the SNCO had struck me and I did not discuss it with anyone. I should add that it is [Sergeant BB]'s common practice to strike individuals, not particularly hard but to cuff them or to go further and punch them, if he picks them up for things on parade or elsewhere."*³⁷

- 8.44 Private BK's complaints continued when he was ordered by Sergeant BB to clear excrement clogging the pipes in the accommodation block toilet without proper equipment. Private BK then consulted the AWS about his concerns and, in the course of coming back from such a meeting, encountered Sergeant BB:

"Later he called me to his office where whilst alone with him, he asked me why I had been to the Welfare Service. When I told him only that it was personal he said, 'You're not leaving camp until you tell me,' or words to that effect.

*"I said, 'It's personal, I don't have to tell you.' At this the SNCO got very angry and began shouting at me, though what he said I do not recall as I was not listening to what he was saying. I left the office after he dismissed me, but I did not believe I could not go out despite his threat."*³⁸

- 8.45 Private BK also witnessed, by chance, from some 20 metres away, an incident with Sergeant BB and members of his Troop:

*"All of the parade were laughing and I saw [Private(f) BN] holding a peeled banana. I then heard [Sergeant BB] say aloud, 'You either deep-throat that banana or the Troop is going nowhere.' I did not see if [Private(f) BN] was laughing or if she did as [Sergeant BB] suggested, but left the area immediately without being seen. I did not then speak to [Private(f) BN] about the incident thereafter."*³⁹

³⁶ 10th February 1999.

³⁷ *Ibid.*

³⁸ *Ibid.*

³⁹ *Ibid.*

- 8.46 An incident missing from Private BK's witness statement, but something that he had mentioned to the AWS on 28th January 1999, was an incident concerning Sergeant BB riding a bicycle over trainees. He told the AWS, on this occasion, that he did not wish to name the trainees as they were afraid to complain themselves. Further evidence of this incident came to light from others, as will be seen.
- 8.47 On the same day as this meeting with the AWS, the Commanding Officer, Lieutenant Colonel Govan, had an interview with Sergeant BB about information he had received from the Commanding Officer of another RLC Regiment at Buller Barracks, Aldershot. That Commanding Officer had banned Sergeant BB from visiting the Barracks, where he was allegedly conducting an affair with a Private who is likely to have been the female trainee Private BK identified, by her nickname, as Sergeant BB's dance partner at the Troop Christmas function.⁴⁰ Lieutenant Colonel Govan was apparently unaware that the Private concerned had, until recently, been a Phase 2 trainee at Deepcut. In his response to the RMP, Sergeant BB denied the affair, as did the female Private concerned, in a short statement, although she acknowledged it was widely rumoured that she had been having such an affair. Other informants in this case recalled seeing Sergeant BB with her on various occasions. Lieutenant Colonel Govan's interview book for 28th January 1999 is terse as to the outcome of his interview with Sergeant BB:

"Seen reference unsubstantiated allegation. Warned as to future conduct."

(v) An anonymous letter of complaint against Sergeant BB

- 8.48 In early February 1999, a few days after his interview with Sergeant BB, Lieutenant Colonel Govan received an anonymous letter complaining about Sergeant BB, apparently written by a female trainee complaining of his abusive treatment. The letter is worth reproducing in full:

"Sir,
I understand I have broken the chain of command, however I have had no help when I've asked for it at 86 sqn HQ.
I am a trainee and since starting at Deepcut I have been under constant physical and verbal abuse from [Sergeant BB] (2 Trp Sgt)
On more than once occasion he has punched me in the face and body. And he always threatens me, that he'll keep on doing it and to not tell anyone.
He puts me down in front of my troop and bullies me at any opportunity. I can accept that as a woman I would hear some comments and take a jibe. But this is not harmless banter.
I had problems when I was little with a male member of my family who abused me and I thought I was getting on with my life, I was until I came to Deepcut.
I had no choice to accept it then, but I refuse to accept it now.

⁴⁰ See paragraph 8.43 above.

He has no right to do these things and if he is doing this to me, what is he doing to others.

I know he is doing this to others because I have seen and heard it.

I am not going to give my name because I am scared that he will find out and get me.

Complaints have been made and ignored, this isn't fair, especially when we have had lessons on Equal Rights and Opportunities, etc.

This lesson and policy is a farce if he is allowed to get away with this bullying.

If something isn't done I will have to leave, and once I become a civilian I won't let this rest and will complain or go to the papers to show everyone what the Army is really like."

- 8.49 Lieutenant Colonel Govan discussed this letter with his staff, and Captain BP, then acting as Officer Commanding 86 Squadron, tried to make enquiries to discuss it with the author but did not confront Sergeant BB with the letter for fear that he would identify the complainant.
- 8.50 It seems likely that Sergeant BB did come to hear about Captain BP's enquiries. According to Private BK, on 5th February 1998, Sergeant BB paraded the Troop and announced to all:

*"I shouldn't tell you this, however, I was called up to the Commanding Officer today about a letter of complaint about myself. It's a girl in this Troop who says I've hit her twice on parade. I've got an idea of who it is from the handwriting. If you've got a problem with one of the Staff come and see us, we are approachable. The CO [Commanding Officer] ripped the letter up and we laughed about it, then he shook my hand and patted me on the back ... ' or words to that effect. I did not know who he was referring to when he mentioned the female member of the Troop, as none of the females have confided in me of such an incident."*⁴¹

(vi) The actions of the Commanding Officer

- 8.51 However, if Sergeant BB had succeeded in keeping allegations against him away from the chain of command until now, by one means or another, things were about to change. On the morning of 8th February 1999, Private(f) BJ, Private BK and Private BL spoke to the AWS and said that they wanted to make a formal complaint against Sergeant BB. The AWS Sergeant spoke to Lieutenant Colonel Govan, who in turn spoke to the MRO, in Glasgow, that same day and sought their authority to remove Sergeant BB from the Training Regiment immediately, in light of the apparently credible information he had received. The MRO agreed to this course of action and asked Lieutenant Colonel Govan to confirm the reasons in writing, which he did.⁴² It was this letter that alerted the Review to the actions of Sergeant BB and prompted it to make further enquiries. Although Lieutenant Colonel Govan's recollection of this incident in conversation with this Review was not, with the passing of time, wholly accurate, a general gist of the procedures adopted and the reasons

⁴¹ *Ibid.*

⁴² See Appendix A4/5.026 D-E.

for them can be gauged from the record of the meeting.⁴³ It is striking that, by the end of the day, Sergeant BB was removed from his post in the Training Regiment and the RMP had been called in to conduct a formal investigation. Indeed, Lieutenant Colonel Govan's interview book noted the following for his meeting Sergeant BB:

"Seen. Banned from camp pending investigation of allegations."

- 8.52 Lieutenant Colonel Govan did make two statements to the RMP about these matters, at some distance apart. He was copied in to the reports of the RMP, but it appears that, as he was no longer Sergeant BB's Commanding Officer, because he had been posted out of his Regiment, Lieutenant Colonel Govan had no formal responsibility for responding to the reports. In terms of ensuring that Sergeant BB no longer represented a threat to the welfare of the trainees in the Training Regiment, Lieutenant Colonel Govan's actions were swift and effective. In terms of ensuring overall accountability for an apparent abuse of power, and that a formal sanction was entered in the records, there remained institutional problems of concern to this Review. The new Commanding Officer who was the recipient of the RMP report and who was not in command of a Training Regiment, might have had little interest in administrative action to maintain ATRA standards of conduct for instructors. In theory, Lieutenant Colonel Govan's letter to the MRO, confirming his reasons for requesting an immediate posting of Sergeant BB, would have remained on Sergeant BB's personnel file as an indication of his suitability to instruct trainees in the future. Whether it would have been given any weight in the light of the official response to the investigation is another matter.⁴⁴

(vii) Private BL

- 8.53 The third informant to the AWS prior to 8th February, the date that Sergeant BB was removed from post, was Private BL. He was a Phase 2 trainee whose father was a Warrant Officer in the Army and a friend of another of the Sergeants at Deepcut. Private BL confirms the occasion, described by Private BK, of Sergeant BB's order to clean the toilets and the urinals without proper equipment.⁴⁵ His evidence also corroborates the use by Sergeant BB of a system of informal punishments. On an occasion when Private BL and a fellow Private, Private BO, were in bed 15 minutes before reveille, Sergeant BB entered the block. Private BL described what happened as follows:

"[Sergeant BB] spoke to [Private BO] and I, informing us that we had messed up which required a punishment. He did not say what we had done wrong, but I presumed that he was referring to us sitting on our beds when we should have been out of bed, however reveille is 06.00hrs. He said that we needed to be punished and gave us a choice of either a punch to the head or abdomen, which he would inflict, or a 24-hour period of guard duty. He used the term 'Head, gut or guard'. Both [Private BO] and I chose guard duty, however, I did not actually complete that duty, as I attained the assistance of [Sergeant BM], another instructor."⁴⁶

⁴³ See Appendix A4/5.025 F to 5.029 B.

⁴⁴ See paragraph 8.84 below.

⁴⁵ See paragraph 8.44 above.

⁴⁶ 10th February 1999.

- 8.54 Apart from these matters, Private BL was not the personal victim of Sergeant BB's abuse. On two occasions, shortly after the above incident, Sergeant BB warned Private BL not to complain about him as he would be sent away. It appears that Sergeant BB was aware of Private BL's line of communication to Sergeant BM. Private BL was, however, a witness to harassment of others.
- 8.55 Private BO was trying to secure a transfer to another Corps as a result of Sergeant BB's harassment. He was of Irish origin and wanted to transfer to an Irish Regiment. He was an amateur boxer and his boxing gloves were noted by Sergeant BB, who appears to have wanted to provoke him into some violent response. On one occasion, Private BO asked Sergeant BB how his transfer application was progressing. Private BL recounts what he saw:

*"[Sergeant BB] walked over to him and said that he had enough of him and pushed [Private BO] with both his arms against his chest, forcing him onto his bed. [Private BO] then stood up and told [Sergeant BB] not to push him and began walking past him. [Sergeant BB] then grabbed his shoulder and pulled him around to face him and [Private BO] told him to get off. [Sergeant BB] then told him to report to his office and he would see him in five minutes. [Private BO] left the room and then [Sergeant BB] left a few seconds later and began shouting at [Private BO]."*⁴⁷

The question of Private BO's transfer was a source of further grievance. At a Squadron meeting in the gym, Captain BP, acting as Officer Commanding, asked the trainees whether anyone had any problems. It should be noted that Captain BP had been asked to keep any eye on Sergeant BB after the anonymous letter had been received, although it is unclear whether this particular incident was before or after that date. Private BL's statement continued:

*"[Private BO] asked about his transfer. [Sergeant BB], who was also present during the meeting said to [Captain BP] that he had the matter under control. After [Captain BP] had left with the other instructors, [Sergeant BB] remained behind and discussed procedures for dealing with members of the unit who were fighting each other in the NAAFI. He then walked over to [Private BO] and put his feet on his chest as he was sitting down. He then pushed him backwards two or three times as he discussed people who wanted to transfer to other units. He then made suggestions that if we have disagreements with each other, he would attack them at night whilst asleep and if we messed with him, he would get us or his Corporal instructors would get us, or he would contact other people he knew who would get us. He also said that he knew how to beat the Army system."*⁴⁸

- 8.56 Private BL observed other acts of harassment, such as Sergeant BB ordering a male trainee to be dry shaved by another whilst walking through the parade ground. He also confirmed Private BK's account of the banana incident:⁴⁹

"[Sergeant BB] was holding the bananas and he told the members of the parade that they were not going anywhere until someone 'deep-throated' the bananas. I understand this to mean simulation of the sexual act of a blow-job on the banana. [Private(f) BN], a female member of my unit, and another male member of my unit, then came to the front of the

⁴⁷ *Ibid.*

⁴⁸ *Ibid.*

⁴⁹ See paragraph 8.45 above.

parade. I do not know if they were ordered to do this or they volunteered. They both then swallowed the bananas, which took about 5 minutes in total. The unit on parade watched this and [Sergeant BB] laughed at the time.”⁵⁰

- 8.57 Private BL was also the first to make a formal statement about the ‘bicycle’ incident with Sergeant BB, although the AWS Sergeant, referred to earlier, confirmed that Private BK raised precisely this incident with him informally.⁵¹ Surrey Police also became aware of the bicycle incident during the course of their investigations into the deaths of Geoff Gray and James Collinson, although the details in the 2001/2 Duty of Care Schedule, and the evidence behind it, are sparse⁵² and it appears that Surrey Police were unaware that this incident had been the subject of a thorough RMP SIB investigation. Private BL’s account to the RMP was as follows:

“I can also remember watching a parade where [Sergeant BB] ordered 3 fat members of the Squadron to lie down in front of the parade. He told them to lie on their backs and then rode his mountain bike over the middle part of each of their bodies. I do not know who these people were who were lying on the ground. Members of the Squadron on parade laughed as he did this. I did not hear if the other people were in pain and just walked away when [Sergeant BB] had finished.”⁵³

(viii) Private BQ

- 8.58 Once RMP investigations were under way, a number of others came to the fore. Private BQ was a trainee who gave a statement to the RMP shortly after their investigation began. Much of it was supportive of the allegations outlined above:

“I saw [Sergeant BB] hit soldiers from the Troop on about 3 occasions and kick people on about 2. These physical assaults would all take place during a Troop parade. The parades are held twice a day, one in the morning and one in the evening. They are only held during the week. The attacks would always be as a result of the soldier making a mistake, i.e. talking on parade, or failing to attend a lesson or not behaving correctly during a lesson.

“Sergeant BB, after identifying who had made the mistake, would approach the person and say, ‘Name a cheek, left or right?’

“The person would reply either ‘Left or Right’.

“[Sergeant BB] would then hit the person with a clenched fist in the area of their lower jaw, on the side elected. This would cause the soldier’s head to move. The direction in which it moved, depended on which side the SNCO had struck. I never saw anybody fall to the floor as a result of the assault. My view was not obstructed because I positioned myself so I could see, either leaning backwards or forwards or by standing on my tiptoes. I could see other people around me doing the same.

“With regards to [Sergeant BB] kicking people, he would make the individual, who had made the mistake, come to the front of the parade and tell them to start doing press-ups. They would be facing the parade

⁵⁰ 10th February 1999.

⁵¹ See paragraph 8.46 above.

⁵² See Appendix 6, entry 21.

⁵³ 10th February 1999.

with the SNCO stood to their left. Whilst they were doing the exercise, he would lecture the remainder of the Troop regarding missing lessons and the fact that this let the Troop down. [Sergeant BB] would say something like, 'We don't need scum like you in our Troop' and then kick the individual in the left side of the body, in the area of their ribs.

"On both occasions the soldiers have grabbed hold of the side of their body, and made a sound which I would describe as someone gasping for breath.

"Sergeant BB would tell the serviceman to continue with the exercise because he had not told them to stop."⁵⁴

- 8.59 As noted earlier, one of those whom Sergeant BB picked on was Private BO, who was seeking a transfer and apparently had prowess as a boxer. Apart from witnessing harassment in the accommodation block, Private BQ observed the following:

"[Sergeant BB] brought [Private BO] to the front of the Troop and had him doing push-ups. The SNCO said something to [Private BO]. I saw his lips moving but I could not hear what was said. [Sergeant BB] then kicked [Private BO] in the left side of the body, in the area of his ribs. Again, I was standing in the front row and saw the incident clearly. [Sergeant BB] did not bring his leg backwards, he appeared to just kick out. [Private BO] seemed to fall to the ground, he remained there for a few seconds and then carried on with the press-ups. [Private BO] carried on doing press-ups until the parade finished, I would say the duration of this was about 10 minutes."⁵⁵

- 8.60 Private BQ was himself the victim of an assault by Sergeant BB, after he had been criticised for poor performance by a civilian instructor. Private BQ recounted what happened when Sergeant BB thought the Troop were out of sight:

" ... he brought his left arm up and struck me with his left hand, which he had clenched into the shape of a fist, on the right cheek. The force of the blow caused my head to move to the left and backwards. My eye watered and later my cheek was sore to touch. I also found it sore when I ate on that side of my mouth. I did not seek medical attention."⁵⁶

- 8.61 This blow to the cheek was not enough to purge the offence. Private BQ continued:

"[Sergeant BB] said, 'this will teach you for messing around in Mr [...]s lesson, now I want you to run round the tennis courts.'

"I then began running around the tennis courts. As I made my way round, [Sergeant BB] walked around the courts in the opposite direction. We eventually met up and I stopped in front of him.

"[Sergeant BB] instructed me to go and get changed into my best working dress and then to report to his office. He told me I had 15 minutes to do this in. After getting changed I reported to his office.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ *Ibid.*

*"[Sergeant BB] made me march in and halt several times, telling me on the last occasion that if it wasn't good enough he would put me in jail. He then said, 'Your behaviour today, was not satisfactory during the lesson and for that you will be buffing floors until midnight'."*⁵⁷

- 8.62 The civilian instructor had, in fact, caught sight of Sergeant BB doing something to Private BQ and asked Private BQ whether Sergeant BB had hit him. Private BQ at first denied it, then admitted it. The instructor told him he should report it and that Private BQ should tell him if it happened again. When questioned by the RMP, the instructor confirmed Private BQ's account of this conversation. Understandably, Private BQ told the RMP:

*"Since being assaulted by [Sergeant BB] I have become afraid of what he is going to do to me next. Specifically whilst on parade or when instructed to attend his office."*⁵⁸

- 8.63 Private BQ also suggested that the background to the banana eating incident was to determine which of two trainees, who had infringed regulations in some way, should perform extra duties:

"He told them that because they had done something wrong during the day, one of them would have to do fire piquet. In order to decide who it was, he was going to hold a competition.

"[Sergeant BB] then produced two bananas and said, 'Whoever can eat the banana in the most provocative way wins'..."

*"This caused people in the Troop to laugh, including myself. I laughed because I found it funny, but I felt sorry for the people at the front of the Troop who were being humiliated."*⁵⁹

- 8.64 Further humiliation was exacted in the bicycle incident. Private BQ's description is as follows:

"[Sergeant BB] then shouted to [Private BR] to bring down his mountain bike from the Troop offices. Approximately 2 minutes later [Private BR] appeared carrying a silver mountain bike, which he gave to the SNCO.

"[Sergeant BB] then brought [Private BS, BT and BU] out to the front of the Troop. He instructed [Private BR] to join them.

"It should be noted that all these people are considered to be overweight.

"[Sergeant BB] told them to lie on the ground on their stomachs with a 2 to 3 foot space between them. They all did this. I cannot remember the specific order they were in but I know [Private BR] was second from the end. He then moved approximately 50 to 60 metres away and sat on the bike facing towards them. He started pedalling towards the serviceman lying on the ground. On the first occasion he stopped just in time before he hit the first person. [Sergeant BB] managed to ride the bike over the first person on the second occasion but could not get over the second. He

⁵⁷ *Ibid.*

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*

then went back to his starting position and pedalled faster. On the second occasion he got over the first two individuals, however, he did not have enough power to get over the third person, so he began pedalling and rode the bike into [Private BR's] face. I believe it was his right side.

"He then got off the bike, told the people on the floor to rejoin the Troop and continued with the parade.

"When he rode the bike across the two individuals, it was always at the lower part of their back where he went across their body.

"When [Sergeant BB] did it the first time everybody laughed, but when he actually rode over them there was silence initially and then people laughed.

"Whilst this was occurring [Private BR] moved position as [Sergeant BB] got closer. The SNCO instructed him to lie back down on his stomach.

"I do not remember anyone actually crying out in pain, however, there was background noise from people in the Troop and [Sergeant BB] was shouting at [Private BR] respectively."⁶⁰

(ix) Other informants to the Royal Military Police

- 8.65 The RMP obtained witness statements from a number of other trainees who gave accounts of Sergeant BB hitting others whilst on parade in front of the whole Troop. One trainee talked of the practice of a 'chin-up' where a trainee would be struck on the chin. Another witnessed the following assault on Private BQ whilst the Troop was on parade:

"Today, I have been asked ... if I can recall any incidents regarding [Sergeant BB] and any trainees. In answer to that direct question, I can recall that during Jan 99, whilst on evening parade, I witnessed [Sergeant BB] strike [Private BQ]. The whole Troop had assembled 'under the Arches' just outside 2 Tp office, for the evening parade, which were normally held about 16.45hrs each day. The Troop was stood in three ranks, [Private BQ] and myself were in the first rank, however, he was stood approximately 5 or 6 men down on my right. Due to the area layout, the Troop could not stand in three ranks in a straight line, the ends of the three ranks had to curve, due to a building, and therefore, whilst I was stood I could see [Private BQ] as he was stood in the curve of the line.

"I could hear [Private BQ] talking, I do not know who to or what about, but [Sergeant BB] heard him. The SNCO approached [Private BQ] and said words to the effect of, 'You can go down the Guardroom or take left or right.' I did not, at that time, understand what was meant by left or right. [Private BQ] did not reply, I do not think he was given enough time to reply, due to [Sergeant BB] raising his right clenched fist and striking [Private BQ]'s jaw area. My view of this incident was unobstructed as I was in the front rank, I could clearly see the front of [Private BQ] and the front and right side of [Sergeant BB].

⁶⁰ *Ibid.*

"I heard the sound of teeth being knocked together as the fist struck [Private BQ], whereupon [Private BQ] stumbled backwards slightly but managed to regain his balance. I did not hear any cries of pain or complaints from [Private BQ]. Within seconds I could see a reddening to the jaw of [Private BQ], which I believed was a result of the strike. The parade carried on as if nothing had happened."⁶¹

- 8.66 Some informants suggest that the 'chin-ups' and the walking on trainees were not particularly painful or violent:

"He ordered the Troop to lie down, he did not say to lie down on our backs or fronts. He gave no further indication as to his intention. He simply ran across and jumped across our bodies whilst we lay on the floor. He jumped across me without touching me, but I know he stood on others. I do not recall the identities of those people.

"As I recall no-one was injured as a result, but [Sergeant BB] did not seek, nor was he given, consent for his action by anyone present.

"I believe Cpls [...] and [...] were present during this incident, but took no part. It was my impression that they did not approve of [Sergeant BB]'s actions.

- 8.67 When asked whether he recalled the expression 'chin up' and, if so, what he understood it, this informant replied:

"I understand this to mean, when [Sergeant BB] used to give punishments to people in front of the Troop on evening parades. These punishments would be, for example, for missing a PT lesson. [Sergeant BB] would call the person out to the front, ask them their excuse for whatever it was. He would then tap them on the chin with his fist. I do not think the blow was ever forceful as such, no-one to my recollection was particularly upset by it, or injured. I don't think their heads even moved. Again though, he did not seek, nor was he given, prior consent to this."⁶²

- 8.68 Private(f) BV was a female trainee who gave supporting evidence and had been dissuaded from making a complaint. The RMP report summarises her evidence as follows:

"About twice a week on Troop parades, [Sergeant BB] would order the Troop to lie down. He would then run and jump physically on them as they lay on the ground. The soldier related how on one of these occasions, [Sergeant BB] had stood with both feet on her back causing her considerable discomfort. She detailed further examples of apparent random physical punishments meted out by [Sergeant BB] during such parades, including punches to the chin and ribs of male soldiers, and trips to the drying room where she believes further violence took place on a one to one basis. [Private BV] also corroborated the name calling detailed by [Private(f) BJ]. She concluded describing how she was dissuaded from making a complaint against the SNCO during Dec 98, during an interview with him alone in the Troop Office. She stated that during the interview [Sergeant BB] shouted, used bad language, banged his fist on the desk, and threatened 'to make her life hell', if she went ahead with the complaint, and as a result she was frightened and did not proceed with the complaint."⁶³

⁶¹ 16th April 1999.

⁶² 4th August 1999.

⁶³ 11th August 1999.

- 8.69 Private(f) BV was not the author of the anonymous letter to the Commanding Officer but had drafted a statement of her concerns that she intended to hand to Major BA.

(x) ATRA's 1998 Code of Practice for Instructors

- 8.70 The RMP also obtained a witness statement from the Head of Recruiting and Training Policy at ATRA commenting on the conformity of Sergeant BB's alleged behaviour with the ATRA Code of Practice for Instructors. He explained that the Code of Practice was not itself a series of instructions but a whole system of approach:

*"ATRA policy is not laid down rigidly for units to follow, rather the spirit of the policy should be interpreted at unit level and this interpretation should be reinforced through seminars and the courses I have referred to. I would also expect some aspects to be detailed in unit's Standing Orders."*⁶⁴

- 8.71 At this point in the narrative, it is worth recalling some pertinent extracts from the 1998 ATRA Code of Practice for Instructors, referred to earlier in Chapter 4:⁶⁵

"2. ... For so long as they remain within the ATRA, both civilian and military instructors are to be in possession of a personal copy to this Code and they will be expected to match the ethos and standards set out within it.

*"7. **Fairness.** Whilst the instructor will remember that he is training people for war – harsh, unforgiving; literally a fight to the death – the instructors must never physically strike a trainee, must never take unfair advantage of the instructor's position of authority over the trainee and must never lose compassion for the weakness of the trainee relative to him/herself.*

...

*"17. **Equality in Training.** All trainees of whatever rank, gender, religion or ethnic origin must be accorded fair and equal treatment. To do otherwise goes against team-building. No discrimination, harassment, intimidation or humiliation of any kind will be tolerated anywhere in the ATRA.*

...

*"19. **Respect in Training.** It is important that a relationship based on mutual respect exists between instructor and trainee. This will come naturally to the good instructors who will continually seek to develop the trainee's self-respect with constructive criticism and forceful encouragement. Nothing is achieved by physical humiliation or the use of violent, filthy or abusive language, apart from the instructor losing the respect of his or her trainees.*

*"20. **Discipline in Training.** An instructor must be entirely clear as to his disciplinary powers as published in the orders and regulations of his Training Centre. Unofficial disciplinary procedures can be interpreted as bullying or as an abuse of authority and, for these reasons, all disciplinary action must be clearly recorded and open for inspection.*

⁶⁴ 23rd September 1999.

⁶⁵ See paragraph 4.83 and 4.105 above.

"21. **Personal Relationships in Training.** *The relationship between an instructor and a trainee is inevitably a close one. Some trainees, particular young recruits, can develop a sense of awe and hero worship which goes beyond professional respect and admiration. Instructors must recognise this and not allow their egos to be inflated which might lead to an unhealthy abuse of their authority or the trainee taking advantage of the situation. At all times a professional distance must be rigorously maintained. Failure to do so can lead to unacceptable personal relationships, accusations of favouritism or even allegations of misconduct.*

...

"24. **Welfare in Training.** *An instructor is responsible for the general welfare of his trainees, particularly the younger ones who are away from home for the first time. Organisations such as the Army Welfare Service and the Council of Voluntary Welfare Work may be able to provide extra help and facilities at first hand.*"⁶⁶

- 8.72 The Head of Recruiting and Training Policy at ATRA was asked to respond to the allegations against Sergeant BB:

"[...] has allowed me access to a typed copy of the SIB enquiry into the activities of one [Sergeant BB], RLC formerly employed as an Instructor at 86 Sqn RLC, Trg Regt and Depot RLC, Prince Royal Bks, Deepcut. He has invited me to comment on the allegation and the admissions of that SNCO.

*"I do not feel it is necessary to comment on the allegations referring to alleged criminal acts like assault ..."*⁶⁷

- 8.73 Having regard to extracts from the Code of Practice for Instructors quoted above, in the opinion of this Review, his conclusion is somewhat of an understatement:

*"... however, having perused the SNCO's response to questions and the overall gist of the witness evidence, I would describe [Sergeant BB]'s approach as heavy handed. In no way could it be argued that he conducts himself in accordance with the Codes of Practice for Instructors, the Policy laid down by ATRA."*⁶⁸

- 8.74 The above account does not attempt to be an exhaustive account of the allegations made against Sergeant BB and the degree to which they are supported or contradicted by others. It is clear that some of the trainees supported Sergeant BB against those who complained. Some of those participating in the 'banana' and 'bicycle' incidents considered that this was done as a 'laugh' and that the participants were not forced to act. These were matters taken in account by the Army Prosecuting Authority in due course.

(xi) Victimisation of complainants

- 8.75 More seriously, it seems that some trainees were critical of those who had reported the allegations leading to Sergeant BB's transfer. The AWS officer in whom Private BK had confided had this to tell the RMP in March 1999:

⁶⁶ *Supra*, footnote 2.

⁶⁷ 23rd September.

⁶⁸ *Ibid.*

"About 15.05hrs on Tue 9th Feb 99, I received a telephone call from [Private BK], who explained that he believed [Private(f) BJ] was experiencing verbal abuse from other recruits, and that [Private BL] and himself believed themselves to be in physical danger from other recruits, to the extent that they locked themselves in a bunk the previous night for safety.

"Since that date I have kept in contact with [Private BK], who has been posted to a unit in [...]. I have also had contact with his wife, who had expressed her concerns for her husband's safety. Whilst [Private BK] has been with his new unit, he informed me that just prior to his move he was attacked in the toilets at Deepcut, during which he received a blow to the head and a cut to his arm. He did not inform me of any further details, nor could he describe his assailant."⁶⁹

- 8.76 When Lieutenant Colonel Govan spoke to this Review about these events and what light it threw on the under-reporting of bullying, he explained as follows:

"Ans.: And we were aware that they were behaving in a manner that we would not wish. There was clearly some element of bullying and cajoling and that sort of unpleasantness. But one of the problems with bullying of that nature is actually getting any evidence to deal with it.

Qn.: Because the victims don't complain?

Ans.: Yes.

Qn.: Why don't they complain?

Ans.: Because they're frightened of what will happen to them by other members of the same organisation, the Scottish mafia. If we could have got evidence against individuals, then we would certainly have taken proper action against them. By which I mean calling the RMP in, having it investigated in that way. As far as I recall, we never got to that situation. If we go back to the [Sergeant BB] bit, there were some trainees that were, if you like, siding with [Sergeant BB].

Qn.: A 'good for them' kind of line? Being ridden over by a bicycle is good for you?

Ans.: Yes. It makes you robust and all that sort of stuff. To the point where I think they put razorblades in some of the trainees' boots. Again, we didn't have any evidence to say who that was.

Qn.: Was that the RMP discovering this or your staff?

Ans.: As far as I recall, this was reported to me by my RSM. That would be the normal conduit for that. Whether it came from the RMP or whether it came up the unit chain of command, I really don't know.

Qn.: Which does to me suggest that there is a real problem of under-reporting of bullying.

⁶⁹ 31st March 1999.

Ans.: Absolutely. I don't know to what extent it was going on, but we did have a feeling that this particular group was responsible, if not for all of it, then for the vast majority of it."⁷⁰

- 8.77 Sergeant BB himself was interviewed by the RMP about all these matters and denied physical violence and abuse. The most he accepted was some jocular name-calling of overweight trainees. An RMP report on the incidents involving Sergeant BB at Deepcut, and their investigation to that point, was delivered on 11th August 1999.

(xii) Sergeant BB's conduct after being removed from Deepcut

- 8.78 However, by this stage, the RMP had become aware of further allegations against Sergeant BB made by two Privates in the Regiment to which he was assigned after removal from Deepcut. It is sufficient to summarise these matters as having involved two Privates, a male and a female, who alleged that on 20th and 22nd June 1999 they were slapped about the face by Sergeant BB following a transport exercise, either for no apparent reason or as a result of poor driving skills in the exercise. Both were happy to make statements to the RMP. Sergeant BB was interviewed about this on 17th August 1999 and denied the allegations.
- 8.79 In December 1999, while the RMP report into these matters was pending, Sergeant BB had a confidential review by his Commanding Officer:

*"a very effective SNCO in a most demanding post ... forceful and effective leader ... He would be even better if he could develop more subtlety and flexibility when dealing with those who struggle to meet his professional standards."*⁷¹

(xiii) The legal advice

- 8.80 The RMP reports on Sergeant BB were considered by the legal adviser in 4th Division⁷² who, on 9th November 1999, recommended that five charges of common assault, four charges of ill-treatment of trainees and two charges of conduct prejudicial to good order and military discipline be brought against him for his conduct at Deepcut and at his next posting between January 1998 and June 1999.
- 8.81 Ill-treatment of a subordinate is an offence under s.65 of the Army Act 1955. Under the proposed Armed Forces Bill, currently before Parliament, in which it is intended to create a service-wide disciplinary code and system, it will remain an offence punishable with up to two years' imprisonment. The Manual of Military Law has the following helpful commentary in a footnote to the section titled 'Ill-treatment of officers or men of inferior rank':

"It appears that before a person may be convicted of ill-treatment under this section, the prosecution must prove deliberate conduct by that person that may properly be described as ill-treatment (irrespective of whether the ill-treatment damaged or threatened to damage the health of the victim) and a guilty mind involving either an appreciation by the person at the time that he was inexcusably ill-treating the victim or that he was reckless as to whether he was inexcusably acting in that way, see R. v. Newington. The question of what may be described as ill-treatment

⁷⁰ See Appendix A4/5.042 D – 043 B.

⁷¹ 19th December 1999.

⁷² See paragraph 4.64 above.

is one of fact for the court to decide, giving the words their ordinary dictionary meaning. It may include behaviour that degrades or humiliates the victim as well as violent physical contact. The particulars of offence must state how the victim was ill-treated, e.g., by striking, punching, kicking, by being locked in a cupboard or by whatever other means. An averment of more than one such means of ill-treatment which is part of the same transaction will not, it is considered, be bad for duplicity.”⁷³

- 8.82 In the opinion of this Review, that commentary describes well the general nature of the harassment and bullying allegations made against Sergeant BB. If there was any issue as to whether any conduct proven against Sergeant BB was ill-treatment, this Review would have expected the standards set out in the ATRA Code of Practice for Instructors to be admissible evidence for the court to take into consideration. That Code of Practice is clear that physical assault, threat of assault or abusive language as a tool for training and discipline will not be tolerated.

(xiv) The decision of the Army Prosecuting Authority

- 8.83 As these matters were too serious for summary dealing by the chain of command, the file was passed to the Army Prosecuting Authority (APA) with a view to advising on the prospects of a Court Martial. At some point after the advice of 4th Division was obtained, there was a Formal Preliminary Examination where some of the complainant evidence was tested.
- 8.84 On 15th August 2000, the APA's legal advice was delivered. In brief, the conclusion was that, pursuant to s.83B(4) of the Army Act 1955, Sergeant BB should not be tried by Court Martial, on the basis that, in respect of most of the allegations, there was not a realistic prospect of conviction; and, *“in respect of some of the allegations, that a trial would not be in the public, including the service, interest.”*
- 8.85 This Review's function is not to form a second opinion on an issue of legal judgment in a matter of serious concern to the individual Sergeant and the Army. In any event, it has not seen all the material that may have influenced the judgment. Nevertheless, this Review has read the reasons given for this conclusion with some surprise and considerable dismay.
- 8.86 Each allegation was regarded as essentially an allegation of common assault that was by that time stale and over six months old, essentially a 'one against one' complaint against an instructor who:

“... appears to be a joker with an odd sense of humour (although it appears that some found him amusing, and helpful as an instructor; it also seems that some allegations may be based on misunderstandings of what he was doing).”⁷⁴

- 8.87 Weight was attached to the fact that, in some cases, the trainees themselves no longer wished to pursue a complaint, and that the name-calling was not serious enough to be in the public interest to pursue. Private(f) BH's incident was disposed of on the basis of inconsistency as to whether the mug was actually aimed at her; Private(f) BJ's because there was some doubt as to whether Sergeant BB had said 'head or gut' or 'head or guard'.

⁷³ Footnote 1606, Miscellaneous offences; Misconduct in action and other offences arising out of military service; Part 2, Discipline and Trial and Punishment of Military Offences; The Manual of Military Law, 12th Edition.

⁷⁴ 15th August 2000.

- 8.88 This Review is concerned that there was no self-direction by the decision taker as to whether each of these trainees at different times and different places had conspired to make false allegations against the instructor concerned. There was no reference to the ATRA Code of Practice for Instructors and its potential use to deciding what was humiliating and unacceptable, whether or not other trainees found it amusing. There was no recognition of the obvious reluctance of trainees to complain against their instructors and the fears they understandably felt in doing so. There was no self-direction as to the importance, in the public interest, of setting standards for instructors and stamping out bullying. The cases were considered separately as common assaults. The Review doubts that the six-month time limit for common assault could conceivably have been relevant as an answer to the evidence in this case, where the investigation was extended as more and more allegations came to light, apparently independently. The question of the suitability of a charge of ill-treatment was not referred to in the advice given. The fact that Sergeant BB was in a position of trust as an instructor was noted, but as against that the age of the allegations, their triviality and the conflicts in the supporting evidence, did not persuade the decision taker that the evidence supported a realistic prospect of conviction.
- 8.89 This decision by the APA stands in stark contrast to the persistent public pronouncements of the most senior officers in the Army, and the repeated assurances of Ministers to Parliament, that there is a 'zero tolerance' policy on bullying. Bluntly put, in the opinion of this Review, if the product of a careful and prolonged investigation producing evidentially supported allegations of the quantity, and quality, noted above do not result in the pursuit to a judicial determination in formal disciplinary proceedings, it is difficult to see what could.
- 8.90 If the Army does not pursue formal action in such a case, it cannot credibly claim any sort of delivery of a regime that protects young soldiers from abuse as its part of the Military Covenant with them.⁷⁵ It is true that the serious nature of the abuse recorded in the statements in this case does not lie so much in the degree of severity of pain or physical injury that it has caused. Rather, in the opinion of this Review, the gravity lies in the flagrant contempt for the standards of respect for trainees contemporaneously espoused by ATRA and the apparent impunity with which those standards could be flouted.
- 8.91 This Review cannot predict what the outcome of any disciplinary proceedings against Sergeant BB would have been. It is no part of its role to express an opinion on the guilt of Sergeant BB. It may be that, under forensic scrutiny, doubts, not apparent from the written statements seen, may have arisen. However, this Review's concern is with the fact that there was no such scrutiny of a *prima facie* case to answer. Whether or not the complainants accounts would have eventually prevailed, there was an important public interest in public evaluation of their testimony.
- 8.92 The code for civil prosecutors at the time made clear that the objective assessment in deciding whether to initiate proceedings was whether there was "*a realistic prospect of conviction*". This should not be used as a basis to replace the function of the court and substitute the prosecutor's estimate of whether guilt beyond reasonable doubt could be established. As Lord Chief Justice Bingham (as he then was) said in *R v DPP ex p Manning*⁷⁶ at [22]:

⁷⁵ See paragraph 4.2 above.

⁷⁶ [2001] QB 330.

"[The test of realistic prospect of conviction] had to be satisfied. If it was not satisfied there should be no prosecution, no matter how great the public interest might seem in having the matter aired in court. It was not the role of the Crown Prosecution Service simply to give cases a public hearing, regardless of the strength of the evidence. There had to be an objective assessment of that evidence. The Crown Prosecution Service should not look for the same standard of proof that a jury or bench of magistrates would need to find before it could convict, which would set too high a standard and tend to usurp the role of the court. The test based on "more likely than not" meant just that."

- 8.93 In the opinion of this Review, the cogency of the case against Sergeant BB depended on the sub-stratum of demonstrable conduct from mug throwing, slapping, bicycle riding and name calling, and, from there, the correlation of independent accounts by anxious witnesses of different occasions of oppressive behaviour. On the face of the documents seen by the Review, there was a cogent case that it was more probable than not that the collection of witnesses gathered by the RMP were accurate in their assertions that Sergeant BB substantially over-stepped the line dividing discipline and training from bullying and ill-treatment.
- 8.94 The Review is surprised by the reference to the public interest in the prosecutor's decision. For this Review, the public process of a fair trial itself plays an important part in the policy of law and disciplinary codes in maintaining standards. If an NCO in the Armed Forces does not even have to answer for his actions in a case such as this, then a culture of impunity, of silent acquiescence and of not complaining against NCOs is vindicated, and the perpetrator may be free to continue as before.
- 8.95 The Review understands that the APA was designed to increase accountability to due process standards in consideration of criminal proceedings against officers and soldiers in controversial circumstances. Its purpose was to take matters out of the sole province of the Commanding Officer, where there may be loyalty considerations against endorsing action resulting in prosecutions of comrades, and make recommendations as to further action. The Armed Forces Bill currently before Parliament extends this process further by creating the office of the Director of Service Prosecutions, who can initiate prosecutions and issue directions in respect of it.⁷⁷ The Review understands the purpose and potential benefit of such measures. In the case in hand, Lieutenant Colonel Govan had an awareness of the need to protect his trainees from abuse. By contrast, this awareness does not appear to have been considered a factor in the reasoning of the APA. The decision of the APA prompts the question "*who guards the guards?*"⁷⁸

(xv) Army General Administrative Instruction (AGAI) action

- 8.96 If the Army does not use formal disciplinary proceedings with a view to deterring abuse of power, then it must ensure that procedures are in place to deliver effective administrative action under the AGAI system.
- 8.97 The Review is grateful for the assistance provided by the officers at the Adjutant General's Headquarters, Upavon. The discussion, recorded in a transcript reproduced in the Appendix to this Report, is a useful summary as to the two systems available to the Army to deal with the conduct of officers and soldiers – disciplinary and administrative – and

⁷⁷ Armed Forces Bill published November 2005, clause 124.

⁷⁸ "*Quis custodiet ipsos custodes?*", Juvenal 6th Satire.

how the two inter-relate.⁷⁹ Although administrative action should not be used as a substitute for criminal prosecution, if the evidence raises sufficient concerns, a decision to take disciplinary action, on the criminal standard of beyond reasonable doubt, does not prevent administrative action being taken, on the civil standard of on the balance of probabilities.

- 8.98 In seems that AGAI 67, which first came into effect from January 2001, started a process of making a clearer distinction between disciplinary and administrative action. The January 2005 formulation of AGAI 67 spells this out with greater clarity (with emphasis added by the Review):

“67.003 Commanders also have lawful command authority to administer their commands. This authority complements their statutory powers and is granted by the Army Board (of the Defence Council) under Queen’s Regulations. Taken together, these powers and authorities define the two components of the Army’s Discipline System:

*a. **Disciplinary Action:** The Military Criminal Justice System. Disciplinary Action is action taken (to uphold good order and military discipline) by commanders using their statutory powers. It encompasses military custody, summary dealing, courts-martial and review of courts-martial. The statutory military criminal justice process involves investigation; charge; trial; conviction and sentence; review; and appeal. Sentences range from admonition and restriction of privileges to, in the most serious cases, imprisonment. Section 70 of the Army Act 1955 makes any offence under civil law an offence under military law. Disciplinary Action is a distinct and formal process, which is officially recorded and may result in individuals receiving criminal and prison records. Military courts, but not summary hearings, are conducted in public.*

*b. **Administrative Action.** Administrative Action is action taken to safeguard or restore the operational effectiveness and efficiency of the Army by commanders using their command authority under Queen’s Regulations. The Administrative process involves investigation; reporting; determination; sanction; review; and appeal. This process of self-regulation is familiar to most employers and employees. It is entirely separate from the military criminal justice system. Administrative Action may result in a range of outcomes from an informal warning or rebuke to, in the most serious cases, termination of Service. It is taken in accordance with the procedures set out in this AGAI.*

67.004 Disciplinary Action and Administrative Action are both necessary; and complementary to one another. Although their uses are entirely separate, their uses are not mutually exclusive: ‘upholding good order and military discipline’ and ‘safeguarding or restoring the operational effectiveness and efficiency of the Army’ cover much of the same ground. Commanders must use their powers and authority appropriately and effectively in the context of the offence or misconduct and the operational circumstances. As a general rule, Disciplinary Action should only be used where the offence is wholly deserving of the consequences of the application of military law. On the other hand, Administrative Action – which is intended to set straight professional shortcomings – should not be used in clearly criminal matters.

⁷⁹ See Appendix 4/15 for the full discussion at Upavon.

*67.005 Administrative Action may be taken subsequent to Disciplinary Action or prosecution in a civil court, regardless of whether the accused is convicted or acquitted. Such action does not amount to double jeopardy, nor is it in principle oppressive or unfair. It is an established and legally robust dimension of employment practice and is entirely in keeping with the regulation of other professions. It is entirely reasonable for the Army to take into account the employment consequences of a serviceman's failings.*⁸⁰

- 8.99 AGAI 67 is, no doubt, helpful in a number of ways, but it will only promote improved standards in the training personnel if it is used appropriately by Commanding Officers who are aware of the standards of behaviour in their Regiment, and are pro-active in ensuring that they are appropriate. Decisions not to prosecute, or even acquittals in the military criminal process, do not necessarily amount to a positive finding in favour of the suspect. The basis for the decision must be understood. It is particularly important to know whether there is any reason to treat a complaint as unreliable or malicious. There is still the danger that the principle of double jeopardy will linger on in substance, and deference may be given to the decision of the criminal law authorities where it would be inappropriate to do so in respect of employment decisions. It should be remembered that the issue to be addressed, the evidence that can be considered and the standard of proof is, in each case, different.
- 8.100 Nevertheless criminal sanction is the prime means of deterring abuse of authority and protecting the welfare of young soldiers. Administrative action may have the disadvantage that a problem soldier is passed on to a new posting, where the expectations of behaviour may be different. In the case of Sergeant BB the Review has seen no evidence that consideration was given as to whether the basis for an administrative sanction could be established. There is no evidence that his new Commanding Officer considered a reprimand, or other administrative sanction, in respect of Sergeant BB.

(xvi) Comparative action by Commanding Officers

- 8.101 The case of Sergeant BB invites comparison with other cases considered in Chapters 6 and 7, where Commanding Officers had to act in respect of allegations against senior NCOs or other members of staff. Lieutenant Colonel Josling conducted an investigation at Regimental level, which prompted the resignation of Regimental Sergeant-Major Z.⁸¹ However, the evidential basis of Lieutenant Colonel Josling's concern was not recorded in a formal procedure or other letter on the personnel file, and the statements obtained during the Regimental investigation have not been retained, as they would have been had there a formal investigation by the RMP.
- 8.102 As noted in Chapter 5, there was never any investigation into Sergeant B because there were no complaints recorded against him whilst he was in the Army. Lieutenant Colonel Harding had the problem of employing Leslie Skinner following his first Court Martial in July 1996. When a sexual allegation was made against Skinner in August 1997, Lieutenant Colonel Harding called in the RMP, who investigated and found evidence of a case to answer. However, Skinner remained in place pending his trial and was not suspended or transferred out of the Regiment, the place where he had abused his ostensible authority. By contrast, Sergeant BB was suspended from post and removed out of the Training Regiment the day Lieutenant Colonel Govan became aware of apparently credible allegations made against him. A letter was sent to MRO that remained on Sergeant BB's

⁸⁰ Reference D/DPS(A)/67/1/PS2(A). AGAI 67, Edition January 2005.

⁸¹ See Appendix A4/9.047 E – 051 D for Colonel Josling's description of the procedure he followed in this respect. See also paragraphs 6.142-144 and 6.153 above.

personnel file explaining the reasons for his removal. However, once Sergeant BB was away from the Training Regiment and the RMP had completed their investigation, the APA decided that criminal charges should not be brought and Sergeant BB's new Commanding Officer did not, apparently, consider whether the evidence obtained disclosed a good case for administrative action. Each of the outcomes has unsatisfactory features for the future safety of trainees.

(xvii) Collective responsibility

- 8.103 For the Review, the case of Sergeant BB poses a key test for the question as to whether the recommendations of the Evans Report of 1995, as implemented, and the ATRA Code of Practice for Instructors of 1998 were, together, sufficient or effective to deter abuse at Deepcut? The case of Sergeant BB is important because the trainees concerned, unlike most of those recorded in Surrey Police's Duty of Care Schedules, attempted to follow the rulebook that the Army laid down and complained through the chain of command.
- 8.104 Private(f) BJ reported the abuse through her chain of command to her Troop Commander, who told her that she should not endanger the career of an NCO and that informal action would suffice. Private(f) BJ, Private BK and Private BL utilised the AWS to bring to attention allegations of persistent abuse and Sergeant BB's intimidation of those who sought to raise concerns as to his conduct. As has been discussed, it appears that Sergeant BB came to know about this and threatened the confidentiality of the proceedings and otherwise emphasised his claimed immunity from sanction. It is of note that it was only an anonymous letter to the Commanding Officer, followed by a determined collaborative decision by three victims to make formal what they had previously raised informally, that resulted in prompt action.
- 8.105 This Review has put the brief facts of how the AWS dealt with the incident before Colonel Strutt, Commanding Officer of the 4th (Training Support) Battalion, Infantry Training Centre, Catterick and his opinion was that the AWS was too slow to report the nature of the allegations to the chain of command, so that Sergeant BB could have been informed that he was being watched:

"Ans.: The weakness here is that she [the AWS Sergeant] was unsure what sort of action to take. Three things that should have happened there. [She] should have outlined what action was available. Should have invited her initially to say what action she would like taken if she was solving it herself and then say 'well if you really want this fixed I need to speak to the Commanding Officer about it now.' If she says 'no', the next line is 'well I am going to speak to the Commanding Officer about it, I won't name you, but it is important that if this is happening it is stopped.' And what that does immediately is, even if it is a false allegation, it immediately identifies to the Sergeant, the accused, that he is being watched ... and, if nothing else, the Sergeant then has two options, it either stops immediately or he takes revenge.

Qn.: Which is what he does.

Ans.: Because they didn't get to him early enough.

Qn.: No, but he takes revenge.

Ans: Yes once you get a Sergeant in front of the Commanding Officer and you say 'Sergeant, there has been a complaint about you, we are going to investigate it. At the moment I have still got

confidence in you, it is not proven yet but just be aware we are watching you.’ And very few Sergeants once they know they are being watched, actually, do anything afterwards because they know that eventually they are going to be found out. So actually there is two months there lost.”⁸²

- 8.106 The case of Private BO suggests that, even if Captain BP, who was acting as Officer Commanding, was trying to communicate with the Squadron as to whether they had any problems, Sergeant BB was able to intervene and victimise any trainee who dared to raise any matter. It is ironic that the AWS told the RMP that the notes they had taken of the trainees’ allegations could not be handed over because they were confidential. The confidentiality is surely that of the complainants who made the brave decision to report on their Sergeant to the RMP. Confidentiality can never be used to weaken the RMP investigation into complaints made by the trainees concerned. Evidence of consistency in a complaint can assist the APA in making up its mind as to the credibility of witnesses.
- 8.107 A civilian instructor had reason to believe that one of the trainees was assaulted, and yet did not report his concerns of his own initiative. Private(f) BH reported her problems to one Troop Commander, while the other Troop Commander had to physically restrain Sergeant BB from aggressive abuse of Private(f) BH having thrown a mug of tea at her. The Troop Commander involved in this incident did not think it fit to report this extraordinary conduct through the chain of command to his Officer Commanding. This Lieutenant was well aware that Sergeant BB and his colleagues had immense power of informal punishment and control over the day-to-day lives of the trainees, yet nothing was done to protect them from reprisals or abuse from Sergeant BB.

(xviii) The subsequent career of Sergeant BB

- 8.108 Having been transferred to a new posting in the RLC in February 1999, Sergeant BB faced no sanction – disciplinary or administrative. A year later, a Private BX made a complaint that he was punched twice in the face by Sergeant BB for falling asleep on a night exercise. A fellow Private saw swelling to Private BX’s face shortly afterwards but it was not reported until a few weeks later, when Private BX went AWOL because he did not want to receive more physical assaults from Sergeant BB. The RMP were called in and Private BX revealed that he had been the subject of abuse from Sergeant BB in April 2001 when he was unable to complete a cross-country running competition.
- 8.109 Again a decision was taken that there was insufficient evidence to support a criminal conviction. This Review is unimpressed with the reasoning behind this decision and does not consider it represents a fair recital of Private BX’s evidence as a whole, nor the evidence supporting it. However, this was a case of a single complaint of assault by someone who had gone AWOL. It was a less strong case than the Deepcut allegations against Sergeant BB, where all the counts could have been tried together and the witnesses could have supported cogent evidence of a pattern of behaviour.
- 8.110 Five months later, Sergeant BB faced further difficulties in his career. He was brought before his Commanding Officer on 9th January 2003 and admitted a relationship with a female Private from another Regiment. His Commanding Officer ordered him to discontinue the relationship with the Private forthwith, as it was prejudicial to the interests of the Service as he was married. Nine days later, Sergeant BB was arrested in the company of his female Private partner at a local supermarket where they were held on suspicion of

⁸² See Appendix A4/14.040 G – 041 D.

theft. He was transferred out of the Regiment to await the result of the civilian criminal proceedings and he was then administratively discharged from the Army for the resultant criminal conviction. His subsequent petition for redress was unsuccessful.

Conclusions

- 8.111 Sergeant BB is no longer subject to military discipline. Civilian proceedings for common assault or any other summary offence, or even a civil claim for damages, are no longer possible under the limitation periods applicable. Sergeant BB's own conduct is not linked to any of the four deaths with which this Review is primarily concerned. He was not at Deepcut at the same time as any of them. The issue for the Review is not any personal culpability of Sergeant BB but what these events tell us about systemic failures.
- 8.112 In the opinion of this Review, the events described above show a failure of the disparate branches of the Army to come together and promote the values they collectively espouse. ATRA needs to take a meaningful interest in the selection and training of its officers and NCOs, and ensure that the standards it sets are genuinely understood by all who are required to apply them, and that there is no ambiguity as to what an instructor is, and is not, permitted to do. The Training Regiment needs to ensure that all its staff – military and civilian – work to the same end in promoting high standards of conduct by instructors and trainees alike, and that physical and mental abuse is reported at the first sign of it emerging, irrespective of a trainee's willingness to complain. The MRO must identify what qualities make a suitable or unsuitable instructor, select them accordingly and encourage frank reporting by Commanding Officers on the efficacy of those selected. Land Command should ensure that the Commanding Officer has the support and the resources to move swiftly and effectively to maintain morale and high standards and to ensure that abusers do not have the opportunity to intimidate witnesses and frustrate investigations.
- 8.113 The APA, or the staff of the proposed Director of Service Prosecutions, should be aware of the real predicament of trainees who make complaints against instructors and the fact that training staff may divide and rule, explaining why some trainees attack those who speak out. The concern of this Review is that the reasons given by the APA for its decision in relation to Sergeant BB appear inadequate to address the public interest aspects discussed above. There needs to be clear guidance in a 'prosecutor's code of practice' reflecting these aspects of the public interest, as well as peer review before any decision to abandon proceedings is implemented to ensure that such guidance is given effect to.
- 8.114 Consideration should perhaps be given to whether the existing range of military offences sufficiently captures the predicament of soldiers living in close quarters in a disciplinary hierarchy. Is ill-treatment of subordinates a sufficient offence to cover all forms of abuse of power alleged in the case of Sergeant BB? Does it cover verbal abuse, intimidation and threats of reprisals?
- 8.115 Where, for good reason, no prosecution can be brought, a process needs to be established to ensure that the implementation of AGAI action is considered. In the final Chapter of this Report, the Review will consider how procedures could be strengthened to specifically deal with the case of abuse of power by instructors, training staff and others.⁸³
- 8.116 The Review strongly recommends that the Army convenes a multi-disciplinary case conference of all the interested military agencies in Sergeant BB's case to examine all the available papers with a view to developing a common approach to deterring abuse,

⁸³ See paragraphs 12.79 ff and Recommendations 20 and 21. See also Recommendations 15.

harassment and the undermining of the complaints system.⁸⁴ A specific learning account on the lessons from this case could prove valuable.

- 8.117 To encourage a culture of greater collective responsibility, the Review recommends that, in the future, disciplinary action is taken against staff who fail to record and report any abuse that they witness or that is reported to them.⁸⁵
- 8.118 The Review will consider the role of an independent military complaints ombudsman in Chapter 12.⁸⁶ It is perhaps the events described in this Chapter that best support the case for such a role to be established.

⁸⁴ See paragraph 12.83 and Recommendation 20.

⁸⁵ See paragraph 12.77 and Recommendations 17 and 18 below.

⁸⁶ See paragraph 12.94 ff.

9 Suicide Prevention and Supervisory Ratios

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Introduction

- 9.1 In this Chapter, the Review first examines further documentary material supplied to it by the Ministry of Defence (MOD) in which means of detecting and preventing self-harm, and self-inflicted fatal injuries, are further discussed at a national level, or at locations outside Deepcut. The second part of this Chapter then reverts to the Training Regiment at Deepcut and examines the available documentary material in the form of guardroom daily occurrence logs, Royal Military Police (RMP) reports and personal data dealing with selected cases of self-harm. It will also consider the quarterly management reports sent by the Commander of the Royal Logistic Corps (RLC) Training Group at Deepcut¹ to the headquarters of the Army Training and Recruiting Agency (ATRA) that provide a contemporaneous record of matters of concern to him and his command. In particular, the Review will consider in detail the Quarterly Reports of Brigadier Brown, Commander of the RLC Training Group from January 1999 to January 2002. One of the themes that emerges, and which is already familiar, is the shortage of supervisory staff. A subordinate theme, that will be equally familiar, is concern about the frequency of guard duty and what can be done to reduce it.
- 9.2 This material contributed to the decision by ATRA² to commission a report into duty of care and supervision by Lieutenant Colonel Haes,³ designed to assist on what level of supervisory ratios were needed in the training regiments. Finally, this Chapter notes the response of ATRA to the report by Lieutenant Colonel Haes.⁴ In January 1999, Major General Palmer (as he then was) took over as the Director General of Army Training and Recruiting until December 2001. Major General Palmer was to be subsequently appointed as the Deputy Chief of the Defence Staff (Personnel), following his promotion to Lieutenant General, with overarching responsibility for service personnel policy for the Armed Forces from 2003-2005. His knowledge of policies, practices and problems concerning the management of trainees has been of particular assistance.

Army policy on suicide prevention

- 9.3 From 1996 to 1999, the Army responded to the awareness of suicide amongst its ranks with a number of research studies commissioned to assist it to understand the nature of the problem.

The Walton Report

- 9.4 The most comprehensive analysis was a five part study of 'Suicide in the British Army' written by Dr Walton (the Walton Report), a Senior Psychologist working for the MOD.

(i) Part 1 – Prevalence and Methods, December 1996

- 9.5 In December 1996, Part 1 of this study, 'Prevalence and Methods', was produced.⁵ It noted the different ways in which suicide rates in the Armed Forces, and between the three Services, can be compared, the difficulties of accurate data retrieval and the importance of terminology. The preferred phrase was 'Intentionally Self-Inflicted Death' (ISID) rather than 'suicide', because the latter may have moral or legal connotations in different jurisdictions resulting in under-recording.

¹ Renamed the Defence Logistic Support Training Group in August 2001. See paragraph 4.63 above.

² See Appendix A4/13.020 C.

³ See Appendix 13 for a copy of the Haes Report.

⁴ See Appendix 14 for DG ATR's response to the Haes Report.

⁵ Dr Walton, 'Suicide in the British Army', Part 1: 'Prevalence and Methods', December 1996.

9.6 Part 1 found that for the selected period of study, 1990 to June 1996, there were 148 ISIDs in the British Army.⁶ This led to a computation of deaths per 100,000 as follows:⁷

Females: 4
 Males: 17
 Officers: 8
 Other Ranks: 17
 Gurkha Regiments: 7

The locations of these deaths were predominantly in Great Britain (75), with BAOR⁸ Germany (36) and Northern Ireland (22) the next major locations.⁹ Death from gunshot wounds from small arms was the most common type of ISID.¹⁰ With 30 deaths per 100,000, 1995 was the worst year for ISIDs in all locations. It was noted that ISID rates in the British Army appeared to be at least twice as high as those in the civilian population.¹¹ That appeared to be inconsistent with the general conclusions noted elsewhere that suicide rates were lower in the Armed Forces than for the civilian population generally. This statistical data has been the subject of further analysis and is considered below. In the conclusions to Part 1 of Dr Walton's study, it was noted:

*"Clearly suicide is a problem for the British Army. This preliminary research on data from the 1990s shows that the rate is twice that of the general civilian population in the same age range. Most victims are male and are Other Ranks. Few women and Officers commit suicide. It is suspected however that this trend would not be mirrored in attempted suicides."*¹²

It was also noted:

*"The fact that Army suicide rates and methods vary over time and by location, coupled with the fact that they surpass civilian rates, indicates that what is happening is not due to chance effects. Factors in the infrastructure of the Army or within the individual themselves (or some combination of the two) are in some way contributing to the decision, by some soldiers, to take their own lives. What these factors are and how they could be harnessed to develop preventative measures are issues which later phases of this research will address."*¹³

(ii) Part 2 – Correlates of Suicide, April 1997

9.7 Part 2 of Dr Walton's study, 'Correlates of Suicide', was produced in April 1997.¹⁴ The executive summary of this work revealed the following summary data on British Army suicides:

⁶ Using expert assessment, rather than Coroners' formal verdicts as the guide. This assessment included an investigation of suicide records held by Defence Analytical Services Agency (DASA), the RMP and Personal Services 4 (Army), see paragraph 2.0 of Dr Walton's report.

⁷ *Ibid*, paragraph 3.1.

⁸ British Army of the Rhine, as it was then.

⁹ *Supra*, footnote 5, paragraph 3.2.

¹⁰ *Ibid*, paragraph 3.3.

¹¹ *Ibid*, paragraph 3.12.

¹² *Ibid*, paragraph 4.1.

¹³ *Ibid*, paragraph 4.6.

¹⁴ Dr Walton, 'Suicide in the British Army', Part 2: 'Correlates of Suicide', April 1997.

"Age: 43% aged 20-24. Peak at age 24. 16% less than age 20. 20% 25-29.

"Marital status: 53% unmarried, 27% Married Accompanied, 19% Married Unaccompanied ...

"Age x method: under 20s favour poisoning, 20-24 Small Arms/Hanging, 35-39 Small Arms.

"Place: 58% in barracks.

"Discordant Relationships: 78% yes.

"Domestic Dispute Just Before: 51% yes (note that 71% of those with a history of discordant relationships have a domestic dispute just before. ...

"Suicide Notes: Left by 52% (but hardly ever left by those aged under 20 and commonly left by the over 30s).

"Previous Crimes: 40% have an RMP history.

"Previous Attempts: 22% attempted suicide previously.

"Alcohol: A factor in 40% of suicides.

"Financial/Legal concerns: A factor in 51% of suicides.

"Psychological Ill-health: A factor in 93% of suicides.¹⁵

"Regiment/Corps: After the Infantry, REME [Royal Electrical and Mechanical Engineers] see most suicides followed by Royal Engineers followed by RLC then R Sigs [Royal Corps of Signals]. Infantry analysed in its constituent parts but when put together, predictably, it accounted for most suicides. Most of these findings are not surprising given the size of each Regiment as a proportion of the Army. ...

"Regiment/Corps x Method: Infantry favour Small Arms. RA [Royal Artillery] + REME favour poisoning. No other method 'preferences' found.

"Rank: 55% Private or equivalent, 12% LCPL [Lance Corporal]. Rates fall with rank but a small rise at the rank of Major is observed ..."¹⁶

9.8 The conclusions in Part 2 of the study then discussed preventive measures that should be taken:

- "a. How to decrease vulnerability to ISI death amongst those serving Married Accompanied ...
- "b. How to better limit access to the most popular means of death (Small Arms) for all ranks and how to ensure that higher ranks do not abuse their power to gain access to weapons other than for legitimate purposes.
- "c. How to optimise supervision of soldiers (both on and off duty) in barracks and when consuming alcohol (whether it be in or out of barracks).
- "d. How to heighten awareness of ISI death amongst all ranks and how to spot those potentially at risk (i.e. behavioural and cognitive correlates of ISI death found in the British Army).

¹⁵ References to psychiatric and general ill-health have not been reproduced as they have no special relevance to the Deepcut deaths.

¹⁶ *Supra*, footnote 14, Executive Summary, paragraph F.

"e. How to respond to persons deemed objectively or subjectively to be 'at risk' of ISI death. Further, how the response should be varied depending on the relationship between the 'at risk' soldier and the responder (i.e. different aide-memoirs for COs, medical staff, Chaplains, family, friends etc.).

"f. The feasibility of moving 'at risk' soldiers into shared accommodation.

"g. How to best to communicate to those 'at risk' how they can help themselves (i.e. oral briefings vs. aide-memoirs) and the content of such communication including information on where to go for assistance. Furthermore, the issue of how to get this information to soldiers must be addressed. Whilst medical personnel, Chaplains etc. would be useful sources for distribution, there are some soldiers who may never approach medical or welfare personnel ..."¹⁷

9.9 This part of the study found that the preventive measures listed should be underpinned by the following assumptions: that most ISIDs are not spur of the moment decisions but are premeditated and, therefore, potentially preventable; but neither are they cries for help, as most are determined to successfully carry out their plan. It then noted:

"c. That an 'at risk' person may not apparently be 'at risk' through the objective eyes of a third party. What is important is the 'at risk' person's subjective view of their own personal circumstances and problems.

"d. That for those who know what to look for, indicators of an impending ISI death are almost always present. In only one death in the period 1990-1996 (June) was there a total absence of any identified cognitive or behavioural correlate of ISI death."¹⁸

9.10 What was emphasised, therefore, was that information flows were critical to identifying risk and that a prevention strategy had to be part of the Commander's responsibility with a line of reporting through confidential helplines and the chaplaincy service.

(iii) Part 3 – Development of a Suicide Vulnerability Questionnaire (SVQ), July 1997

9.11 Part 3 of the study by Dr Walton, 'Development of a Suicide Vulnerability Questionnaire' (SVQ), July 1997,¹⁹ embarked on the ambitious task of trying to find, from the 148 deaths under study, the factors that suggested greatest risk to the individual and, by completing the SVQ, give Commanders a management tool to identify those who exhibited those factors and, therefore, statistically, were most at risk.²⁰ Once risk was identified, cases could then be managed by reducing the opportunity to self-harm. Unsurprisingly, it was noted:

¹⁷ *Ibid*, Recommendations, p. 61.

¹⁸ *Ibid*, p. 62.

¹⁹ Dr Walton, 'Suicide in the British Army', Part 3: 'Development of a Suicide Vulnerability Questionnaire', July 1997.

²⁰ *Ibid*, Introduction, p. 2.

"The first objective upon finding a high SVQ score must be to make it as difficult as possible for the soldier to engage in suicidal behaviour. Therefore procedures to prevent 'access to means' must be implemented immediately. What these are will depend on the circumstances and location but could include some or all of the following:

- a. a temporary change of duties to those not requiring a weapon to be carried.
- ...
- b. restricted access to weapons.
- e. close supervision both in and out of the barracks.
- f. temporary cessation of any solitary tasks."²¹

- 9.12 Dr Walton's work to that date was noted and fed into committees concerned with personnel and welfare in the Armed Forces.²² In October 1997, the first edition of a document titled 'Suicide Prevention - A Commanders' Guide' (the Guide or Aide-Memoire) was issued.²³ The first sentence of the document stresses the theme of the Guide (with emphasis added by the Review):

*"Preventing suicide is mainly about:
Commanders at all levels knowing their soldiers sufficiently well to identify when and what help is required.
All soldiers fully supporting their vulnerable colleagues where necessary."*

- 9.13 A similar message was stressed on the Commanding Officers' Designate Course, held on 18th November 1999:

"Prevention is also about commanders ensuring that the environment makes it less likely that those at risk will want, or indeed be able to attempt to take their own life.

- must know your soldiers
- team building
- environment; minimize boredom, stress and frustration.
- supervision of potentially vulnerable people (access to weapons, not given lonely duties."

- 9.14 The Aide-Memoire gave a specific profile to look out for:

"A typical victim in the British Army will be a male private in his early twenties. He will most probably carry out the act in barracks. Small arms are the most frequently used method. It is likely that he will be experiencing some psychological distress of a degree of severity that he will have told somebody else."

²¹ *Ibid*, Conclusions, p. 22.

²² House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev 311, the written evidence of the Army Suicide Prevention Working Group.

²³ The 2000 and current editions are called 'Army Suicide Prevention – Aide-Memoires'. The three versions are reproduced in Appendix 12 of this Report.

(iv) Part 4 – Validation and Modification of the SVQ, May 1998

9.15 In May 1998, Part 4 of Dr Walton's study, 'Validation and Modification of the Suicide Vulnerability Questionnaire',²⁴ recommended that the SVQ be used as a tool, although noted that it should never be seen as the sole means of preventing suicide.²⁵ The relevant questions to be recorded by staff who were seeking to make an evaluation were those regarding rank, age, marital status, gender, previous self-harm attempts, health, alcohol use, relationship problems, financial difficulties and the like.²⁶ Answers to these questions were scored based on the comparison with the profiles extracted from the 148 cases.

(v) Part 5 – Suicide Prevention and Management, September 1998

9.16 The fifth and final Part of Dr Walton's study, 'Suicide Prevention and Management', was produced in September 1998. It was noted that the 16 to 24 age group accounted for 59% of all suicides studied. The executive summary noted the following:

"Suicide prevention encompasses suicide management since sensitive handling of completed suicides and thorough data collection can reduce the risk of further suicides.

"The British Army's current approach is characterised by the desire to help the soldier in distress but due to the previously unknown complexity of the problem the following summarise current resources:

"limited central databases of suicide information; limited Suicide Awareness Packages; good availability of staff (military and voluntary) with whom to share problems; poor utilisation of available support; keenness to treat most self-harm cases as disciplinary offences; lack of documented policies and procedural directives." ²⁷

The Hawley Report, October 1998

9.17 The completion of Dr Walton's study was followed, in October 1998, by a study of attempted suicide in the Army conducted by Lieutenant Colonel Hawley.²⁸ He noted that females were at greater risk than males.²⁹ Regardless of gender, the young, specifically those aged 15 to 24, were at the greatest risk of self-harm.³⁰ Attempted suicide was associated with alcohol but not specifically with psychiatric illness.³¹ Beyond this:

"Most authorities are agreed that there is usually a background of long-term problems concerning marriage or partners, children, work and health. Specifically, the agreed factors which are associated with increased rates of attempted suicide include the following: low socio-economic status, social deprivation, single or divorced, unemployment,

²⁴ Dr Walton, 'Suicide in the British Army', Part 4: 'Validation and Modification of the Suicide Vulnerability Questionnaire', May 1998.

²⁵ *Ibid*, Recommendations, p. 48.

²⁶ *Ibid*, 'Research Question 1: Relationship of SVQ Factors to Suicide', p. 19 ff.

²⁷ *Ibid*, Executive Summary, p. v.

²⁸ Lieutenant Colonel Hawley, 'A Study of Attempted Suicide in the Army: 10 Years of Experience 1987 to 1996'. Lieutenant Colonel Hawley's own footnotes are deleted from the following quotations from the report.

²⁹ *Supra*, footnote 24, Conclusions and Recommendations, p. 38.

³⁰ *Ibid*, Literature Review, p. 15. The identification of this age group as being at risk is related to the civilian population in general and not specifically to members of the Armed Forces.

³¹ *Ibid*, p. 17.

family discord, early parental loss, physical and/or sexual abuse as a child, and physical illness or disability (particularly epilepsy). Underlying most of these factors is a failure or inability to interact successfully with others.”³²

9.18 In the Army, specific issues were noted:

“Many of these are additional to those acting upon the individual because of his previous life experience before joining the military. Separation from home and partner has been identified in some attempted suicides as being significant, as is the shock and stress of joining a new organisation which is different from all prior experience. This gradual acclimatisation into a different set of customs, ethos and even language takes time but the initial stages take place during the period of early entry. This time coincides with the age at most risk from attempted suicide, namely the 18 to 25 year olds. Part of the difficulty arises from the hierarchical environment with a number of attempted suicides being precipitated by disciplinary action or conflict with superiors.”³³

9.19 By contrast, he noted the nature of the military ethic that traditionally supports an individual:

“An embodiment of this is seen in the regimental system which is intended to provide the social cohesion to enable soldiers to deal with the demands of the battlefield. Since these demands are specific to the army, a distinctive presence and ethos has been evolved. An individual is strengthened and supported by these psychological supports. The closeness of comrades and the shared experience of the dangers and tests of combat have been repeatedly described as central to unit cohesion, unit effectiveness and individual well-being. However, this situation only works maximally if the soldier feels himself part of the organisation. Alienation from the group will serve not only to render the support systems ineffective, it will result in additional social pressures acting upon the individual at a time when other stresses are likely to be extreme.

“So powerful are the social links bonding a group together, that outsiders are likely to be rejected.”³⁴

9.20 The problem is what the Army should do with the individual whose self-harm indicates he or she does not fit:

“It is this relationship between the needs of the individual and the organisation which is crucial to the question of operational capability. The psychological dimension is self-evidently fundamental to the question and is inextricably linked to the problem of mental health at work, albeit in a military setting. In addition, the Army prides itself upon its leadership and command functions. Any suggestion that avoidable psychological

³² *Ibid*, p. 15.

³³ *Ibid*.

³⁴ *Ibid*, Introduction, p. 10.

morbidity³⁵ is being tolerated is inimical to the tradition of a caring employer. It can also be seen as an indictment of the benign paternalism which epitomises most of the man management systems inherent in the regimental system.”³⁶

Growing Awareness of Intentionally Self-Inflicted Deaths in the Army

- 9.21 Although this Review focuses on Deepcut and the treatment of trainees, it has been provided with some broader data on ISIDs in the Army. It has also seen evidence regarding the growing awareness of the problem of suicide, and attempted suicide, in the Army and has noted the increasing concern in the media and in Parliament as to the disparate rates of ISIDs in the Army compared to the other two Services and the civilian population.
- 9.22 The problems of developing a strategy to address those concerns were discussed in the Army Suicide Prevention Working Group, set up in 1998 to review the Walton Report.³⁷ It seems to have met irregularly through this period. In 1998 and 1999, it was particularly concerned with how to establish the so called ‘psychological post-mortem’, examining how to learn lessons about why someone died after the death.
- 9.23 Other material provided to the Review by the MOD suggests that translating the Walton Report into an effective policy throughout the Army was to prove difficult. Further, it seems that lessons from earlier deaths may have been confined to the Corps or region where the death occurred, rather than informing Army-wide practice. Two examples are noted here.

The death of Private CR in Scotland, March 1999

- 9.24 Thus on the 21st March 1999, Private CR, a 20 year old male, was found dead from gunshot wounds whilst he was on lone guard duty at Fort George, near Inverness. The civil police retained primacy for the investigation and found that the death was self-inflicted. The Scottish Lord Advocate decided not to hold a Fatal Accidents Inquiry.³⁸
- 9.25 In June 2000, a Board of Inquiry (BOI) into the death was held to determine, amongst other things, why Private CR was authorised to do lone guard duty with a weapon and ammunition. It transpired that, apart from a difficult personal background and disciplinary history, he had been reported to the medical and welfare authorities for two previous attempts at self-harm some months before. He was on a three-month warning order for poor discipline. This would appear to make him a classic candidate for protective measures under the criteria identified by the Walton Report.³⁹ The BOI found that it was impracticable to have two armed guards on sentry duty unless the alert state demanded it. It noted that medical services did not find Private CR psychiatrically ill or not responsible for his actions. It concluded that the level of assessment of risk required to prevent his return to full military duties was too high, and that there should be greater co-ordination of information. Apart from the fact that this soldier was not a trainee and had been part of his unit for some time, the resonance of this death with that of Sean Benton appears obvious.

³⁵ ‘Morbidity’ is the state of being diseased and the morbidity rate is the number of cases found to occur in a stated number of the population usually 1:100,000, see Oxford Concise Medical Dictionary.

³⁶ *Supra*, footnote 28.

³⁷ *Supra*, footnote 22. The Group subsequently changed its name to the Army Suicide Management Working Group.

³⁸ See the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 s.1(1)(b). See also paragraph 2.15 above.

³⁹ As identified in Part 2 of her study ‘Correlates of Suicide’, p. 18 ff and later modified in Part 4 ‘Validation and Modification of the Suicide Vulnerability Questionnaire’, p. 19 ff. See paragraphs 9.7 ff and 9.15 ff above.

The death of Private CS at Catterick, April 1999

- 9.26 In April 1999, Private CS, a 21 year old male, was found dead by hanging in his room at Somme Barracks, Catterick Garrison. Death by ISID was established. This was the second such death by hanging in that Regiment in three months. This led the Commanding Officer in June 1999 to commission a review to identify the causes of the suicide of Private CS and the lessons to be learned from it. The informal review noted factors relevant to this death. Amongst these factors were the breakdown of a long-term relationship, debt problems and the fact that the Private had self-harmed on two previous occasions over the past three years. The latter was known to other soldiers but not to the chain of command, Private CS having been out of his chain of command for the five weeks preceding his death due to Regular Army Assistance to Training (RAAT) commitments of officers and NCOs.
- 9.27 Four observations in that review have some resonance for the four deaths at Deepcut with which this Review is primarily concerned. First, under 'Communication' it was noted:

*"At some stage those contemplating suicide will intimate this fact to someone. This will not necessarily be someone in the chain of command or in a position of authority. Soldiers often view depression or personal problems as 'wimpish'. These two facts quite often conspire to prevent an individual that can deal with a problem from doing so, e.g. a Platoon Commander or Company Commander is not informed. All ranks need to therefore be educated that whilst they may have been spoken to in confidence they have a duty of care to that individual to see that his problems are dealt with. Any mention of self-harm should immediately be conveyed to either the chain of command or to the Padre, RMO [Regimental Medical Officer], Families Officer etc."*⁴⁰

- 9.28 Secondly, it was noted that previous self-harm attempts should be taken seriously and entered in an 'at risk' register for medical assessment and attention. Whilst seeking to enable individuals with problems to remain in the Army was admirable, it was noted that there came a time when the Army must *"cut its losses and discharge those who are unsuited."*⁴¹ This was considered to be in the interests of the Army and the soldier, as an unsuited individual will frequently go AWOL and have disciplinary problems. A more robust discharge policy was called for.
- 9.29 Thirdly, the importance of a soldier belonging to a unit with experience of him, or her, and continuity in dealing with their problems was stressed:

"Chain of Command. Leadership is about trust both up and down the chain of command. This trust takes time to develop and must be strong at all levels. Critically an individual must have a sense of belonging to a team and feel important. We must strive to preserve the integrity of our teams and sections as the building blocks for the future. Under-manning does lead one to spread our man-power and then to constantly re-group for training, RAAT tasks etc. This temptation must be resisted and a strong and constant chain of command established. When considering postings of commanders, in particular, the impact on the organisation

⁴⁰ Reference G106/6 – 'Suicide – Indicators and Education: 1 HLD RS Experiences' dated 10th June 1999, paragraph 9.

⁴¹ *Ibid*, paragraph 11.

needs to be examined. Commanding Officers now routinely complete a 30 month tour, yet we move lower ranks with alarming regularity generating little continuity for their subordinates. This problem is acute for young, graduate officers who spend little time with their soldiers and consequently do not get to know them well.”⁴²

- 9.30 The report concluded with a now familiar call for the education of Commanders about the risk of suicide and better dissemination of information about its prevention.

The link between supervisory ratios and self-harm

- 9.31 Although the deaths of Private CR in Scotland and Private CS at Catterick have different features from the four deaths at Deepcut, the need to address suicide and self-harm in the context of the whole military unit in which the individual is engaged is striking. In the case of Private CS at Catterick, vulnerable individuals were left unsupervised through the demands of RAAT. In both cases, other ranks who had information as to self-harm or problems affecting the soldier had not been educated to report self-harm, or threats of self-harm, up the chain of command so action could be taken.

- 9.32 As this Review has come to learn about how relations are forged in the Army, it is increasingly persuaded that effective action to avoid risk must be taken by all soldiers in the Troop or Squadron working together. Privates must trust and relate to their NCOs. In terms of the welfare of a soldier, collective awareness and cohesion at all levels cannot be substituted by external agencies or ‘empowered officers’.⁴³ If this collective sense is contaminated by bullying, intimidation and oppressive behaviour, by harassment or sexual favouritism, the information flow, as well as the functioning of the whole unit, is affected. It is wrong to rely on the individual at risk, whose confidence in reporting a concern may have been diminished, whether by bullying or other personal factors, to bring the matter to the attention of the chain of command. Their comrades can and should. Being sensitive to even casual conversations mentioning self-harm or the deaths of others may be helpful to alert the chain of command to the need for prompt and effective action, removing opportunity to give effect to a suicidal disposition.

Age as a risk factor for self-harm

- 9.33 The Walton Report,⁴⁴ and the experiences of other Commonwealth forces, had indicated that young single people were a statistically vulnerable group when it came to risks of self-harm in military service. The Hawley Report identified a number of factors connected to the experience of living away from home in a strange environment that could put Army personnel at risk.⁴⁵ This is hardly a surprising or novel finding. Adolescence and the teen years are difficult and vulnerable times of transition. Those whose previous life experiences may have least equipped them for these changes will find them more difficult to make and are more vulnerable to damaging a fragile sense of self-esteem.

⁴² *Ibid*, paragraph 14. See, as an example, the discussion of Lieutenant(f) A at paragraph 6.169 ff.

⁴³ House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, paragraph 47.

⁴⁴ In particular Part 1, see paragraphs 9.5 – 6 above.

⁴⁵ *Supra*, footnote 28 at p.15 ff. The Report mentions “the shock and stress of joining a new organisation which is different from all prior experience.”

9.34 This Review notes the persistent problem of adolescent self-harm and suicide within the penal system and in young offender institutions.⁴⁶ Voluntary service in Her Majesty's Armed Forces can not be equated with a sentence of loss of liberty in one of Her Majesty's penal institutions. However, the extensive literature on self-harm by young people in prison indicates that there are points of comparison: social disadvantage, poor self-esteem, a sense of despair, fear of complaining about abuse, poor staff ratios and, consequently, poor supervision. In the opinion of the Review, being young, under or about 18, and living 24/7 within the disciplined regime of an institution such as the Army is, itself, a significant factor indicative of risk.

Defence Analytical Services Agency statistics

9.35 A similar message was being propagated by the Defence Analytical Services Agency (DASA). In August 1999, it published its analysis of ISIDs in the Armed Forces compared to the civilian population.⁴⁷ In summary, it found the seven year period under study, 1991 to 1997, had, in general, a lower number of ISIDs than statistically expected on the basis of the United Kingdom male population. The Army had an average of 21 ISIDs per annum compared with the expected 26. For the Royal Navy and the Royal Air Force, in no age group did the number of ISIDs exceed the expected number on the basis of civilian comparables.⁴⁸

9.36 For the Army, two age groups did exceed the expected civilian number. Those in the age group 20-24 were slightly higher: nine compared to the expected eight. This was not considered statistically significant. For the age group 15 to 19 the rate of ISIDs was almost double the rate for the civilian population: 23 as opposed to the expected 12.1. This gave a rate per 100,000 for this age group of 24.8 as compared to a civilian rate of 13.1. The Review appreciates that statistics must be handled with caution and that the numbers involved were so low that statistically relevant deviance could be encountered by one or two deaths over the period. The Review does not use the data to seek to focus on variations in the rates from year to year to micromanage causal explanations of such trends. Nevertheless, it is striking that the Army, alone of the three Services, had this anomaly and that it was confined to the younger age groups where the most ISIDs occurred.

9.37 In February 2001, an official in the Directorate of Service Personnel Policy (DSP Pol) in the MOD sought input from each of the Services and DASA to assist in a Ministerial response to an enquiry from a Member of Parliament concerning ISIDs in the Armed Forces.⁴⁹ The MP was concerned by the apparently high rates shown from 1996 to 2000 and was pressing for an investigation into why there were so many deaths through self-inflicted injury.

9.38 The official pointed out that the response that military deaths were not out of line with civilian rates may be difficult to sustain. He added the point that a bland comparison with overall civilian statistics of ISIDs per 100,000 may hide the scale of the problem, as the civilian statistics will include those who suffer from mental health problems and the high rate of deaths in custody, that one would expect to see excluded from the Army by selection and a robust disciplinary and welfare regime:

⁴⁶ In 1999, Her Majesty's Chief Inspector of Prisons, Sir David Ramsbotham, was commissioned to prepare a report on 'Suicide and Self Harm in the Prison Service 1999'. A series of seminars explaining the findings of this study were held and the documents came to the attention of ATRA. See also the Inquest publication 'In the Care of the State: Child Deaths in Penal Custody in England and Wales' by Barry Goldson and Deborah Coles (2005) that quotes extensively from the work of the present Chief Inspector of Prisons, Anne Owers. See also Lord Bingham's remarks in *Middleton*, quoted at paragraph 2.49 above.

⁴⁷ 'Self-inflicted deaths in the Armed Forces 1991-1997: A comparison with the UK civilian population', DASA, August 1999.

⁴⁸ *Ibid*, p. 1.

⁴⁹ Loose Minute D/SPPol(P&W)/8/3/13 dated 14th February 2001.

*"I am not sure that the statistical average argument holds water any longer and would welcome advice on the point. Nevertheless I should also advise that DSP Pol P&W doubts whether the line traditionally taken bears in-depth scrutiny. He takes this view because the rate for the population as a whole reflects a particularly heavy toll among distressed groups such as prisoners and the mentally disturbed. Unless we accept that we put abnormal stresses on people which adversely affect our rate we should perhaps be looking to do better than the average."*⁵⁰

- 9.39 On the face of it, this is an observation of substance given the persistent concern of the high rates of ISIDs in young men (in particular) in the penal system,⁵¹ whilst recognising that there are limits to what can be derived from statistical analysis alone.
- 9.40 A similar pattern of higher rates of ISIDs for the Army in the under 25 age group was still observed by DASA in July 2003, when the data analysed was extended over a longer period from 1984 to 2002.⁵² For the period 1992 to 2001, for each age group, the following data was recorded:

Age	Actual deaths ⁵³	Expected deaths ⁵⁴
17	3	2.6
18	9	5.9
19	15	8.7

- 9.41 Further, the statistical data also pointed to the use of firearms as a favoured method of death by young people in the Army, where a verdict of 'suicide' was returned. In November 2002, DASA published an analysis of methods of suicide in the Army from 1984 to 2001 for such deaths:⁵⁵

Age \ Method	Under 20	20-24	25-29	30-34	Over 35
Poisoning	6 (17%)	24 (23%)	14 (23%)	8 (26%)	24 (48%)
Hanging, strangulation and suffocation	11 (31%)	31 (30%)	24 (40%)	10 (32%)	10 (20%)
Firearms and explosives	15 (43%)	40 (39%)	14 (23%)	11 (35%)	7 (14%)

⁵⁰ *Ibid.*

⁵¹ *Supra*, footnote 46.

⁵² Dr Nicola T Fear and Scott Williamson, 'Suicide and Open Verdicts among Males in the UK Regular Armed Forces: Comparison with the UK civilian population and the US military', DASA, 14th July 2003.

⁵³ *Ibid.*, note the report refers to 'deaths' as those where a 'suicide' or 'open' verdict is returned at the inquest, rather than using the term ISID.

⁵⁴ *Ibid.*

⁵⁵ Dr Nicola T Fear, 'Army Suicides and Open Verdicts', DASA, 20th November 2002.

Overview of the material

- 9.42 Taking the statistical data, along with everything else that had been observed, learnt and reflected on over the previous five years or so, the Review would expect this to have prompted particularly focused proposals to seek to inform, educate and monitor risk factors in Regiments where young people were likely to congregate. Although suicide and self-harm is an issue for the whole Army and its Commanders, it must surely be seen as a particular issue for ATRA, with its focus on young people at the vulnerable moment of transition from civilian to military life.
- 9.43 The Review would also consider that this material might have led to further reflections and a continuing review of the benefits and risks of Single Entry.⁵⁶ With recruits as young as 16 mixing with older soldiers in Single Entry, this at least suggested that careful reflection on the duty of care regime was needed to create as safe an environment as was reasonably possible. The ability to recruit secondary school leavers into the Army to make up numbers was, doubtless, a necessary measure to maintain manpower levels. In the opinion of the Review, it brought with it corresponding obligations to safeguard the welfare of these young people. In Chapter 4, we have seen that whether these are regarded as moral obligations, or are the obligations spelt out in the United Nations Convention Rights of the Child, they demand to be sensibly addressed in policy, rather than disputed within the parameters of the law of negligence or breach of statutory duty.
- 9.44 Further, in light of the recognition that restricting access to the means and to an opportunity to fatally self-harm was a significant factor in preventing ISID, and given the prevalence of gunshot injuries as the dominant mode of death in the Army, the Review would have expected to see the senior policy makers in the Army also examining when and why young people have unsupervised access to lethal weapons. In particular, this raises the question of the nature and frequency of unsupervised guard duties. Prior to 2001, the deaths of Sean Benton and Cheryl James at Deepcut in 1995, and the deaths of Sapper Manship in Germany in 1992 and Private CR in Scotland in 1999, had all occurred whilst they were on guard duty. On the shooting range and in weapon firing exercises, the use of firearms by recruits and trainees is always carefully monitored and supervised. In the middle of the night, armed guard duty is not.
- 9.45 The Review has tried to investigate, through meetings with the Commanding Officers and senior officers of the Adjutant General's Headquarters at Upavon, whether consideration was given in the period from 1998 onwards, or at all, to the implications of the studies and reports, referred to earlier in this Chapter, on the previous experience of training organisations in general, and the training regime at Deepcut in particular.⁵⁷
- 9.46 After all, it was the demands of guard duty that appears to have been the main theme of disillusion with military life at Deepcut, and it also provided the opportunity and means for self-harm. Further, the Evans Report in 1995⁵⁸ and the BOIs into the deaths of Sean Benton and Cheryl James⁵⁹ showed it was the nature of the Soldier Awaiting Trade Training (SATT) phenomenon that had left many young people unsupervised, or without stimulating activity, for substantial periods at Deepcut. The conclusions of the expert advice available by 1998, considered above, stressed that to redress risk the soldier must be stimulated and occupied, and that, for the Commanding Officer to be aware of risk, the staff ratios must be such that soldiers are well known by those that supervise them and that fellow Privates should be taught to readily communicate anything they hear of potential concern.

⁵⁶ Paragraph 4.30 above.

⁵⁷ See for example Appendix A4/15.027 F – 028 B.

⁵⁸ See Appendix 11.

⁵⁹ See Appendices 9 and 10, respectively.

- 9.47 There is little evidence available to the Review that at ATRA, or elsewhere in the Army or MOD, the separate themes and factors from the events and various strands of research, noted above, were being brought together and recognised as contributing to the risk to trainees.

Self-harm in the Training Regiment at Deepcut

- 9.48 There were no suspected ISIDs at Deepcut between November 1995 and September 2001, although in light of some of the material reviewed in Chapters 7 and 8 it might be thought fortunate that this was the case. There were, however, regular incidents of self-harm or threatened self-harm. These have been referred to earlier in the context of the Evans Report and also at paragraph 8.21 above.
- 9.49 The guardroom daily occurrence logs for Deepcut provide the best snapshot of what was going on at the Barracks during this period of time. Members of the Review team have abstracted data from these logs that recorded reports of self-harm or suspected, or threatened, self-harm brought to the attention of the guardroom.
- 9.50 It is difficult, from the brief entries, to assess the seriousness of the incidents and whether they could be classified as attempted suicide. The attempt at a rigid distinction is probably unrealistic and inappropriate. The tenor of the expert advice noted above was that self-harm should be noted as a warning sign that increases risk of progression. Further, the Review is satisfied that recording self-harm is not a proper basis for a critical comparison between units on the basis of raw statistics. A unit with a higher record of reported events may simply be more conscientious at logging the incidents in the first place.⁶⁰ However, recording the information is a first step to responding to it and understanding what it reveals. The lack of consistent data and effective analysis, until the studies noted above were commissioned, is striking.
- 9.51 The analysis of the guardroom daily occurrence logs at Deepcut is set out below in Figure 9.1. It must be approached with some caution. Not all the events occurred at Deepcut and some may relate to personnel on home leave or at training establishments elsewhere. Not every individual recorded will belong to the Training Regiment, although most appeared to.

⁶⁰ See Appendix A4/15.031 F – G, where ATRA's Chief of Staff explains how awareness and proper process influence the reporting standards.

Figure 9.1: Evidence of self-harm abstracted from the guardroom daily occurrence logs at Deepcut, December 1996 to June 2000

Period of log	No. of Incidents	Form of reported or suspected self-harm
16th December 1996 – 25th June 1997	7	6 wrist cutting (2 minor) 1 overdose
26th June 1997 – 2nd September 1997	3	2 wrist cutting 1 overdose
3rd September 1997 to 7th May 1998	6	4 overdoses (1 by Sergeant outside unit) 2 other (1 away from unit)
8th May 1998 to 7th February 1999	8	2 wrist cutting 4 overdose 2 other
8th February 1999 to 22nd July 1999	3	2 wrist cutting 1 threatened use of fire arm if go on guard
23rd July 1999 to 16th January 2000	10	1 wrist cutting 4 overdoses 5 other
17th January 2000 to 4th June 2000	10	2 wrist cutting 4 overdoses 4 threats of self-harm (including 1 firearm)
Total 3½ years	47	15 wrist cutting 18 overdoses 14 other

9.52 Some attempt was made to establish what the follow-up to these reports was. This was hampered by the fact that there was no column in the guardroom daily occurrence log indicating whether the case was reported to the RMP, as should have been the case. From RMP records, the Review identified 17 cases of self-harm reported to them in the period covered by Figure 9.1, including trainees from 86 Squadron who self-harmed at other training establishments. From the RMP reports available, selected medical files were made available to members of the Review team for analysis of the medical files. Such analysis indicated that, for individuals who had self-harmed more than once, only one of the incidents had been reported to the RMP.

9.53 Members of the Review team analysed all the RMP records from 1994 and identified individuals who had self-harmed. The Review then obtained the medical files for 26 of these individuals, who between them generated 38 self-harm attempts. From the medical files, there is some evidence of self-harm being treated as manipulative or attention-seeking by the health professionals. Some are suspected of being attempts to get discharge outside the Discharge as of Right (DAOR) window. However, it seems that persistent self-harmers were eventually discharged from service. Nevertheless, there are individuals with records of serial self-harm who do not appear to have been discharged or, indeed, hospitalised.

- 9.54 The Review cannot now ascertain whether the trainees involved in all these cases were ever removed from the roster of those eligible for guard duty. Few of the trainees whose medical records this Review has seen were ordered by their doctor not to undertake guard duty. Clearly, the Guard Commander still has to exercise discretion as to an individual's suitability for guard duty on the day but, given that the Guard Commander may not know the soldiers assigned for duty, there is a danger of undue reliance on 'medicine' rather than 'management' in this respect.⁶¹
- 9.55 There is some evidence that trainees trusted their NCOs more than the medical team. By way of further reflection on the different perceptions of Sergeant B, who has been discussed in some detail in Chapter 5, the Review noted one case of a female trainee with a troubled personal history and four self-harm attempts who was unwilling to see the army psychiatrist alone in 1996 but wanted Sergeant B to attend and explain her problems. It would appear that the army psychiatrist wanted her to 'soldier on' but Sergeant B and the Officer Commanding the Squadron were unhappy about this and were concerned that the unit did not have the resources to monitor her welfare effectively.⁶²
- 9.56 The RMP and the medical files reveal no recorded complaint of bullying by those who self-harmed, save for one reference back to an experience during Phase 1 training at ATR Bassingbourn. Upon referral to the RMP, it is standard for the individual to be asked whether or not they have been subjected to bullying. Where they have not been subjected to such behaviour, the RMP action ceases and the case is generally referred back to the Training Regiment for any medical or management consideration.
- 9.57 What does emerge from these records are consistent accounts of what may be called the Deepcut, or SATT, characteristics of boredom, under-stimulation, ill-discipline and abuse of alcohol, evident from the material considered in Chapters 5 and 6 of this Report and noted, in detail, in the Evans Report in 1995. The following summaries, prepared by members of the Review team, and using quotations from RMP files, are worthy of note in this respect:

⁶¹ See paragraphs 5.15, 5.20 and 5.172 above and 10.70 below.

⁶² This would appear to be another example of Sergeant B's compassionate behaviour, see paragraphs 5.104 and 7.24 above.

Figure 9.2: Extracts from self-harm cases at Deepcut reported to the Royal Military Police

Trainee 1
<ul style="list-style-type: none"> • Attempted suicide while held in guardroom. Recognises self to be alcoholic. Complains of only completing $\frac{1}{4}$ of his trade training in 13 months at Deepcut. • <i>"The rest of the time I have been left to my own devices, with nothing to do but drink to pass the time."</i>
Trainee 2
<ul style="list-style-type: none"> • <i>"Deepcut was monotonous and over the previous two months he had become depressed and homesick."</i> • The RMP made the following comment concerning the trainee's Troop Commander and Troop Sergeant: <i>"Neither had any significant contact with the soldier and described him as a 'grey man'."</i> • This is in spite of the soldier having recently been given 14 days' sick leave due to depression.
Trainee 3
<ul style="list-style-type: none"> • Complains of sitting around doing nothing at Deepcut for five months in his statement. • <i>"The sheer boredom factor and lack of continuation training led me to ponder on my life in HM Forces ..."</i>
Trainee 4
<ul style="list-style-type: none"> • States that he <i>"... felt bored and irritated by waiting between courses and whilst incapacitated with a broken foot, having nothing constructive or stimulating to undertake."</i> • His Troop Sergeant referred to him as a 'grey man'.

Supervisory ratios at Deepcut

9.58 If trainees were under-occupied or not known to their officers and NCOs, this was partly the result of poor supervisory ratios. The Review has seen a consistent sequence of quarterly management reports (Quarterly Reports) written by the Commander of the RLC Training Group to HQ ATRA from October 1997 through to 2002, and the response of ATRA to the concerns raised. These Quarterly Reports provide a record of concerns about financial resources, staff numbers and other aspects of the regime at Deepcut that might have affected the delivery of an effective regime addressing the reasonable welfare needs of trainees. The Review understands that these Quarterly Reports would have been supplemented by oral briefings to the ATRA Management Board, of which the Commander is a member.

(i) Quarterly Reports to ATRA in 1998

9.59 The Quarterly Report to ATRA for the end of the financial year April 1998 gives a picture of 1,666 Phase 2 trainees posted to the field army during the previous year, all but 14 of whom passed their Basic Fitness Test. It was noted that during the year formal induction training had been provided for 139 civilian and military staff, and those taking up instructional posts were given the ATRA Code of Practice for Instructors.⁶³ It perhaps would have been helpful if trainees and welfare staff were also provided with the Code of Practice if it were to substantially define standards of behaviour.⁶⁴

⁶³ See paragraphs 4.105 and 8.70 ff above.

⁶⁴ See paragraph 12.69 ff below.

- 9.60 Brigadier Dalby-Welsh was the Commander at Deepcut from January 1996 to January 1999. There is no indication in his Quarterly Reports of a crisis of supervisory ratios or a serious number of self-harms. Two cases at St Omer Barracks, Aldershot and six at Deepcut were noted, none of which resulted in hospitalisation. In conversation with this Review, the Brigadier has emphasised that in oral representations he was stressing the case for greater numbers of supervisory staff.⁶⁵

(ii) Quarterly Reports to ATRA in 1999

- 9.61 A rather different picture emerges from Brigadier Dalby-Welsh's successor. In his first Quarterly Report in April 1999, Brigadier Brown noted, under the heading 'duty of care personnel':

"The RLC Training Group is responsible for the day-to-day management and administration of all RLC Phase 2 trainees irrespective of their training location.

*"The average number on Held Strength is about 1000 personnel. Of this some 500 to 600 are physically located in Deepcut at any one time. They are either on course, awaiting a course allocation or start date, pending posting or discharge. Currently the Training Regiment and Depot RLC is established with 10 Cpls for direct face to face duty of care responsibilities, this equates to a ratio of One Cpl to 120 Phase 2 trainees. Although attempts have been made to improve this situation we have been continually hampered by the lack of establishment guidelines for duty of care responsibilities. Given the immediacy of the Working Time Directive, together with the pending implementation of the Young Worker's Directive, I believe that this issue must be addressed at a corporate level. Whilst noting your staff holding reply to our concerns I would ask that we take this matter forward as soon as possible."*⁶⁶

- 9.62 The Review has considered the reality of life at Deepcut as captured in this quotation. If the ratio of Corporal to trainee is 1:120, and some of the trainees are away on courses for much of the time, how can it be said that any level of Commander – be it at Troop, Squadron or Regimental level – can 'get to know' their soldiers? Yet knowing the soldier was, and continues to be, a factor emphasised as the central aspect of the suicide prevention policy of the Army.
- 9.63 Admittedly, the Review notes that in the April 1999 Quarterly Report, and in conversation with Brigadier Brown,⁶⁷ the main concern expressed was with the staff and the need for their duties to be brought within the hours permitted under the Working Time Directive. However, there is a clear link between overburdened staff and the welfare of trainees. Apart from not having an opportunity to get to know their soldiers, the staff will only be able to organise less stimulating activities for the soldiers whilst they await training. If they are over-stretched and over-committed, staff are less likely to display tact, patience and adopt a trainee-focused educational approach.
- 9.64 The same April 1999 Quarterly Report notes that the zero target for self-harm had not been met. There had been six cases of self-harm – *"none of the cases concerned has been considered to be 'life threatening'"* – out of a trainee population of 1,813. It expresses concern at the high level of discharge of Phase 2 trainees (177 or 9.8%) who attended the induction courses. This statistic suggests that the number of trainees passing through

⁶⁵ See Appendix A4/2.008 F.

⁶⁶ 'The Royal Logistic Corps Training Group End of Year Report – Training Year 1998-1999', p.5.

⁶⁷ See Appendix A4/1.008 B – E.

Deepcut at this time had risen from the 1,666 mentioned at paragraph 9.59 above. The Quarterly Report emphasised that ATRA should consider *“the need to develop establishment criteria for Duty of Care manning levels.”*⁶⁸ It is this issue that was subject to more detailed analysis by Lieutenant Colonel Haes in February 2001, considered below.⁶⁹ ATRA’s response to the April 1999 Quarterly Report was that the concern was shared, and would form the basis of future discussion the following month.

- 9.65 However, in July 1999, Brigadier Brown was still pressing the issue in his next Quarterly Report:

*“Although we still wait guidance on how some of the more pressing and substantive issues are to be taken forward, I am keen that we continue to give this important area high level attention. For instance the need to establish definitive manning criteria for Phase 2 could not be clearer. My Phase 2 training population has grown by over 20% in the last year (883 to 1132), however I have not had any additional resources given to me for administration and Duty of Care. Furthermore, the incidence of Permanent Staff seeking early moves is on the increase.”*⁷⁰

- 9.66 The point was also made that 40 trainees had reading and writing difficulties that slowed their progress through courses and led to them being ‘returned to unit’. It was noted that this problem was getting worse.⁷¹ The poor educational attainment of a number of his trainees is a theme Brigadier Brown picked up on a number of occasions in his Quarterly Reports. This issue led to higher failure rates, delays in training and added pressure on staff.

- 9.67 ATRA’s response to those concerns started with an unpromising reference to financial constraints but at least acknowledged that Deepcut may have had a special problem to be discussed:

“(a) Your deep concern is shared. We have no alternative but to manage ATRA business within the resource restrictions imposed upon us. However, you will be aware of the discussions at the ATRA MB [Management Board] and the intended direction articulated at Ref B.

“(b) The overall study into Duty of Care in ATRA is uncovering a complex matrix of varying difficulties between ODs [Operating Divisions]. There is no single solution to ATRA DofC [Duty of Care] and retention problems, although there are some common policy projects e.g. defining the parameters of DofC that are now being worked on, which may help.

“(c) RLC Trg Gp clearly has a particular problem that appears to revolve around the ability of 86 Sqn’s 21 people to provide the desired DofC for the numbers of trainees passing through RLC TrgGp. WTR [Working Time Regulations] and civilianisation may also impact on this. We recommend you also raise this at the bi-lateral in Sep.

⁶⁸ *Supra*, footnote 66, p.7.

⁶⁹ See Appendix 13, the Haes Report, ‘ATRA Duty of Care and Supervision (DofC&S) Report 98-01’, 24th April 2001.

⁷⁰ ‘The Royal Logistic Corps Training Group First Quarterly Report – FY 1999/00’, 13th July 1999, p.3.

⁷¹ *Ibid.*

"(d) To enable HQ staff to see the scale of the problem, would your staff please provide a rough order measure/cost of:

(1) What additional resources would be required to meet the minimum DofC?

(2) What reduction of output is proposed if this cannot be met?"⁷²

9.68 In October 1999, Brigadier Brown emphasised his concerns, yet again, with the education standard of trainees, which was causing time to be spent in basic remedial training at the expense of other activities.⁷³ Welfare and duty of care remained a concern with over 100 cases of sexually transmitted disease⁷⁴ and long queues at the Medical Centre.

(iii) Quarterly Reports to ATRA in 2000

9.69 The problem of insufficient resources to provide "the essential additional benefits of service life – sport, adventurous training and competitions" for the Phase 2 trainees and staff was stressed in Brigadier Brown's Quarterly Report of April 2000.⁷⁵ It appears that SATT had been reduced by a scheme to send Phase 2 trainees to the field army for work experience, rather than holding them within an ATRA training establishment. This eased the problem of under-employed soldiers at Deepcut but it was noted that it created the alternative problem of insufficient soldiers to perform guard duty.⁷⁶ Other duty of care problems remained. ATRA noted in response:

"... discipline appears to be an increasingly widespread cause for concern."⁷⁷

9.70 In July 2000,⁷⁸ there was repeated concern about personnel levels and the inability to train due to other demands being made. The duty of care to trainees was hampered by the length of time it took serious disciplinary cases to come to Court Martial, during which time the individuals concerned remained at Deepcut and were a bad influence on others.

9.71 In October 2000,⁷⁹ the results of a satisfaction survey of trainees were reported on.⁸⁰ Dissatisfaction with the quality of the accommodation was most noticeable with 48% rating their room as 'poor' or 'unsatisfactory'.⁸¹ It seems that 30% had participated in adventure training and 66% in sporting activities. Nearly all rated sporting and welfare facilities 'satisfactory' or above.⁸²

⁷² 'Response to Quarterly Report for RLC Trg Gp', 26th July 1999, p.1 ff.

⁷³ 'Second Quarterly Report', 12th October 1999, p.1. See also paragraph 4.8 above.

⁷⁴ *Ibid.*, p.2. During the preceding three month reporting period, 58 new cases of sexually transmitted diseases had been recorded.

⁷⁵ 'The Royal Logistic Corps Training Group – End of Year Report', 12th April 2000, p.3. Brigadier Brown noted that these benefits "are becoming impossible to accommodate."

⁷⁶ *Ibid.*

⁷⁷ 'ATRA Response to Quarterly Report for RLC Trg Gp', April 2000, p.2.

⁷⁸ 'First Quarterly Report – 01 Apr – 30 Jun 00', 12th July 2000.

⁷⁹ 'Second Quarterly Report – Defence School of Transport and RLC Training Group', October 2000.

⁸⁰ The satisfaction survey initiative was introduced by Brigadier Brown, see Appendix A4/1.018 F – 019A. The survey aimed to gauge Phase 2 trainees' satisfaction with various aspects of services and amenities provided, as well as their satisfaction with awareness levels of equal opportunities and harassment procedures.

⁸¹ See paragraphs 12.15 and 12.57 below.

⁸² *Supra*, footnote 79, p.3.

(iv) Quarterly Reports to ATRA in 2001

9.72 These trends from the satisfaction surveys were noted in Brigadier Brown's next Quarterly Report in January 2001,⁸³ when it was noted that 60% of trainees found the amenities in their accommodation block to be below expectations. 93% rated the Welfare Support, and 81.3% rated their overall Phase 2 training, to be satisfactory or above. Improved morale was, in part, attributed to the policy of getting rid of troublemakers and poorly motivated soldiers.⁸⁴

9.73 The satisfaction surveys were noted to be a useful tool in the following April 2001 Quarterly Report, as frequent surveying enabled trends to be monitored.⁸⁵ It was noted that 68% of trainees said they enjoyed their overall Phase 2 training, while 100% stated that they performed more than 14 days' guard duty during their training. It may be that this picture is partly a result of the fact that RLC recruiting was significantly down in the financial year and output was only 59% of target.⁸⁶ However, there had been seven cases of self-harm and 26 cases of alcohol-related injuries in the previous three months. Over the preceding 12 month period, 91 new cases of sexually transmitted diseases had been recorded. This represented approximately 8% of the trainee population and continued to be a matter of concern with respect to the duty of care issue.⁸⁷ The response from ATRA noted:

*"The issue of self-harm and alcohol misuse is an indicator of general levels of psychiatric morbidity in units. This adds to a case that SMO [Senior Medical Officer] ATRP is making that there should be better community psychiatric nurse support for ATRA training units. This individual could deal with cases and provide weekly clinics. This case will be pursued further in light of this information."*⁸⁸

The Haes Report, April 2001

9.74 In October 2000, Major General Palmer (as he then was), Director General of Army Training and Recruiting (DG ATR), the head of ATRA, commissioned Lieutenant Colonel Haes to report on Duty of Care and Supervision within ATRA (the Haes Report).⁸⁹ The terms of reference for this study were significant and suggested that ATRA would answer the issues of concern raised by a number of Brigadier Brown's Quarterly Reports since 1999. The terms of reference to the Haes Report stated:

"OBJECTIVE

A Study is to be undertaken to establish policy and provide a basis for Op Divs to identify the minimum resources needed to deliver ATRA's legal Duty of Care and adequate levels of supervision and support to trainees. This Study should also inform STP [Short Term Plan] 02 and guide development of ATRA risk assessment.

⁸³ 'RLC Training Group Third Quarterly Report', 15th January 2001

⁸⁴ *Ibid*, p.5.

⁸⁵ 'RLC Training Group and DST End-of-Year and Final Quarterly Report', 12th April 2001, p.8.

⁸⁶ *Ibid*, p.2.

⁸⁷ *Ibid*, p.8.

⁸⁸ 'ATRA Response to Quarterly Report for RLC Trg Gp', April 2001, p. 2. For 'morbidity' see footnote 30 above. The observation raises the concern that the toleration of morbidity that Colonel Hawley found unacceptable was now in effect an everyday part of the Training Regiment, see paragraph 9.20.

⁸⁹ See paragraph 9.2 above.

"SCOPE

The Study is to concern itself with the support facilities and resources needed to ensure the safety and welfare of trainees over and above the requirements for the efficient delivery of training per se, but is also to take account of ATRA's duty to its staff."⁹⁰

9.75 Amongst the purposes of the study were the following:

- "d. *Duty of care, welfare and supervision requirements will be identified and categorised.*
- "e. *The potential risks associated with failure to provide each element of support identified will be assessed.*
- "f. *Based on that assessment, a statement of minimum requirements will be produced.*
- "g. *A flexible target range of military staff/trainee ratios, based on full manning and maximum trainee numbers, will be produced to calculate the resultant manpower requirements.*
- "h. *Recommendations will be made as to staff supervisor training requirements."*

9.76 Lieutenant Colonel Haes completed his report in April 2001. The Haes Report did much to bring together persistent concerns about lack of clarity as to the Commanding Officer's obligations in this field and the ability of ATRA to provide the resources to deliver on its duty.

9.77 The Haes Report noted that 40-50% of ATRA's recruits were under 18 and that ATRA depended on Land Command⁹¹ for welfare support at a time when delivery of Army welfare was *ad hoc*.⁹² It suggested that the Commanding Officer's responsibilities and liability must be defined and then adequate resources provided to meet them, or else the obligations modified to match the resources. It noted:

*"The dilemma is that military staff are being reduced at a time when the Duty of Care and Supervision needs of trainees appear to be increasing; a credibility gap is opening up."*⁹³

9.78 The report noted that the demands of guard duty stretched staff and put security at risk:

"The Guardroom and Security The guardroom resources are being overstretched OOHs [Out of Hours] and security put at risk.

- a. *Where MPGS [Military Provost Guard Service] are not employed, the guard is found from SATT, SAD [Soldiers Awaiting Discharge] and Phase 2 trainees. Security may be in the hands of dissatisfied, disinterested or unqualified soldiers with live ammunition."*⁹⁴

⁹⁰ The Haes Report is reproduced as Appendix 13 to this Report.

⁹¹ See paragraph 4.64.

⁹² See Appendix A13.003, paragraph 13.

⁹³ *Ibid*, paragraph 14.

⁹⁴ See Appendix A13.005, paragraph 25.

- 9.79 The demands of guard duty as interfering with training had previously been raised by the then Commander at Deepcut, Brigadier Dalby-Welsh, with ATRA in January 1998.⁹⁵ It was noted that Phase 2 trainees at the Army School of Catering at St Omer Barracks, Aldershot were being held back from joining the field army by up to four weeks by the need to perform guard duty. ATRA responded the next month in the following terms:

*"Unfortunately, the ASofCat is not alone in this problem. It is intended that MPGS will replace students on guard duties in due course but the timescale is not yet clear. HQ 4 Div did not respond to LAND's request for additional MPGS under the parallel scheme and will be tasked with doing so again. Replacement of students on security duties will be given additional impetus when the Initial Trainees budget comes to the ATRA."*⁹⁶

- 9.80 It is fair to observe that when guard duty was mentioned by Lieutenant Colonel Haes, self-harm, as opposed to risk of harm to others, may not have been central to his concerns. However, with the experience of the deaths of Sean Benton and Cheryl James at Deepcut, and others elsewhere, joined with some of the other deaths the Review has noted above, it is difficult to see why this should have been the case.
- 9.81 The Haes Report noted ATRA's evolution, from the former Regimental and Corps training establishments and depots via the AITO (Army Individual Training Organisation),⁹⁷ and the discrepancy between training functions to be performed and the number of available soldiers to perform them.⁹⁸ The training function was being squeezed by the initiatives on the deployment of resources to the front line. The consequence was:

*"The tightly costed SOTR [Statement of Training Requirement] has compacted recruit training in time and content, with resources pared to a minimum. 'Just enough just in time' is squeezing delivery of ethos, including DofC&S [Duty of Care & Supervision]."*⁹⁹

- 9.82 The report also noted that much time at training regiments was being spent on discipline and repeat offenders:

*"Attitudes in Society and Discipline. Trainees are reportedly less robust morally, physically and mentally; recruits bring more problems with them than previously and there is concern about trainee attitude towards attendance and time keeping. ATRA currently represents 40% of Army discipline cases and one Op Div (Armr Cen) [Operating Division (Armoured Centre)] recorded discipline rates more than doubled in 99-00 but offenders number about 20% of trainees and many are repeat offenders. The approach to Army discipline in training is being softened and the effort to inculcate ethos and produce trained, disciplined soldiers requires greater supervision and time."*¹⁰⁰

⁹⁵ Reference HQTG 3801/1A(Plans & Res) dated 14th January 1998.

⁹⁶ Annex A to ATRA 15/29/2 dated February 1998.

⁹⁷ See paragraph 4.35 above.

⁹⁸ See Appendix A13.009, paragraph 46.

⁹⁹ *Ibid*, paragraph 47.

¹⁰⁰ *Ibid*, paragraph 49.

- 9.83 What was called the 'grey face' factor meant that there was often nobody who knew the trainees well unless they became disciplinary cases. As a result, some 80% of trainees passed through their training unknown to the staff.¹⁰¹ As noted, this had already been well documented by, amongst others, the RMP in their reports on self-harm.¹⁰²
- 9.84 Lieutenant Colonel Haes based his report on a 48-hour working week for instructors, and multiplied hours and staff needs to address ATRA's throughput of trainees.¹⁰³ From surveys of working practice, he then sought to identify which units of the training estate were most at risk. He concluded that the RLC Training Group was one of four who were:

*"... not delivering satisfactory levels of DofC&S to students, and in some cases, staff. They are considered to be at risk."*¹⁰⁴

- 9.85 The duty of care owed to staff was considered to be jeopardised by the excessive working hours in breach of the Working Time Directive.¹⁰⁵ As far as recruits and trainees were concerned, Lieutenant Colonel Haes did not spell out in detail what the risk entailed. He recognised a general failure to deliver adequate training and he noted that many trainees were unlikely to have attained the minimum fitness standard upon leaving ATRA.¹⁰⁶ Understaffing meant that most trainees passed through their training without staff getting to know them, which also meant they were unable to address their welfare needs. Lieutenant Colonel Haes did not, however, deduce any particular foreseen consequence. Self-harm is rarely mentioned in his report, although it was clearly noted as one consequence of poor staff ratios. Thus, he noted:

*"There is not enough programme time for interviews or admin and personal problems go unnoticed eg U18 female with an alcoholic history; depression leading to self-harm; a suicide case lay undiscovered in his accommodation for a number of days (5?). In most Phase 2 Op Divs U18s get little if any more supervision than over 18s (18+). Unless an incident occurs that exposes a problem, it is unlikely to be discovered before the individual reaches the Field Army or becomes a wastage statistic."*¹⁰⁷

- 9.86 He noted that instructors for training regiments were not always selected because of their skill at this task and called for better training and selection:

*"Selection of Ph2 instructors in technical arms is not necessarily on the ability to provide suitable DofC&S. Whilst ITGIS [Initial Training Group Instructor School] supports Phase 1 instructors, there is a need to training ATRA instructors and supervision staff to cope with the legalities and practice of delivering DofC&S. The Commanders Guide to dealing with Self-harm should be issued to all ATRA supervisors."*¹⁰⁸

¹⁰¹ See Appendices A13.011, paragraph 52 (f) and A13.015, paragraph 61. The latter points out that *"the other 20% are more likely to be known for the wrong reasons."* See also Figure 9.2 above.

¹⁰² See Figure 9.2.

¹⁰³ See Appendix A13.008, paragraph 44.

¹⁰⁴ See Appendix A13.013, paragraph 58 (a).

¹⁰⁵ *Ibid*, paragraph 58 (b). At paragraph 59 it stated: *"ATRA is technically breaking the law."* See also Appendix A4/10.030 D – G.

¹⁰⁶ See Appendix A13.017, paragraph 75.

¹⁰⁷ See Appendix A13.015, paragraph 62.

¹⁰⁸ See Appendix A13.016, paragraph 65.

- 9.87 Lieutenant Colonel Haes noted the link between alcohol and indiscipline, particularly with respect to under-18s.¹⁰⁹ He called for better supervision at weekends and in accommodation blocks. He further observed that supervision by NCOs in Barracks led to a reduction in damage of property.¹¹⁰
- 9.88 The last paragraph of the report repeated Lieutenant Colonel Haes's recommendation with respect to guard duty:
- "Camp Security. The practice of using Ph 2 SATT and SAD (soldiers awaiting discharge) for guard duties, means that-soldiers who may not have qualified on their rifle are issued with live ammunition. In the case of SAD, the security of the camp may be in the hands of the disaffected and disenchanting. Moves to get MPGS in all ATRA sites should be given greater priority ..."*¹¹¹
- 9.89 It can be seen from these quotations that many of the issues touched on by Lieutenant Colonel Haes repeated matters previously noted by the Evans Report in 1995¹¹² and the BOIs¹¹³ into the deaths of Sean Benton and Cheryl James, as well as the Commanders' Quarterly Reports to ATRA. Lieutenant Colonel Haes recommended that the under-manning in ATRA be reduced *"by all means possible"*¹¹⁴ and that there should be *"no new tasks without resources."*¹¹⁵ He did not propose that the Army should accept the risk of harm, self-harm and the inability to deliver competent and satisfied trainees.
- 9.90 In summary, what the Haes Report recommended was either a reduction in the throughput of trainees and/or the levels of training or that the duty of care be stripped down to a basic minimum.¹¹⁶ The option of a more minimalist approach to duty of care sat uneasily with the recognition of a responsibility towards under-18s in ATRA and the founding philosophy of Single Entry. Therefore, he recommended that resources be extended to increase the number of supervisors per trainee to discharge duty of care obligations.¹¹⁷
- 9.91 The case made by the Haes Report seemed compelling, particularly when set against the history already recounted by this Review. However, as has been pointed out to this Review, implementation of the recommendations of the Haes Report would have required experienced NCOs to be diverted from front line duties (where the limits on hours worked imposed by the Working Time Directive did not apply), to the training regiments (where the Directive did apply, subject to specific exemptions). The Working Time Directive argument was hardly likely to appeal to Commanders in the field army, whose task would be made more difficult by the loss of experienced NCOs. A more compelling argument to persuade the higher echelons of the Army to support these proposals would have been an assessment of the nature of the risk of harm to the recruits and trainees, and the potential breach of legal duty of care represented by the *status quo*.

¹⁰⁹ See Appendix A13.017, paragraph 74.

¹¹⁰ See Appendix A13.018, paragraph 80.

¹¹¹ *Ibid*, paragraph 81.

¹¹² See Appendix 11 to this Report. See also paragraph 7.2 ff above.

¹¹³ See Appendices 9 and 10 to this Report.

¹¹⁴ See Appendix A13.006, paragraph 31(a).

¹¹⁵ *Ibid*, paragraph 31(c).

¹¹⁶ *Ibid*, paragraph 29.

¹¹⁷ See Appendix A13.016, paragraph 66.

The Haes Report under debate

- 9.92 Brigadier Brown has told this Review that the Haes Report was discussed at the next ATRA Management Board.¹¹⁸ It did not command support from the heads of those training establishments who did not have the supervisory ratios causing concern.¹¹⁹ That seems to have set the seal on the subsequent discussion.
- 9.93 The precise shortfall in supervisory ratios at any one time at Deepcut is a matter that cannot be gauged with precision. Brigadier Brown's April 1999 Quarterly Report (noted at paragraph 9.61 above) compared Corporals per trainee and came out with a ratio ten times greater than the normal ratio for an infantry regiment or other field army unit. Of course the numbers of trainees actually at Deepcut awaiting training, posting or discharge varied from week to week as trainees were loaded onto courses and arrived from Phase 1, but the fact remained that the Training Regiment retained responsibility for all these Phase 2 trainees, irrespective of their temporary physical location or their progression in training.¹²⁰
- 9.94 On 29th June 2001, the Adjutant of the Training Regiment was asked by the Post Trials Section of the Adjutant General's headquarters at Upavon to comment on the evidence provided in support of a plea in mitigation made by a Private who had been sentenced by a District Court Martial to 15 months' detention for assault. The summary of the evidence in support of the Private's plea was from a female Troop Commander in 86 Squadron who painted a familiar picture of an unsupervised regiment:

*"She described a situation at the time in question in which trainees had far too little to do for months on end, spending most of their time hanging around aimlessly and drinking heavily in the NAAFI bar, with fights and violence an everyday occurrence. Prior to July 2000 she was aware from speaking to others that [another Pte] was the most difficult of soldiers from a disciplinary point of view, regularly involved in violence and part of a group (or as she put it a "mafia") of soldiers that were very intimidating to those (like [the Pte making the plea in mitigation]) who were not part of the group. Supervision of soldiers was inadequate with only approximately 1 officer and 4 NCOs to about 500 men."*¹²¹

- 9.95 The Review has been provided with the response of the Adjutant at Deepcut, dated 3rd July 2001, to the request from the Post Trial Section. The Adjutant gave a slightly different picture of supervisory ratios to that portrayed in the Haes Report two months earlier. He sought to rebut the plea in mitigation with specific figures given as a snapshot of supervisory ratios in January 2001 as follows (including original footnotes):

<i>"Phase 2 Recruits on strength –</i>	859
<i>Not at Deepcut (i.e. courses) –</i>	203
<i>Sick/AWOL etc. –</i>	47
<i>Leave (post Xmas) –</i>	99
<i>Detached</i> ¹²² <i>–</i>	63

¹¹⁸ Appendix A4/1.036 C – E.

¹¹⁹ *Ibid*, D – E.

¹²⁰ *Supra*, footnote 66, paragraph 17.

¹²¹ Fax A/OR/25101053 dated 29th June 2001.

¹²² *"It is policy to detach as many of those awaiting trade training to the field army. This is dependent on the co-operation of receiving units and not always possible for all. Other initiative to keep soldiers occupied are satisfied soldier schemes, adv trg [adventure training] and RAAT [Regular Army Assistance to Training]."*

TOTAL at Deepcut –	447
On course at Deepcut –	164
Guard –	64
TOTAL SATT/Cont Trg ¹²³ [Continuation Training] –	219
<i>At the time 86 Sqn had on established strength of 2 x Tp Comd and 3 x SNCO and 8 x JNCO.</i> ¹²⁴	

- 9.96 These figures can be computed in different ways. Taking the total number at Deepcut (447), and the number about to return from Christmas leave (99), there is a picture of a community of some 546 trainees, whether they be on a course, on guard or on SATT, to be supervised by eight junior NCOs – Corporals or Lance Corporals – giving a ratio of approximately 1:68. It will be recalled that it was the ratio of Corporals to trainees that was the subject of Brigadier Brown’s April 1999 Quarterly Report.¹²⁵ All of the 546 trainees were resident, or about to reside, at Deepcut and, therefore, in need of supervision of some sort. The need for supervision was particularly acute at night, a time when fewer of the junior NCOS were typically available. In his response of 3rd July 2001, however, the Adjutant cited statistics that were based on the 447 trainees at Deepcut and the 219 on SATT and undergoing continuation training. In addition to the eight Junior NCOs, he included the three Senior NCOs and two Troop Commanders. His analysis was, therefore, as follows:

“This gives rise to a staff: recruit ratio for those at Deepcut of approximately 1:34. For those who were awaiting course the ratio during the day stood at 1:17. It should be taken into account, however, that those recruits at Deepcut change regularly and the Permanent Staff still retain some of the responsibility for the administration and welfare of all Phase 2 Recruits on strength.”¹²⁶

- 9.97 It is, perhaps, unfortunate that a reassuring message about staff ratios was being sent to Upavon to address concerns regarding a plea in mitigation at a time when the Haes Report, calling for greater supervisory ratios in training regiments – including at Deepcut – was under consideration. There is, however, no evidence that the ATRA Board seized on this data to justify its response to the Haes Report. Doubtless, they would have been aware that there may have been an element of a self-serving nature in the Adjutant’s reply. No Commanding Officer would want to admit that the Regiment he commands is out of control and full of undisciplined trainees. Even so, there is no warning here that the supervisory levels were so defective that a fatal incident was about to occur.

Violent conduct at Deepcut in 2001

- 9.98 The Adjutant’s same reply to Upavon in response to the plea in mitigation also outlined the scale of violent behaviour by trainees at Deepcut at this time. He noted that there had been regular outbreaks of violence at Deepcut, but disputed the impression given, in the plea in mitigation, of daily assaults. He noted the following recorded incidents for the first two months of the year when the Court Martial had taken place:

21 Jan [01] –	Minor assault in NAAFI
22 Jan [01] –	“Scuffle” between 2 females outside barracks
31 Jan 01 –	Assault by Phase 2 Recruits on course personnel

¹²³ “A 6 week cycle of continuation trg is conducted by the Permanent Staff for SATT who remain in Deepcut.”

¹²⁴ Reference 25/RHQ/1470 dated 3rd July 2001.

¹²⁵ See paragraphs 9.61 and 9.93 above.

¹²⁶ See *supra*, footnote 124.

01 Feb 01 – *Assault in Shots Nightclub, Aldershot*
 21 Feb 01 – *Fight in NAAFI*
 24 Feb 01 – *Fight in NAAFI*
 02 Mar 01 – *Serious assault on Court Martial witness in barracks.*"¹²⁷

9.99 From conversations with Lieutenant Colonel Govan and Brigadier Brown, the Commanding Officer and the Commander, respectively, for this period, there seems little doubt that Deepcut did have serious disciplinary problems from certain trainees with respect to violent conduct.¹²⁸ Clearly, there is some connection between misbehaviour of trainees – and the ability of staff to identify, record and deter – and the numbers of staff available after hours to supervise them.

ATRA's response to the Haes Report, September 2001

9.100 The Review has had the very significant advantage of being able to discuss ATRA's response to the Haes Report with Lieutenant General Palmer (now retired). As noted, before his promotion and appointment as Deputy Chief of the Defence Staff (Personnel) (DCDS (Pers)), he had served as DG ATR. It was Lieutenant General's Palmer who commissioned the Haes Report in order to assist him in making a case for increased resources in an unpromising financial environment.¹²⁹ ATRA's budget was part of the Adjutant General's top level budget and, as such, was subject to pressure to reduce costs. ATRA's room for manoeuvre was constrained also by the policy that existing instructors be sent to the field army where the level of operational commitment was increasing.¹³⁰ Lieutenant General Palmer had also earlier been party to the decision to abolish the Junior Leader's scheme and the move to Single Entry training.¹³¹

9.101 At the meeting with Lieutenant General Palmer in June 2005,¹³² this Review was concerned to know how Single Entry was linked to supervisory ratios and the problems identified in the Haes Report.¹³³ It was also concerned to understand ATRA's response to the Haes Report and whether a risk assessment was conducted as to what the consequences of not increasing resources, or reducing throughput, would be. The reader is referred to the transcript for the full exchange and context of the extracts quoted below. It was pointed out that Single Entry was implemented on the understanding that the necessary resources would be made available:

"Qn.: I can see something in the Adjutant General's paper¹³⁴ saying 'if we are going to do this we are going to have to take extra resources' ... So if you've got the germ of an awareness of risk then, the suggestion is you are going to have to back this challenging decision by particular skilled staff, more staff, good trainer ratios, a part we will come to later on, and a duty of care ratio.

¹²⁷ *Ibid.* The original document referred to "21 Jan 00" and "22 Jan 00". The Review assumes, given the context of the reply, that these must be misprints and that "01" should replace "00".

¹²⁸ See for example Appendices A4/1.015 D – E and A4/1.033 D – E.

¹²⁹ See paragraph 9.74 and footnote 2 above.

¹³⁰ See Appendix A4/13.016 A – B.

¹³¹ See Appendix A4/13.002 E – G. For the Junior Leader's Scheme and Single Entry, see paragraphs 4.26 ff and 4.30 ff above.

¹³² See Appendix A4/13 for the transcript of that meeting.

¹³³ See Appendix A4/13.020 D – F.

¹³⁴ Paper on Single Entry dated 2nd November 1992.

“Ans.: Of course I accept that. The question though is: ‘what is the balance here? What is the manifestation of the risk?’ Although we may not have done a formal risk assessment, I can’t remember at the moment, but actually there are other things that would tend to indicate the success of the training organisation as a whole, i.e. the good experience that the vast majority had. I am not at all saying we got it right; please don’t think I am. I’m just saying it is not as clear cut as saying: there was a risk there, it eventually ended in the four suicides, therefore the whole thing must have been got wrong.”¹³⁵

9.102 Later in the discussion, Lieutenant General Palmer explained that he recognised supervisory ratios were inadequate, but could not implement the proposals of the Haes Report without generating a risk in the field army.¹³⁶ Improved management of existing resources was the preferred solution, with attempts made to reduce the effects of SATT by various means. The exchange was summed up as follows:

“Qn.: Is it fair to say, for the purpose of this conversation, that the response that you were giving down to your Commanders, your Commanding Officers, is along the lines of ‘the other constraints upon ATRA and the MOD generally, prevent us tackling head-on the supervisory ratio? At the moment, we’re going to have to think about other things to do, like cutting down SATT, merging Phase 1 and Phase 2, finding better ways so that young trainees are not so bored out of their skulls or are unhappy at Deepcut, waiting for things, so that the only alternative is to have sex or get drunk’.

“Ans.: Well, I’ll agree with that. Basically you phrased it very well.

“Qn.: And that was the post-Haes solution as well? Haes was too ambitious.

“GP: Well, we needed to look at Haes. Because the figures that he produced were way out of size, and some of them looked odd anyway, like the number of extra instructors that he was asking for at Sandhurst and he took a very mechanical sort of, which wasn’t really what I was after. But Haes did confirm obviously that we needed to do something about supervisory ratios. But one has to make a balanced judgement about where risk lies.”¹³⁷

9.103 Doubtless, as this Review has acknowledged in Chapter 4, many soldiers were coming out of ATRA establishments – including Deepcut – with useful skills and a state of mind to make them effective soldiers. In interview, and in subsequent correspondence with the Review, Lieutenant General Palmer made the point that over 85% of the trainees were successfully passing into the field army, and that, of those who did not, disciplinary and self-harm problems were very much a minority. However, for the Review this minority was sufficiently significant to be a continuing concern. This is not just a case of those who apparently took their own lives. It concerns those who self-harm, at least in a serious way, those who go AWOL, those with disciplinary problems that make them unsuitable for service and those who are discharged, or apply for discharge, because they do not meet

¹³⁵ See Appendix A4/13.006 F to 007 B.

¹³⁶ See Appendix A4/13.021 C.

¹³⁷ See Appendix A4/13.024 B – E.

the required standards. As referred to earlier, the issue of self-harm and ISIDs was already a very prominent one in Parliament and the media at the time. The disproportionate rates for ISIDs in the Army have also been noted.¹³⁸

- 9.104 In the opinion of this Review, it was ATRA that had, or should have had, a strategic perspective on issues of welfare, training and suicide prevention and the importance of supervisory ratios to the effective implementation of policies. If ATRA, despite having commissioned the Haes Report, did not accept a need for change if the supervisory ratios noted in that Report remained, it would be difficult to criticise those in command of the Training Regiment at Deepcut for failing to do so. As we shall see in the following Chapter, despite the publication of 'Suicide Prevention – A Commander's Guide',¹³⁹ the Commanding Officers may well have been unaware of the mass of material, statistical and anecdotal, arising from different investigations throughout the Armed Forces.¹⁴⁰ Further, it is difficult to see how the Commanding Officers could take preventive measures to address information suggesting risk if there were not enough staff to get to know the soldiers.
- 9.105 Lieutenant General Palmer has emphasised that ATRA did recognise the need for change, but that the changes that were feasible at that time were to reduce SATT and borrow resources from elsewhere. He made the point in his meeting with this Review that there were other priorities of greater importance for the Army – buildings, families, front line personnel – and failings in those areas created risk to the delivery of military service and compromised the duty of care obligations to soldiers in the field army.¹⁴¹ The Review accepts the point that the Working Time Directive was not the best way of making a case to divert resources from the field army back to the training regiments. Further, the Review does not pretend to be able to form a judgement on the competing demands for resources that the defence budget must inevitably face.
- 9.106 It appears that ATRA took the decision to respond to the Haes Report at its own level of responsibility. It did not seek to push the issue up to the Adjutant General. Nor did ATRA bring it to ministerial attention, for a broader political view on whether to increase resources or diminish Army recruitment or make such other adjustments of policy so as to reduce the risk.

Conclusions

- 9.107 The Review accepts that the Adjutant General and the chain of command were aware of the lack of resources to provide appropriate supervisory levels in general terms. There is no evidence that ATRA used the Haes Report to press either for a reduction in throughput of trainees or for resources to enable staff to discharge the duty of care. The difficulties facing ATRA, at the time, must be acknowledged and cannot be underestimated. There was general under-manning and under-resourcing in the Army. The risk of not having experienced NCOs on the front line might be significantly greater than the risk faced by training regiments. If such a comparison was to have been made by the senior Commanders in the Army, then the Haes Report, and its focus on the Working Time Directive that did not apply to the front line, may not have been the most persuasive reasoning available to DG ATR to make a case. In conversation with the Review, Major General Charlton-Weedy, the Deputy Adjutant General (DAG) in 2002 (whose report on the deaths at Deepcut is considered in Chapter 11) has pointed out that DG ATR has to make a tightly focused case for greater resources, explaining why risk elsewhere is more acceptable.

¹³⁸ See paragraphs 9.6 ff and 9.21 above.

¹³⁹ *Supra*, footnote 23.

¹⁴⁰ See paragraphs 10.62 – 63 below.

¹⁴¹ *Supra*, footnote 136.

- 9.108 Nevertheless, the disjuncture between the terms of reference for the Haes Report and the practical reception its ideas received, gives rise to the concern, reflected elsewhere in this Report, that the demands of training and the welfare of trainees in training regiments did not command the priority they deserved. The Haes Report had been some time in being commissioned and prepared. It was a further five months, September 2001, before ATRA informed Commanders formally of the response finally given to it. It seems to the Review that it was insufficient to leave the Haes Report on the shelf, as merely aspirational, because of the real difficulties in personnel resources presently available to the Army.
- 9.109 If the problem of poor supervisory ratios in training regiments could not be immediately dealt with, other aspects of the overall problem needed to be addressed, and a clear understanding of what the Army faced by way of risk if the *status quo* remained. In particular, addressing the question of armed guard duty by employing Military Provost Guard Service (MPGS)¹⁴² personnel as a matter of priority in training regiments – whilst, in the meantime, restricting access to unsupervised weapons by young trainees, and in particular those acknowledged to be welfare cases – would appear to address a particular kind of risk associated with the training regime, that should have been well known to ATRA. If ATRA was not persuaded by the language of the Haes Report that the risk was sufficiently acute at places like Deepcut, then, perhaps, it should have commissioned a more senior officer with knowledge of the relevant factors to perform that task for it.
- 9.110 Lieutenant General Palmer responded to the Haes Report by writing, on 6th September 2001, to the heads of the various training organisations within ATRA, including Deepcut. The full response is reproduced at Appendix 14 to this Report. The call to deliver on the additional manpower projected by the Haes Report was flatly rejected:

*"In the current climate of undermanning and operational overstretch, it is self-evident that there is no possibility of achieving enhancements to the manning liability without compensating reductions and gapping of posts elsewhere. In short the study has usefully highlighted a number of areas concerned but has not provided a practical solution."*¹⁴³

- 9.111 In essence, as Lieutenant General Palmer explained in conversation with this Review, and in subsequent correspondence, it was a response that the training regiments and their Commanders would have to juggle resources and manage their staff as best they could with strictly non-training functions, until more resources could be made available.¹⁴⁴ The Haes Report was not Deepcut-specific, although it did identify the Training Regiment at Deepcut as one of four of particular concern.¹⁴⁵
- 9.112 11 days after Lieutenant General Palmer's response, Geoff Gray was found dead from two gunshot wounds to the head inflicted in the early hours whilst on guard duty at Deepcut. The circumstances surrounding his death will be reviewed in the next Chapter. Of course, whatever the response to the Haes Report, it is unlikely that any measures could have been implemented with sufficient speed to have made a significant difference at Deepcut in 2001.

¹⁴² See paragraph 11.113 below.

¹⁴³ See Appendix A14.001, paragraph 1.

¹⁴⁴ See paragraph 9.102 above.

¹⁴⁵ See paragraph 9.84 above.

- 9.113 15 months later, in different circumstances, the DAG's final report of December 2002 accepted that guard duty at Deepcut imposed unacceptably high levels of risk to Phase 2 trainees on SATT there.¹⁴⁶ Resources were made available to improve the ratios of NCOs to trainees and to bring in the MPGS to relieve trainees of the burden of armed guard duty. All this sadly came too late for Geoff Gray and James Collinson.
- 9.114 The disheartening question that must be posed, against the background of the observations made in this Chapter, is whether the factors giving rise to the deaths ought to have been foreseen and, therefore, addressed with a view to prevention. As a matter of individual foresight, any answer must await such analysis of all the deaths that it is possible for this Review to undertake.
- 9.115 Whilst there was no single document bringing together the disparate streams of concern identified in this Chapter, it is the conclusion of this Review that, by early 2001, there was sufficient data available that should have led to a more formal risk assessment made of the sources of possible harm to trainees, and the dangers created by under-staffing in non-stimulating training environments, such as Deepcut. In the opinion of this Review, this only happened in December 2002, when the DAG, Major General Charlton-Weedy, produced his final report.
- 9.116 The Review has posed to Major General Charlton-Weedy the question as to whether ATRA could have reached the conclusions he did earlier in the sequence of events. He has pointed out that the Haes Report, unlike his, did not establish a scientific assessment of risk, based on known factors derived from statistical analysis and a detailed study of particular events. The Review accepts that point, but suggests that this merely shows that ATRA was not looking at the issue in the round when they could, and should, have been. Supervisory ratios were not a stand-alone concern, but were a symptom of an inability to deliver on a duty of care regime, acknowledged to be owed to trainees generally, and those trainees under 18 in particular.
- 9.117 Ultimately, such an assessment can only be made by ATRA, strategically placed within the Adjutant General's organisation as overseeing both general policy and its practical implementation with respect to training throughout the Army. The training establishments should have contributed to this assessment, fully and frankly, by reporting upon practical problems they faced and forming their own evaluation of the consequences. Any formal assessment would have needed to take into account the work of the Army Suicide Prevention Working Group and the statistical analysis of risk. Only ATRA could have made the bid up the chain of command for extra resources to fulfil its functions or, alternatively, modified its training and recruitment criteria to recognise the practical inability to provide those resources.
- 9.118 As far as the Review is able to assess, ATRA did neither. The problem was not passed up the chain of command. Lieutenant General Palmer, as DG ATR, made the judgement call he did, on the circumstances known to him in light of ATRA's policy objectives. Those objectives included the throughput of substantial numbers of trainees from a variety of social and educational backgrounds into a Single Entry system, where there was little time to improve any deficiency in their intellectual and social skills. Acknowledging that encouragement was given to Commanders to meet the deficit in supervisory numbers by *ad hoc* diversion of personnel, and by speeding up the training pipeline, the Review concludes that attempts to ameliorate the problems of SATT were unlikely to be sufficient to address the concerns, given the previous history of attempts to do so.

¹⁴⁶ See Appendix A15.011, paragraph 24. See paragraph 11.100–102 below.

- 9.119 In the opinion of this Review, the Army, through ATRA, failed to link up the disparate threads of the elements suggestive of risk encountered by different units connected to ATRA over the years. These elements were: age, Single Entry, SATT, poor supervisory ratios, evidence of self-harm and undisciplined behaviour, the factors suggesting risk of self-harm identified by the suicide prevention work and the effective opportunity of self-harm offered by assigning young trainees to regular armed guard duty without close supervision.
- 9.120 This is not an individual failing by any one officer. The material was too diffusely spread through the Army's corporate memory. Thus Lieutenant Colonel Haes had not linked to the Evans Report in 1995 and the need for the training regiment to know its members well. The cases of Private CR in Scotland and Private CS at Catterick were not linked to the poor supervisory ratios and the dislocating nature of training regiments, such as at Deepcut. The vulnerability of young people in ATRA was not specifically linked to the DASA statistics. The importance of promoting the welfare of young people under 18, acknowledged in the 1993 Single Entry Implementation Plan, was not linked to the current priorities for expenditure and supervision. The peculiar nature of regular guard duty at the Training Regiment at Deepcut – regularly performed by young trainees in isolated places unsupervised by experienced NCOs – was not linked to other factors indicating risk.
- 9.121 It is not possible to say what the outcome would have been if such a comprehensive approach had been adopted earlier. In correspondence with the Review, Lieutenant General Palmer has indicated that having re-assessed the options open to him, even with the benefit of hindsight, he would not have acted differently.
- 9.122 Surrey Police have informed the Review that one of the catalysts for the decision to publish their Fifth Report¹⁴⁷ was their concern that the Army did not appear to have implemented the recommendations of previous reports, or sought to sufficiently address the issues identified in them. Indeed, paragraph 3.46 of the Fifth Report noted:

"However, the questions of why funding has not previously been forthcoming and why structural changes were not made to reduce the repeatedly identified risks remain unanswered."

- 9.123 In light of the analysis of policy and practice from 1993 to 2001 contained in this and previous Chapters, for this Review, the answer appears to be that the Army had not previously analysed all the material in its possession to make a formal overall assessment of risk. Further, given the budgetary constraints on it, as well as the balance of commitments between training and the front line, the Army was either not aware of the continued risk at places like Deepcut, or did not think the risk was serious enough to justify a more exacting response.

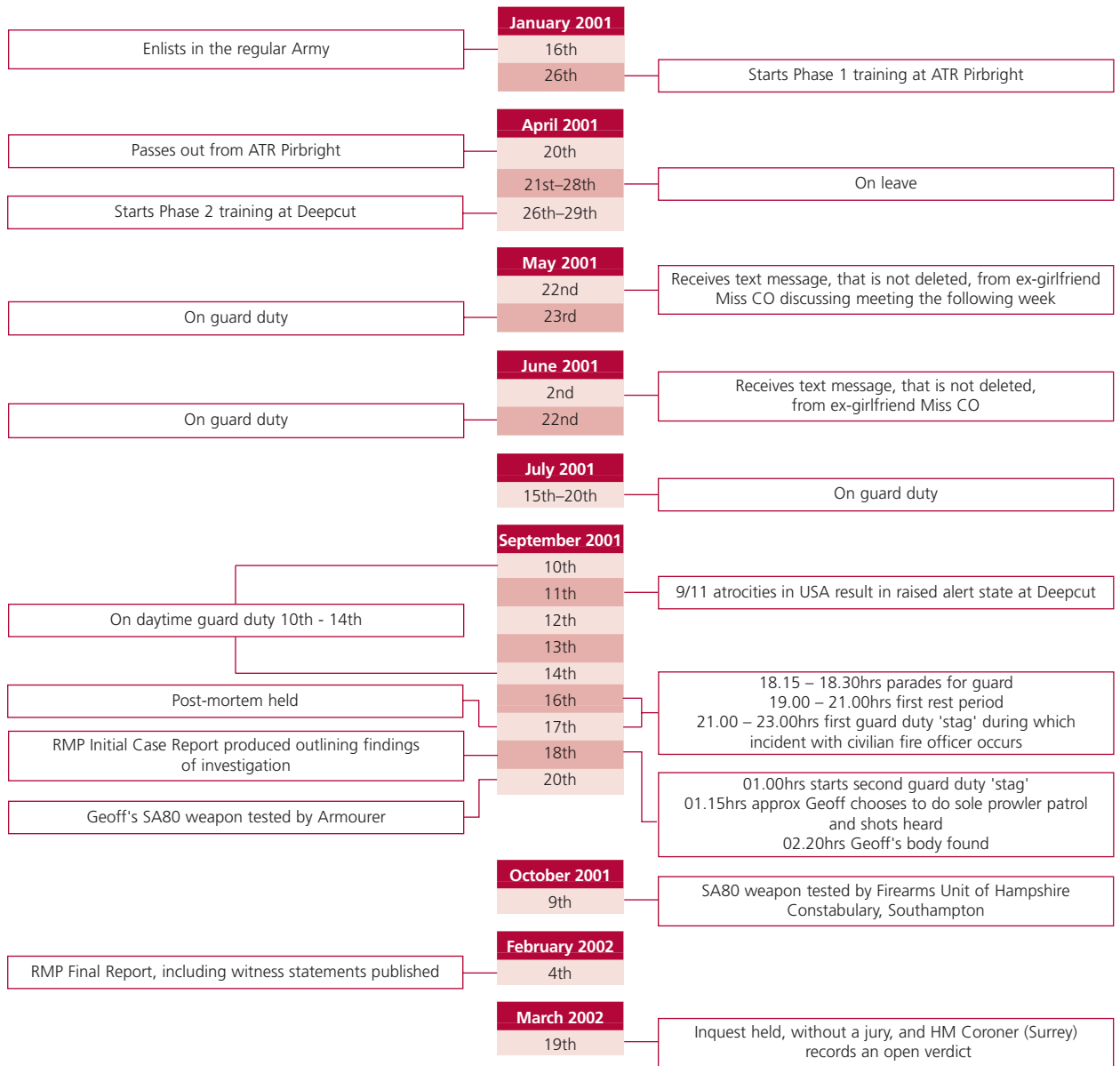
¹⁴⁷ See paragraph 1.15 above.

10 The Death of Geoff Gray

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Figure 10.1

Timeline – Geoff Gray



Enlistment and recruitment

- 10.1 Geoff Gray was born on 28th January 1984 in Sunderland. He lived with his parents in Hackney. He was a keen Scout who had long wanted to join the Army and applied in August 1999 with parental consent. He had achieved one grade C and four Grade D passes at GCSE and showed some promise in athletics. On his application, Geoff explained his reasons for wishing to enlist in the Army:

“For many years I have wanted to join the Army. I see it as a new experience giving me a challenge and a chance to learn new skills. I always work my best and like to be pushed to new extremes both physically and mentally. I think the army will help me build myself to a new person teaching me many new things.”

- 10.2 As the interviewer noted in a comment in the margin next to this part of Geoff’s application: *“what more can I say?”*. This was an enthusiastic recruit from a sound family background who was excited about a new and challenging career. The assessment was understandably positive:

“a very good egg and plenty of potential. Cheerful, articulate and easy to interview.”

A medical questionnaire was completed by Geoff’s GP showing no medical problems apart from childhood asthma, on which follow-up questions were addressed in correspondence.

- 10.3 Geoff enlisted on 16th January 2001 for Phase 1 training at the Army Training Regiment (ATR) at Pirbright, starting on 26th January, with a view to becoming a supply controller in the Royal Logistic Corps (RLC). He was noted to be shy and lacking in confidence on arrival. Geoff passed out of ATR Pirbright on 20th April 2001, having succeeded in attaining all the standards required of him and with steady improvements in his weekly grades. His Troop Commander’s final comments were:

“Private Gray was very quiet and had little confidence on starting CMS(R) [Common Military Syllabus (Recruit)] but has matured a great deal over the past weeks. His confidence has grown and he has come out of his shell considerably. His personal admin has also improved dramatically. Always a hard worker he tries hard in all lessons and has shown no difficulties throughout. I believe Private Gray is ready to progress to the next phase of his training.”

- 10.4 On passing out, Geoff took six days’ leave until 29th April 2001. On arrival at Normandy Troop, Deepcut, Geoff wrote a short essay about himself (a helpful part of current induction practice). An extract sheds light on his impression of ATR Pirbright and hopes for the future:

“My ‘ambition’ is to enjoy life, travel around the world and experience new things. I’m a person who acts off impulse and I love a challenge, therefore the army life is perfect for me. My time at ATR Pirbright was tough but I enjoyed it. It was a hard and intense course and I’m proud of myself for keeping my head down and working hard.”

- 10.5 It appears from Geoff’s personnel file, and the subsequent re-investigation of his death by Surrey Police, that Geoff remained at Deepcut from April 2001 until his death on 17th September 2001, apart from visits home. It is known that he passed his weapon handling test on 2nd May 2001, when he was 17 years and three months old. He was due to start

driver training at Leconfield on 21st September 2001, along with a friend, Private BY. It appears that Geoff and Private BY shared a room and were living in a block specifically for those under 18.¹

Deepcut in 2001

(i) The observations of the Commanding Officer

- 10.6 During Geoff's time there, Deepcut still suffered from the familiar problems of SATT (Soldier Awaiting Trade Training), poor supervisory ratios, a sense of under-employment, under-stimulation and misbehaviour. Lieutenant Colonel Laden took over as Commanding Officer in July 2001 and was to remain in command of the Training Regiment until September 2003. The Regiment had, by the time of his appointment, been renamed the 25 Training Support Regiment. He remains in service in the Army. He has told the Review that, on the day he took over, he had to deal with a case of serious sexual assault in the female accommodation at St Omer Barracks (Aldershot).² Lieutenant Colonel Laden had been previously posted to the Regimental Headquarters of the RLC, located within the Garrison complex,³ and, from there, had had some chance to observe the activities of the Training Regiment and the mood of staff and trainees alike for 12 months prior to taking up his command. Unique amongst the Commanding Officers of the Training Regiment with whom this Review has spoken, Lieutenant Colonel Laden, therefore, had the opportunity to view his forthcoming command from close by and consider whether changes were required.
- 10.7 The Review has benefited from a number of frank and open exchanges with Lieutenant Colonel Laden, for whom the experience of the deaths of Geoff Gray and James Collinson by gunshot wounds under his command has clearly been a devastating experience with profound personal impact. He met with the Review informally early on.⁴ He also participated in a meeting, that the Review arranged, where Mr and Mrs Gray were able to press their concerns with him in the presence of their solicitor.⁵ Lieutenant Colonel Laden subsequently met with the Review again to clarify issues relating to guarding policy.⁶ The Review is extremely grateful for the time and assistance provided by this officer and his willingness to communicate frankly and openly about his concerns. He has also made available to this Review an academic dissertation he wrote in 2005 describing what he perceived to be the culture at Deepcut that he needed to turn around.⁷ In conversation with the Review, he has confirmed the accuracy of this account from his point of view.
- 10.8 Of course, the Review is conscious that it can be said that any Commanding Officer who wants to prove that he has made a difference would seek to present a dramatic distinction between the state of Deepcut before and after his tour. Nevertheless, the following extensive quotations give a sense (albeit a subjective and retrospective one) of a training organisation apparently lacking direction and morale. Under the heading 'Why change was needed', Lieutenant Colonel Laden wrote as follows:

¹ Paragraph 5.3.2 of Surrey Police's report to Coroner in 2003, supported by evidence of the individual behind entry 5 of the 2001/2 Duty of Care Schedule.

² See paragraph 4.63 above.

³ See 'RHQ the RLC' in Figure 1.1 (map of Deepcut) above.

⁴ This was before the Review had started tape-recording its meetings. See Annex B.

⁵ See Appendix 4/11.

⁶ See Appendix 4/10.

⁷ 'Strategic Leadership and the Management of Change: The Change Management Programme for a British Army Training Regiment based at Deepcut between June 2001 to October 2003'.

“There was little evidence that the permanent staff had any sense of urgency or excitement about their role. In military terms the Regiment seemed to be slow and sluggish, staff were regarded as slow to respond to challenges and crisis. Visitors to the regiment frequently mentioned the poor attitude of the permanent staff they came into contact with.

“The role of the Regiment was un-clear; it had no “Vision”, as there was a lack vision, there was no vision to communicate, without this vision the staff and the recruits were each unable to decide what their role was and how they should relate to each other. This lack of vision created a vacuum which made it difficult for the staff in particular to set themselves standards and roles when interacting with recruits. Without a vision it had proved difficult to identify ways in which failure was occurring, as there was no base line against which to measure success ...”

10.9 His personal observations as to the Training Regiment he inherited were:

“The Regiment was at the very least stagnating. The staff were doing just enough during their working day and were unsure what their role was or how to develop the recruits in their charge. This professional vacuum had an impact upon the recruits who where unsure as to what was expected of them. With poor leadership and role models they often reverted to their pre-military behaviour patterns [under] the mistaken view that this was acceptable, this leading to further pressure on staff and driving overall standards subtly ever down ward.”

10.10 He also noted the planning blight acknowledged by subsequent reports and concluded:

“The unfortunate truth was that 25 Regiment had lacked leadership at all levels for many years, all the more important in a formal hierarchical structure such as the Army. Why this leadership was lacking is a complex area with a great deal of the reasoning tied up with the way the Regiment was set up in parallel with the creation of the ATRA and the RLC. There had developed since the reorganisation of Phase 1 and 2 training under the ATRA a detached attitude within the RLC and by default within 25 Regiment, to the institutional problems created by these changes. This institutional detachment was compounded by an inability to influence the ATRA particularly as the ATRA was driven by two conflicting imperatives; the drive to train as many soldiers as possible but against a falling resource level. The view had grown up that many of the problems and failings of the system were a product of the ATRA’s management imperatives, therefore any local initiatives and proposed solutions were bound to fail.”

10.11 He added his voice to the succession of Commanding Officers, from Lieutenant Colonel Josling in 1994 on, who have made the same point to the Review or their superior officers:

“Other than this lack of leadership from the perspective of “looking in” it seemed that the most important problem that the Regiment faced was a lack of staff to administer but also to lead the Phase 2 Recruits. Given the manning ratios and the downward spiral of behaviour brought about by successive intakes adopting the worst elements of behaviour from their slightly senior peer group this situation needed to be stopped and a new approach to Phase 2 training need to be adopted. ”

- 10.12 For the Review, these observations provide compelling support for the tenor of previous accounts of Deepcut from 1995 onwards, whether in the Board of Inquiry (BOI) convened into the death of Cheryl James,⁸ the Evans Report,⁹ the Royal Military Police (RMP) reports cited in Chapters 7 and 8, some of the general observations noted in the Haes Report,¹⁰ or the persistent theme of disillusion and discontent from former trainees recorded by Surrey Police in their Duty of Care Schedules and the products of their investigations.
- 10.13 It is apparent that sexual activity in out of bounds accommodation was still a problem at Deepcut. Lieutenant Colonel Laden told the Review that a survey of how secure trainees felt revealed that women were concerned that men unknown to them had access to the female accommodation block, although the same women apparently considered it acceptable to invite their own boyfriends in for the night.¹¹ Lieutenant Colonel Laden, therefore, employed a regime of increasingly punitive sanctions to deter this persistent problem.¹² For example, one of the guardroom daily occurrence log entries during his command records an incident of an unauthorised male found in a state of undress in the female block that was reported to the RMP and civilian police. At this time, it seems that male trainees under the age of 18 were housed in a separate accommodation block in the Barracks.¹³ This policy, at least, identified some of the special needs of those under 18 but, in the absence of onsite supervision, may have lead to unruly behaviour unchecked by wiser counsel.
- 10.14 Sexual misconduct was not limited to trainees. In the period of Lieutenant Colonel Laden's command there were five recorded incidents of sexual fraternisation by NCOs, although the first occasion for punishment noted in his interview book is in July 2002. It is easier to identify the nature of the disciplinary conduct recorded in Lieutenant Colonel Laden's interview book as there is an explanatory side note to many disciplinary entries. No complete comparison can be made from the data as to the frequency with which fraternisation allegations came to the attention of Commanding Officers during the period before Lieutenant Colonel Laden's arrival. It can be said that the fact that Lieutenant Colonel Laden's interview book is the source of such information during this period means that a policy decision must have been taken early on, by him, that offending NCOs would face the Commanding Officer, and not the Officer Commanding. The sanctions available were therefore that much greater and the seniority of the determining officer that much more significant.¹⁴
- 10.15 Lieutenant Colonel Laden has spent much time explaining to the Review the intensive measures, such as sporting and other diversions, that were put in place to stimulate the trainees on SATT,¹⁵ although this all created extra pressure for the overworked staff, some of whose physical well-being and home lives are said to have suffered.¹⁶ He has also pointed out that care needs to be taken when assessing complaints by young people that they were bored, as these may be a product of not taking advantage of the recreational activities the staff were working hard to provide, rather than reflecting a lack of interest in, or concern for, their welfare.¹⁷ The Review accepts that the unsupported complaints of trainees made to Surrey Police in the course of their investigations into Geoff Gray's and

⁸ See Appendix 10.

⁹ See Appendix 11.

¹⁰ As discussed in the previous Chapter. The Haes Report is reproduced in Appendix 13.

¹¹ First meeting with the Review, see Annex B.

¹² See Appendix A4/10.025 A – B, where he compares dealing with the problem to trying to “stop a tiger”.

¹³ As noted at paragraph 10.5 above, Geoff lived in the under-18s accommodation block. See also Appendix A4/11.062 E – F.

¹⁴ See paragraph 10.29 below. Contrast paragraph 7.91 above.

¹⁵ See as an example Appendix A4/11.020 A – D.

¹⁶ See Appendix A4/10.030 E – G, where Lieutenant Colonel Laden describes some of the problems experienced by his staff.

¹⁷ See Appendix A4/11.021 C – D.

James Collinson's deaths, and recorded in their 2001/2 Duty of Care Schedule, would be an insufficient basis to form a conclusive judgement on the morale of the Training Regiment at the time.

(ii) The Royal Military Police investigations

- 10.16 The Review has also been able to obtain a broad snapshot of Deepcut and its members in 2001 from the list of matters that were reported to the RMP. This useful information was provided to the Review by the RMP in its early stages and has led to additional requests for information. Some caution is necessary in the use of this information as it captures allegations made by, or against, all Deepcut assigned personnel, regardless of where the alleged incident took place. It, therefore, includes incidents that occurred geographically beyond Deepcut at other Army establishments, and offences committed by, or against, civilians whilst personnel were off duty or on leave. Nevertheless, it provides a flavour of the experiences of those at Deepcut or connected to it at the relevant time.
- 10.17 The RMP records suggest that there were three occasions when rapes against females were reported, three indecent assaults, two serious assaults or woundings, eight other incidents of assault or breach of the peace, four attempted suicides, six allegations of theft, 14 cases of being Absent Without Leave (AWOL)¹⁸ for some period and miscellaneous matters relating to administrative action, two cases of drunkenness and four of driving with excess alcohol. This material should be seen alongside that for earlier periods noted in Chapter 9.

(iii) The Surrey Police 2001/2 Duty of Care Schedule

- 10.18 The 2001/2 Duty of Care Schedule, that Surrey Police compiled as a by-product of its investigation of James Collinson's death and its re-investigation of Geoff Gray's death, records a limited number of miscellaneous complaints spanning the period 1998 to 2002.¹⁹ Of the 38 entries recorded in the Schedule, one concerns the practices of Sergeant BB in 1999, whose activities were fully investigated by RMP at the time and have been discussed in some detail in Chapter 8.²⁰ Another is an old complaint about an incident on adventure training by a father of a recruit at ATR Pirbright.²¹ Four entries concern allegations of sexual assault on female soldiers that were the subject of an investigation by the RMP, although one complaint was later withdrawn.²² One case resulted in disciplinary action and in two others the Crown Prosecution Service concluded there was insufficient evidence to bring criminal proceedings. One of the latter cases concerned a 17 year old female who had been drinking heavily and woke to find two male soldiers in her bedroom.
- 10.19 The Squadron Sergeant-Major for 86 Squadron at this time, Squadron Sergeant-Major(f) BZ was a female. She was well regarded by Lieutenant Colonel Laden.²³ One trainee recalled that Squadron Sergeant-Major(f) BZ briefed new arrivals on the equal opportunities policy and warned them against bullying and sexual assault. He added:

¹⁸ Usually recorded by the RMP following notification that an AWOL soldier has been arrested by the civil police for an unrelated offence and subsequently found to be AWOL from the Army.

¹⁹ See Appendix 6. See also paragraph 1.17.

²⁰ *Ibid*, entry 21.

²¹ *Ibid*, entry 18.

²² *Ibid*, entries 14, 20, 35 and 36.

²³ See Appendix A4/11.034 F – G. During the meeting with Lieutenant Colonel Laden, organised by the Review, Mr and Mrs Gray stated that Geoff did not have any problems with Squadron Sergeant-Major(f) BZ. See Appendix A4/11.035 D – E.

*"I am not aware of anyone at the camp being bullied or singled out."*²⁴

Other informants agreed:

*"The NCO's were OK but not approachable, not friendly. I never ever saw them physically, sexually or verbally abuse anyone."*²⁵

- 10.20 However, a number of the informants to Surrey Police thought that Squadron Sergeant-Major(f) BZ, in particular, and other NCOs in general, were too strict and excessive with drill and punishments, including the use of blanket punishments.²⁶ Such complaints were of a verbal, rather than physical, conduct and there is nothing to compare with the allegations of assault contained in the 1995 Duty of Care Schedule:

*"I hated and loathed my time there, it was not the way I thought the army was going to be. The Lance Corporals and Corporals treated and spoke to me and the other recruits like shit. They would discipline us for the slightest thing and we could do nothing about it."*²⁷

*"I did not enjoy my time at Deepcut. I found some of the corporals overbearing. I cannot recall anything specific, but they were often shouting and making us run and do press ups for no obvious reason."*²⁸

- 10.21 Even so, one of those complaining about the drill and discipline specifically told the police:

*"I have never seen or heard of anyone being bullied at Deepcut."*²⁹

Only one informant³⁰ suggests that physical punishment was condoned, alleging that Squadron Sergeant-Major(f) BZ encouraged other Privates to attack trainees with a bar of soap in socks who were letting the Squadron down, but there is no confirmatory support of this from others and there are some doubts as to this informant's credibility.

- 10.22 It appears to the Review if there was bullying going on, it was more a matter of conduct between trainees rather than conduct by, or at the instigation of, NCOs. One informant, who expressly stated that he saw no abuse, verbal or physical, by NCOs, went AWOL on account of his treatment by fellow trainees as he did not feel he could complain:

²⁴ See Appendix 6, entry 4; 30th July 2002.

²⁵ *Ibid*, entry 25; 23rd January 2003. See also entries 8 and 13.

²⁶ *Ibid*, entries 1, 2, 5, 6, 8, 12, 22, 28, 30, 33 and 37.

²⁷ *Ibid*, entry 37; 3rd February 2004.

²⁸ *Ibid*, entry 29; 22nd January 2003.

²⁹ *Ibid*, entry 8; 23rd July 2002.

³⁰ *Ibid*, entry 3.

"I went absent without leave. This was due to the treatment, I was receiving within the accommodation block and primarily Privates within my room. The treatment in general was name calling and there was a little bit of pushing. I think as I am a quiet person I became an easy target and after only 4/5 weeks at Deepcut I had had enough. I did not know the procedures for telling somebody about it and even if I had I do not think the NCOs would have listened to me. I had no faith in the system at Deepcut. I had a weekend off and just went home and stayed at home."³¹

(iv) Private David Shipley

10.23 One informant to Surrey Police³² mentioned a Private David Shipley and suggested that David had been the subject of bullying at Deepcut. This issue has been fully investigated following David's death by drowning in June 2002. He was found dead in 18 inches of water in a temporary pool at the Gutersloh Garrison, Germany, after the Regiment's summer fête. The death was the subject of press reporting by the Daily Express later that month, drawing a link between his death and the four Deepcut deaths.³³

10.24 It seems that David did have some learning problems, and other social characteristics, that may have made him the object of some unpleasant remarks by his fellow trainees and resulted in him being taken advantage of, for example in the way that he lent his mobile phone to others. This was noted by staff at ATR Pirbright during Phase 1 training, who noted in David's reports that he might 'attract' bullying. Surrey Police investigated these matters with some care, as David was part of the guard force with James Collinson on the night James died in March 2002, before David was posted to Germany.³⁴ Surrey Police found no evidence of bullying by staff or any serious ill-treatment by trainees or, indeed, any complaints that David had been bullied. The Coroner who conducted the inquest into David's death found no evidence of victimisation of David in Germany, although he was not entirely happy with the evidence of how David died.³⁵ There had been some drinking after the day's events. Some of the witnesses at the inquest mentioned teasing of David but this was not a strong feature of the evidence. The BOI held into David's death recommended tightening up of supervisory procedures for such social events in the future.

(v) Private CT

10.25 However, the guardroom daily occurrence logs have revealed another death that did occur at Deepcut in July 2001, that of Private CT, who was awaiting authority to leave the Army on health grounds. He was found dead in his bed as a result of a toxic reaction to the medication he was taking for his condition. The Coroner recorded a verdict of accidental death. There is no evidence in the material before the Review of any misconduct, or neglect, and nothing else of relevance to the four deaths of primary interest to this Review.

³¹ *Ibid*, entry 25; 23rd January 2003.

³² *Ibid*, entry 3.

³³ Article dated 31st August 2002.

³⁴ David Shipley was not on the same guard post as James Collinson and his two-hour guard and rest period rotations were the opposite to James's i.e. he would have been on guard when James was on rest, and vice versa.

³⁵ See paragraph 2.19 above.

(vi) Commonwealth trainees

10.26 It appears that the RLC, at this time, was increasingly taking a number of Commonwealth trainees into the Training Regiment from Fiji, West Africa and the Caribbean, in particular. Some of these trainees were somewhat older than the typical British entrant, and probably better educated and more focused than some of their British comrades on progressing through the training to join the field army, with relatively good pay and career prospects a stimulus to success. Although these recruitment practices may have brought a premium in terms of maturity, they may have also resulted in new challenges and problems, as tensions between varying cultural practices and expectations may have played out into disciplinary incidents in the NAAFI, the accommodation blocks or elsewhere.³⁶ One trainee made the following comment to Surrey Police during their investigations:

*"I do feel that there was racial tension between all groups (blacks, Fijians, Africans, Whites, Irish etc). I do feel that the authorities did not deal with it at all. Some of the dormitories were no go areas – filled with one group i.e. Fijians and you could not do anything without that group having a dig."*³⁷

Some of the informants to Surrey Police reported on racial language and racial stereotyping as an issue of concern,³⁸ but others thought racial tensions were confined to disputes and assaults between the trainees.³⁹ A female Corporal at Deepcut in 2001, who stated that she did not see any physical or mental bullying, told Surrey Police that: "The only real issues regarding racism was between the Fijians and the St. Vincent soldiers."⁴⁰

10.27 The Review is of the opinion that, although these factors presented new challenges to staff who may not have been familiar with the way of life of trainees from diverse countries, the staff in general, and Lieutenant Colonel Laden and Squadron Sergeant-Major(f) BZ, in particular, appear to have responded as appropriately as resources permitted to racial tensions, emphasising equal opportunities policies and learning to understand potential sources of conflict. These factors also justified strict enforcement of policies relating to alcohol and the sexual harassment of females.

10.28 In September 2001, immediately after Geoff's death, Captain Skinsley took over the post of Adjutant at the Training Regiment. He has noted that a great deal more disciplinary matters were dealt with at Deepcut when compared to his previous posting as an Adjutant to a field army Regiment. He has told the Review that he estimated he dealt with seven disciplinary cases in six months previously, whereas he was dealing with approximately that many a week at Deepcut.⁴¹

³⁶ See Appendix A4/3.034 A – B.

³⁷ See Appendix 6, entry 26; 2nd May 2003.

³⁸ *Ibid*, entries 1, 3 and 19.

³⁹ *Ibid*, entries 13, 14 and 17.

⁴⁰ 9th January 2004.

⁴¹ See Annex B.

- 10.29 Two informants to Surrey Police complained of the stricter discipline policy brought in by the new Commanding Officer, Lieutenant Colonel Laden.⁴² It seems that a higher level of fines for some offences was noted by the Adjutant General's Headquarters at Upavon and mentioned to Lieutenant Colonel Laden by Brigadier Elderton, the Commander of the Defence Logistic Support Training Group.⁴³ As noted earlier, one of the issues that Lieutenant Colonel Laden was tough on, and was trying to stamp out, was sexual fraternisation between NCOs and trainees, and between trainees, in 'out of bounds' accommodation. Given the past history revealed in previous Chapters of this Report, and the risks that could result in relation to sexual assault, or allegations of sexual assault, such a policy is understandable and, indeed, commendable.⁴⁴ Lieutenant Colonel Laden's record on dealing with disciplinary matters has not been an issue of concern for this Review. Indeed, it has been a valuable source of information. Certainly as regards sexual matters, Lieutenant Colonel Laden took a strong line to address a persistent problem that had been a source of anxiety and persistent allegation for some time at Deepcut. If anything, the increased disciplinary activity suggests that, previously, either the relevant authorities were not aware of what was going on, or took a different attitude as to the level of sanction to be imposed.
- 10.30 Three of the informants to Surrey Police, contained in the 2001/2 Duty of Care Schedule, were those who had self-harmed during their time for one reason or another.⁴⁵ None of them attribute their problems to the behaviour of the NCOs. One spoke of difficulties in his personal life and paid tribute to the sympathetic treatment he received from staff and two different Commanding Officers when he twice went AWOL and was returned to the guardroom for his discharge from the Army to be considered.⁴⁶ On the second occasion, it was arranged that he would be discharged once he surrendered. This provides some support for Lieutenant Colonel Laden's information to the Review as to his policy on discharge of long term AWOLs or self-harmers.⁴⁷

(vii) Soldiers Awaiting Trade Training as a source of complaint

- 10.31 The most common theme from the 2001/2 Duty of Care Schedule is the boredom of SATT and the monotony of continuation training and regular guard duties. Even making allowance for the subjective nature of complaints, for exaggeration or a failure to appreciate some of the opportunities that were on offer, as well as the difficulties involved in compiling guard rosters, the themes look familiar. They suggest that many of the issues identified in the Evans Report in 1995 continued to frustrate aspirations at Deepcut. A few sample quotations suffice.
- 10.32 One informant to Surrey Police, who came to Deepcut after passing out of ATR Pirbright in February 2002, stated:

"I can only describe it as a "hell-hole" and very depressing. The main reason why I describe it like this is because of the way that you are treated and because you just seem to spend most of your time waiting around, rather than learning anything new. Basically, you are held there until you are sent on your next course or posted to your corp. Your time at Deepcut is spent

⁴² See Appendix 6, entries 11 and 16.

⁴³ See Appendices A4/3.012 D – A4/3.015 B and A4/10.023 E – A4/10.025 B.

⁴⁴ Appendix 6, entries 33 and 34 allege fraternisation between NCOs and female trainees.

⁴⁵ *Ibid*, entries 15, 16 and 17.

⁴⁶ *Ibid*, entry 15.

⁴⁷ See Appendix A4/11.069 A – B.

*doing continuation training which consists of physical training, Fire Action Drills and Drill. It is very boring and demoralising and there was a lot of "blanket punishment" whilst I was there. By this, I mean that if one or two people did something wrong, then everybody would get punished."*⁴⁸

He added:

"The other reason why most people don't like it is because, not only do you just do continuation training, but you also do a lot of guard duty. You get rostered at the beginning of each week of guard duty; during the week you do either day or night duty, but at weekends – if you are rostered – it is a 24 hour duty. The unfair thing about guard duty is that not everybody does it all the time – some people get taken off it for certain reasons which means that others have to do more of it ...

*"I found, whilst at Deepcut, that I did a lot of weekend guard duties and therefore did not have many opportunities to go home to see my family or to visit my girlfriend. I have been asked if there was any bullying at Deepcut whilst I was there. There was bullying in so much as the way in which some of the Corporals spoke to some of the Privates, but it was always verbal and not physical."*⁴⁹

- 10.33 Another informant confirms that, as in 1995, driver training at Leconfield was still seen by trainees as a welcome change from Deepcut and that, exclusively amongst the evidence seen by this Review, he preferred guarding to continuation training:

*"Leconfield was like a dream come true after Deepcut. Deepcut is so petty. The training and PT were boring. I didn't like some of the staff at Deepcut. I would volunteer to do guard duty just to get out of training."*⁵⁰

- 10.34 Other trainees echoed more familiar frustrations about guard duties:

*"[Deepcut] was also a boring place and you seemed to be forever on guard."*⁵¹

*"The worse thing was being picked for weekend guard, this would mean that your whole weekend was lost."*⁵²

- 10.35 Others summed up their feelings as:

*"Deepcut is disorganised, repetitive and boring."*⁵³

*"Deepcut was a horrible place. There was too much hanging around waiting for courses and the administration was very slow."*⁵⁴

*"Deepcut was a depressing, demoralising environment to live and work in."*⁵⁵

⁴⁸ Appendix 6, entry 2; 24th June 2002.

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*, entry 10; 29th October 2002.

⁵¹ *Ibid.*, entry 26; 2nd May 2003.

⁵² *Ibid.*, entry 11; 30th July 2002.

⁵³ *Ibid.*, entry 25; 23rd January 2003.

⁵⁴ *Ibid.*, entry 28; 15th May 2003.

⁵⁵ *Ibid.*, entry 12; 2nd October 2002.

- 10.36 Two other informants were equally disillusioned, causing one to end his career in the Army prematurely:

*"I despised Deepcut. I really hated it. It was very boring and disorganised. There were very few NCOs and they had no real control over you. You could go to parade and then sneak away back to bed. Continuation of training was boring & repetitive. I cannot say I ever saw the NCOs physically abuse anyone. They would shout at you if you had done something stupid but that was par for the course."*⁵⁶

*"I now wish to leave the army. I believed that the Army was going to be good for me, instead I have just been sat around at Deepcut getting bored and depressed after finishing my trade courses. I got on well with my instructors and other recruits having no complaints about them."*⁵⁷

- 10.37 One trainee told Surrey Police that he put his weapon in his mouth whilst on guard duty and contemplated killing himself because of bullying.⁵⁸ He went AWOL on a number of occasions and alleges he was assaulted by a Corporal. The Review is aware that this account was reported in the media prior to a statement being given to Surrey Police. If this account is accurate, there is nothing to suggest that either the suicidal thoughts or the bullying were reported to staff at the time.

(viii) The complaints system

- 10.38 Indeed, a number of trainees explained to Surrey Police that they did not feel able to complain about matters of concern to them to the chain of command.⁵⁹ Whether this was merely a matter of perception, or some justified sense that to do so would result in hostility and repercussions, the Review cannot here determine. However, it will consider the adequacy of the military complaints system generally in Chapter 12 and, in that context, take into account the concerns noted here, as well as those expressed in Chapter 8.⁶⁰

(ix) Other matters

- 10.39 The above is intended as a broad summary of the evidence behind Surrey Police's 2001/2 Duty of Care Schedule, rather than of every incident within it. However, one matter of interest concerned a trainee who alleged that whilst he was on guard duty at the Officers' Mess some months before Geoff Gray died, someone, whom he suspected was a training Sergeant, stalked him with a weapon in the grounds of the camp. This has elicited specific enquiries of Surrey Police who have outlined their subsequent investigations to the Review and concluded that the specific allegation was contradicted by, or at least not supported by, other evidence.⁶¹ The Review is also aware, from the guardroom daily occurrence logs and other evidence, that a number of trainees would appear to have risked being potentially shot by those performing guard duty, by climbing over, or cutting into, the

⁵⁶ *Ibid*, entry 13; 23rd January 2003.

⁵⁷ *Ibid*, entry 22; 6th November 2002.

⁵⁸ *Ibid*, entry 23.

⁵⁹ *Ibid*, entries 23, 25 and 26.

⁶⁰ See paragraph 8.103 above.

⁶¹ The Review notes however that 'stalking' was one alleged eccentricity attributed to Sergeant B in 1995. See paragraph 5.114 above. For the avoidance of doubt, it is not alleged that Sergeant B was the training Sergeant in question. Indeed, Sergeant B left Deepcut at the end of 1996.

perimeter fence in order to get back into the camp late in the evening or in the early hours of the morning.⁶² It would appear that such occurrences were not infrequent, and had also occurred in 1995.⁶³

The impact on Geoff Gray

10.40 However, none of the concerns outlined above appear to have had any adverse impact on Geoff Gray. He had no disciplinary record at Deepcut. Squadron Sergeant-Major(f) BZ has given the following portrait of Geoff to Surrey Police:

*"I found Pte Gray to be a very capable and well disciplined soldier. He was always smart and appeared to get on well with his peers. Throughout his training I had no cause to speak to him, on a one-to-one basis, regarding any problems whether personal or disciplinary. I can also state that at no time during his training did Pte Gray notify my unit of any personal problems or other concerns."*⁶⁴

10.41 Geoff did not need medical treatment at Deepcut from May to September 2001.⁶⁵ He was not connected with any of the few and comparatively trivial allegations of abuse made in the 2001/2 Duty of Care Schedule, noted above, for the period he was at Deepcut in 2001 and he does not appear to have come to the adverse attention of anyone, trainee or NCO. There is no evidence to suggest that he was either the victim of, or accused of, racial discrimination or harassment of female trainees. The subsequent Surrey Police re-investigation revealed that he may have had issues of concern to him in his personal life, but these were not related to the regime at Deepcut.

10.42 From all that was known about Geoff during his time at Deepcut, whether from the initial RMP investigation, the inquest into his death or the Surrey Police re-investigation, there is no evidence that he had been the victim of bullying or, other than complaints about guard duty, was finding military life oppressive. He appears to have been a well-liked and popular young man. This, of course, makes the events of 17th September 2001 even more baffling by way of explanation or exploration of the surrounding circumstances.

10.43 Geoff was on good terms with his parents and went home to be with them in the first week of September 2001. He did not mention any matters of concern to them. He appears to have been excited about the prospects of buying a car. None of his family or friends were aware of anything that could have been causing him distress or would be likely to have prompted thoughts of self-harm.

10.44 Geoff was successful in having a number of girlfriends. After his death, his mother was handed his personal property which revealed Geoff had maintained files relating to five young women with whom he had, or appeared to have, an association, some of whom preceded his military career. Four of these young women attended his funeral. Geoff went out with a female friend on his return home in early September and she recalled that he was pleased that he had passed his basic driving test and was looking forward to his Heavy Goods Vehicle training. The only matter of concern was his inability to come home on weekend leave because of guard duty commitments.

⁶² Major Gascoigne acknowledged in his meeting with the Review that such incidents occurred during his time at Deepcut. See paragraph 10.55 below.

⁶³ See paragraph 10.55 below.

⁶⁴ 9th January 2002.

⁶⁵ The Review is aware that Geoff had dental treatment on 3rd July 2001. The notes of the dental treatment record that Geoff said he had sustained an injury on a Saturday when he "had bottle in mouth which was knocked onto front teeth."

Armed guard duty at Deepcut

- 10.45 Geoff Gray was 17 years and seven months old when he died on 17th September 2001 whilst performing armed guard duty. James Collinson was to be even younger when he died in March 2002. Cheryl James was only just 18 when she died. Although Sean Benton was older, 20 years old, he had his own vulnerabilities, as described in Chapter 5, and had been recognised by medical staff as having an immature personality.
- 10.46 The Review has already noted in Chapter 6, when it considered the circumstances surrounding the death of Cheryl James, the apparent confusion between Army policy and local practice at Deepcut concerning the assignment of females to lone armed guard duty. It has not hitherto, however, considered in detail the policies relating to those under 18 years of age conducting armed guard duties. It will do so in the next Chapter, having reviewed the circumstances known about Geoff's death. Some preliminary comments are, however, necessary at this stage.
- 10.47 This Review has been struck by the lack of understanding and inconsistent interpretation of the age requirement for armed guard duty set by Land Command. Successive Commanding Officers of the Training Regiment, throughout the period in question, have been unable to identify what age requirement there was, if any. The Review has noted that trainees questioned in relation to Geoff's death by Surrey Police have expressed different recollections as to their understanding of the age requirement. The following Chapter will explore this confusion in interpretation of national policy, where some appear to have considered completion of Phase 1 training to have been the single determinative factor for eligibility to conduct armed guard duty. However, it is clear to this Review that the minimum age for armed guarding, from at least 1990, was, and remains, 17 years of age.

(i) Local policy at Deepcut

- 10.48 By March 2002, it is reasonably clear, from the investigations conducted by Surrey Police, that there was a local policy in place at Deepcut that trainees under 17½ years of age should not perform armed guard duty. The Review has been unable to identify precisely when this local policy was adopted or why it was thought necessary.⁶⁶
- 10.49 From the information gathered from disparate sources, most informatively from correspondence with Lieutenant Colonel John Kerce (formerly Deputy Chief of Staff (DCOS) of the Defence Logistics Support Training Group at Deepcut, as a Major), it seems that the following picture emerges. Shortly after taking over command of the Training Regiment, Lieutenant Colonel Laden met with his staff who indicated that they were not happy with the prospect of very young trainees performing armed guard duty. They suggested a local policy that only those over 17½ should be in possession of a weapon on guard. The Review has been interested in examining what prompted this concern. It may be that the staff remembered an incident, discussed in the next Chapter,⁶⁷ where a previous Adjutant had concluded that a 16 year old, who had passed Phase 1 training, could conduct armed guard duty.

⁶⁶ It is worth noting that the RMP report into the death of Geoff Gray did not capture the standing orders for the Barrack Orderly Officer which it would appear, at least by the time of James Collinson's death in March 2002, may have included reference to a minimum age requirement of 17 years to perform armed guard duty, which is consistent with Army policy but does not appear to reflect the local policy of 17½ years.

⁶⁷ See paragraphs 11.29–30 below.

- 10.50 It may also have been that the suggestion of 17½ years being an appropriate determinative age came from the age that young soldiers could be sent to Northern Ireland.⁶⁸ For the Review, it would be logical to link the age of unsupervised armed guard duty to the age when a soldier is considered eligible to take a full and unrestricted part in operations. It should be noted that, in 2001, that age requirement was being clarified as 18 years, as the United Kingdom implemented its accession to the Protocol of the United Nations Convention on the Rights of the Child.⁶⁹
- 10.51 Whatever the origins of the local policy at Deepcut, it appears Lieutenant Colonel Laden approved the policy. He was, however, so disengaged from the reasoning behind it that he had forgotten he had authorised it. It was apparent, from the information that Lieutenant Colonel Laden supplied at the meeting, organised by this Review, between him and Mr and Mrs Gray, that there was a discrepancy between his recollection and other information that had been passed to the family.⁷⁰ Following further research by this Review, a further meeting was held between the Review and Lieutenant Colonel Laden and the present position outlined above has emerged.⁷¹

(ii) Unsupervised and isolated guard duty

- 10.52 This Review has identified unsupervised armed guard duty as being an issue of concern. This is taken to refer to guard duty, other than as a supervised training activity, where the guard is left with a weapon and magazine of ammunition, and is out of the eyesight of either the guardroom or of an experienced adult soldier able to monitor how the weapon is being used. Guarding at Deepcut involved a number of places and occasions where such unsupervised guard duties took place. The Review understands that, throughout the events of concern, guarding at the main gate at Deepcut was assisted by a civilian unarmed guard of the Ministry of Defence Guard Service (MGS) and would have been within the eyesight of the guardroom. The gates to which Cheryl James was assigned and at which Sean Benton obtained a weapon, and the Officers' Mess where Geoff Gray and James Collinson died, were all isolated from the main guardroom, and contact was only maintained by occasional visits or radio access. As Lieutenant Colonel Laden has indicated in conversation with the Review, being alone with a weapon at such remote points, particularly at night, could be an unsettling experience.⁷²
- 10.53 This Review is surprised that by 2001 Army policy had not developed further in this respect. There is a substantial difference between teaching a young person how to fire a weapon and how to use it. The mechanics of safely loading, or making ready, a weapon is one thing. The exercise of sober judgement as to when, and under what circumstances, to use it, is quite another. Even highly trained and experienced tactical firearms officers in civilian police service, specially selected for their detached ability to think calmly under stress, can make wrong calls in difficult circumstances.
- 10.54 Guarding an isolated access point at an Army Barracks with a lethal weapon involves the risk that the weapon may need to be used. This is why Rules of Engagement instructions⁷³ are issued along with the weapon and ammunition. If the use of weapons by armed guards is contemplated then, in turn, the Army must be satisfied that the soldiers assigned

⁶⁸ Although such service was restricted to Barracks duties only until reaching 18.

⁶⁹ See paragraph 4.41 above.

⁷⁰ See for example Appendices A4/11.017 B – D, A4/11.064 D – E and A4/11.075 B – F.

⁷¹ See Appendix 4/10.

⁷² See Appendix A4/10.006 A – C.

⁷³ Joint Service Publication (JSP) 385, commonly referred to as the 'Yellow Card'.

a weapon are sufficiently mature and competent to make the judgement for themselves, unsupervised by NCOs, to ensure that the weapon is not misused. If, on the other hand, the arming of guards is only intended as a very general deterrent and the potential use of the weapons is not anticipated, perhaps a more precise balance of the risks and benefits of such an approach should have been made. The judgement required of an armed guard cannot be acquired solely by formal instruction in a lesson or by consulting a card. Whether there is suspicious movement outside the perimeter, or whether life is under threat, cannot always readily be assessed. At time of heightened alert and emergency, an inexperienced trainee may be placed at a considerable disadvantage. In the opinion of the Review, it would be wrong to require them to make life or death judgements that their age and experience do not equip them to make.

- 10.55 As noted earlier, the Deepcut guardroom daily occurrence logs, seen by this Review, record numerous examples of damaged perimeter fencing or soldiers being apprehended climbing over the perimeter fencing after hours.⁷⁴ The Review has discussed such behaviour with Lieutenant Colonels Laden and Govan, as well as with Major Gascoigne. It was acknowledged that such activity could lead to accidental fatalities,⁷⁵ but also that the fact that it was known there were armed guards did not seem to deter such behaviour. The need for soldiers to climb over the perimeter fence rather than report to the guardroom on entering the camp is obscure, as it appears there were no general curfews.⁷⁶ Some might have left camp in breach of Restrictions of Privileges (ROPs). The Review is concerned that a nocturnal encounter, particularly when the alert state is raised, between an anxious 17 year old with a weapon and a furtive apparent trespasser could readily end in tragedy. In an era of the potential suicide bomber and asymmetric warfare, it is difficult to understand where a clear line can be drawn between active service on operations abroad and military activity in defence of a unit in the United Kingdom.⁷⁷ Although a trainee assigned to guard duty in the United Kingdom is not given the duty knowing it is likely that he or she will have to use the weapon to open fire, it must always be a possibility.
- 10.56 This Review does not purport to second guess security judgements made by the Army as to what is an appropriate level of guarding to deter, or resist, attacks in an age of constant, yet changing, danger. What it is concerned to consider is whether policy and practice was appropriate by 2001 with respect to the deployment of young people on the task of armed guarding, and whether there was adequate co-ordination between the different branches of the Army in understanding and assessing the nature of the risks inherent with this practice.

(iii) Understanding the risk of armed guard duty

- 10.57 What is striking is the apparent disconnect in the formation of the policy for armed guard duty and the policy on the duty of care to young trainees and prevention of self-harm. We have seen from the previous Chapter that, for some years prior to 2001, the statistical analysis highlighted the feature that the Army had a higher rate per 100,000 of self-inflicted deaths than for the civilian population in the cohort of young people aged 16-24

⁷⁴ The Review is also aware of witness statements to Surrey Police noting such activity. See also paragraph 10.39 above.

⁷⁵ See Appendix A4/5.036 E – F, where Lieutenant Colonel Govan acknowledged “we came close on one occasion.”

⁷⁶ Major Gascoigne did acknowledge that there were certain days when trainees would have to be in Barracks by a certain time. Lieutenant Colonel Laden noted that, by and large, at weekends soldiers could book in and out without any fuss and that no-one is technically confined to camp unless on a personal restriction, Appendix A4/11.053 C – D.

⁷⁷ See Appendix A4/3.022 G–023 B for Brigadier Elderton’s comments on whether armed guard duty can be considered ‘operational’.

years. Of the means of self-harm, death by gunshot wounds was the most prevalent for this age group in the Army. In other age groups, and in the Royal Navy and Royal Air Force generally, the rate of self-harm was notably lower than for the civilian population.

- 10.58 Although military life, by its very nature, will offer a number of occasions when a person intent on self-harm can be unsupervised whilst in possession of a weapon, as far as the Review understands, in the regime at Deepcut, the only regular and substantial occasion when access was unsupervised was during guard duty. Moreover as the Army knew, Deepcut had the problems of SATT, low staff ratios, a history of disciplinary problems and a sense of it being a frustrating, rather than inspiring, place. The holding function of 86 Squadron and the poor supervisory ratios meant that staff did not know their trainees very well and were less able to make informed judgements about their specific levels of maturity and state of mind. Further, the nature of the site, with isolated detachments beyond the main part of the Barracks, meant that the number of guards required to deliver 24-hour protection was high, and the places where guards were posted were far away from, and out of eyesight of, the guardroom where the experienced Guard Commander and his Second-in-Command were located.
- 10.59 In addition, Deepcut had experienced the trauma of two deaths by gunshot wounds in 1995 and had recognised, in the Evans Report, that reduction of guard duty and the use of the MGS was a desirable initiative to reduce risk. Taken in combination, the Review believes there was a strong case for a risk assessment to be made about the wisdom of using under-18s on armed guard duty by Land Command, the Army Training and Recruiting Agency (ATRA) or those in command at Deepcut.
- 10.60 It can be said that it is to the credit of the staff at Deepcut that they appear to have come to their own conclusion as to the necessity for a policy imposing an age requirement for armed guard duty, and for reaching a decision of 17½ years. The difficulty is that, if this decision was the outcome of an informed discussion based on an assessment of risk, the reasons for the policy, and the strength of the measures needed to put it into effect, cannot be effectively assessed. From conversation with Lieutenant Colonel Laden, not only had he forgotten he had approved such a policy, he was unaware of the reasons for it and was also uninformed of the practical measures that were taken to implement it.⁷⁸
- 10.61 If the policy adopted relied on the self-declaration and self-policing of 17½ year olds to ensure others were aware of their age (and that those minors, themselves, knew not to swap roles between armed and unarmed duties, not to go out on lone prowler patrols and the like)⁷⁹ it may not have been a very effective policy. This is particularly so given that what it was designed to protect against was, precisely, the tendency of younger soldiers not to understand, remember or follow the rules. A series of arbitrary requirements as between 16, 17, 17½ and 18 years of age can be readily forgotten. Indeed, if those in command cannot themselves now remember the qualifying age for armed guarding, or its basis, there is little hope that young soldiers would be able to do so. A principled and consistent distinction between minors and adults is less easily dismissed from mind. To be effective, policies must be simple, sound and clearly communicated to all those likely to be affected by them.
- 10.62 It may further be said that the Army devolved the exercise of judgement on such matters to the Commanding Officer who has the responsibility of marshalling resources, assessing risks and such like. However, it is far from clear that the Commanding Officers of the time were fully equipped with the data and the collective memory of the Army to be able to

⁷⁸ See Appendix A4/10.012 F – G.

⁷⁹ See Appendix A4/10.012 F – 013 C.

effectively make an informed judgement. The Review has had the benefit of access to a wide range of opinions and data addressed to this issue. The Commanding Officer on the ground did not. Lieutenant Colonel Laden was emphatic that he had received no special training in the needs of young people under 18 years of age, their foibles and what may make them particularly vulnerable to self-harm.⁸⁰ In Chapter 9, the Review has noted a presentation prepared in 1999 for the Commanding Officer Designate Course. It did not give particular emphasis to the risks of self-harm by young people.

- 10.63 Similarly, Lieutenant Colonel Laden was unaware of the statistical material collected by the Defence Analytical Services Agency (DASA) and of the fact that young people may have particular vulnerabilities to self-harm. Until after the deaths of Geoff Gray and James Collinson occurred, he saw no distinction between his trainees with respect to access to lethal weapons on the grounds of age. Any previous judgement he would have been called on to make was therefore likely to be weakened by lack of awareness of relevant information. This was a Commanding Officer whose evidence to the Review gives all the appearance of a strong, active and imaginative individual with a genuine commitment to the welfare of the soldiers under his command.

Geoff Gray's guard duty on 16th–17th September 2001

- 10.64 As noted, in September 2001, Geoff Gray was aged 17 years and seven months and so eligible, under both Army policy and the local policy at Deepcut, that would appear to have been in place at this time, to perform armed guard duty. Geoff was assigned to perform guard duty from the evening of Sunday 16th September 2001 for 12 hours, starting at 19.00hrs (parading at 18.20hrs). He was to be on post at the HQ RLC Officers' Mess,⁸¹ with two other guard members.
- 10.65 Following his death, the RMP seized some of the current standing orders – those for the guard at the Officers' Mess and for the guard generally – as well as the guard duty rotas for members of his Troop. From the guard duty rotas, which run from Friday evening to the following Friday day shift, it appears that Geoff had been on daytime guard duty from Monday 10th to Friday 14th September.⁸² After the atrocities of 11th September (9/11) committed in the USA, Deepcut was put on a heightened alert state.⁸³ The heightened alert state seems to have resulted in an increase in the number of personnel assigned to guard duty.⁸⁴ Therefore, while the standing orders for the guard at the Officers' Mess, seized by the RMP after Geoff's death, only refer to two guards being assigned there, since 9/11 there would, in fact, have been three guards on duty at any one time.

⁸⁰ The Commanding Officer Designate Course had a presentation on homesickness but it was only after at least the death of Geoff Gray that Lieutenant Colonel Laden attended a course that dealt with the vulnerability of young people to self-harm.

⁸¹ This Officers' Mess was used by the officers permanently assigned to Deepcut and is not to be confused with the 'Princess Royal Barracks Officers' Mess' which was primarily used by visiting officers attending courses at the School of Logistics.

⁸² See Appendix 6, entry 24 of the 2001/2 Duty of Care Schedule, who recalls being on daytime guard with Geoff for three days just after 9/11.

⁸³ See Appendix A4/3.030 A – D.

⁸⁴ The witness statement of Squadron Sergeant-Major(f) BZ to the RMP dated 17th September 2001 noted that the events in America resulted in an increased security state and, therefore, double manning of the guard "*which has increased the amount of Service personnel on Guard and the duration an individual serviceman has to spend on Guard Staff.*"

- 10.66 The guard rotas from Friday 14th September state that Geoff was on the 'additional guard' for the 12-hour night shifts from Sunday 16th until the morning of Friday 21st September. It would appear that those listed as 'additional guard' were required as a result of the raised alert state.⁸⁵ Prior to Geoff's daytime duties from 10th to 14th September, he had previously been assigned guard duty on 23rd May, 22nd June and from 15th July to 20th July 2001. During Surrey Police's re-investigation in 2002, they took a statement from a Sergeant at Deepcut who described the logistical problems of organising the guard rota:

*"Arranging guard at Deepcut is a nightmare. If a private is due to go to Leconfield on the Monday/Tuesday of a week, they often get a 24-hour guard duty prior to going to Leconfield. This alleviates problems with personnel ... Friday morning was normally spent swapping/changing guard personnel due to courses, discipline and sickness ... When Privates come to us to try and get out of their guard, we have to listen but the chances are if they are due to go to Leconfield (where they have fewer guards than at Deepcut) they will do the 24-hour guard whatever their excuse. The policy was if you were on course during the week, you would do a 24-hour guard stint at the weekend. Continuation training Privates tended to get the weekday guards. Obviously if you have not got enough for weekend guard you then look towards those that are going on course the following week i.e. Leconfield. In September 2001, there were less Privates at Deepcut than there are now which in itself caused problems with staffing the guard."*⁸⁶

- 10.67 Geoff was due to go to Leconfield on Friday 21st September. Whether Geoff was on night guard duty from Sunday 16th September as a result of his imminent departure for Leconfield, or simply due to the increased requirement for guard personnel as a result of the heightened alert state following 9/11, is not important to decide. Either explanation would appear to be consistent with local practice at the time.⁸⁷ There is no evidence that Geoff was on duty as a punishment or that he was being unfairly assigned guard duty relative to other trainees.
- 10.68 Deepcut, as we have seen, had a large guard commitment. Its irregular shape, with discrete perimeter fences, meant that guards had to be allocated during the day to six locations and at night to three, two of which were isolated and some distance from the guardroom. The policies that required such a guard commitment were Army-wide and national, and passed down through the regional command system. They will be examined in the next Chapter. When armed guards were required, it seems that, from 1994 at least, ammunition was always issued, despite the local RLC orders in 1993 suggesting that this was not always the case.⁸⁸ The loaded magazine would either be retained in a pouch on the soldier's jacket or inserted into the weapon, depending on the alert state. The Second-in-Command of the guard on the evening of 16th September 2001 described the normal safety precautions he took that evening with Geoff and his colleagues as:

⁸⁵ Compared with the rota from Friday 7th September, the rota from Friday 14th has 'additional guard' listed separately under the usual timetable.

⁸⁶ See Appendix 6, entry 9; 17th January 2003. The evidence of the individual behind the entry noted that, as she had been at Deepcut for so long, she "tended to get the better jobs, easy guard shifts etc." This trend is consistent with the evidence from the 1995 period.

⁸⁷ Indeed, Private(f) CE, who, like Geoff, was also on the 12-hour night guard duties from Sunday 16th to the morning of Friday 21st September, had also been on night guard duties for the period Sunday 9th to Friday 14th September, when Geoff had been on daytime guard duty from Monday 10th to Friday 14th September.

⁸⁸ The local orders make a distinction between being issued a weapon and being issued ammunition.

*"... loading of the magazines of ten (10) rounds of live ammunition onto the weapons being carried by Ptes Gray and [Private CF]."*⁸⁹

This suggests that, at the raised alert state, the magazine containing ammunition would have been attached to the weapon for all guards, rather than retained in the pouch on the jacket.

- 10.69 The broad picture of the events concerning Geoff's death is captured by the RMP investigation and the inquest into his death, held in March 2002, although there was some confusion,⁹⁰ ultimately resolved, as to the times of the two-hour periods when he was on guard (referred to as a 'stag'), as opposed to on a two-hour rest period. Nothing in the subsequent Surrey Police re-investigation undermines these timings and the basic narrative of events. For the Review, the following appears to be the most accurate reconstruction of events.
- 10.70 The guard was paraded and verbally briefed, in accordance with written instructions, at 18.15hrs to 18.30hrs by the Guard Commander,⁹¹ Sergeant CB, in the presence of the Barrack Orderly Officer,⁹² Warrant Officer (Class 2) CC. The guard consisted of 40 soldiers and a Second-in-Command of the Guard, Lance Corporal CD (who was at Deepcut on a course), and the first two-hour stag (at which time those not on guard would be on a rest period) started at 19.00hrs. The Barrack Orderly Officer reminded the guard of the conduct expected, including that the use of mobile phones, ordering takeaway food and chatting in the guard hut when prowler patrols should be conducted, were prohibited. A request for anyone who had problems, or didn't think they would be able to conduct the guard duty that night, to identify themselves was made and met with a negative response. Sergeant CB, the Guard Commander, had recently joined the Training Regiment at Deepcut and, therefore, like Lance Corporal CD who was two weeks into a temporary course at Deepcut, did not know the trainees forming the guard, who would have been selected for duty by the Squadron NCOs.
- 10.71 Geoff was assigned to the HQ RLC Officers' Mess gate where three guards were assigned, with instructions that prowler patrols should only be conducted in pairs.⁹³ According to Lance Corporal CD, the Second-in-Command of the guard,⁹⁴ Geoff's first stag was from 21.00hrs to 23.00hrs and he was assigned to perform this with a Private(f) CE, who came from St Vincent (and not from Fiji, as is sometimes described by others) and a Private CF (who was, indeed, Fijian). According to their RMP statements, both of Geoff's comrades were over 18 years of age and knew Geoff fairly well. Private(f) CE, like Geoff, had been on night guard duty from Sunday 9th to the morning of Friday 14th September (Geoff had been on daytime duty from Monday 10th to Friday 14th).

⁸⁹ 9th October 2001.

⁹⁰ See paragraph 10.78 below.

⁹¹ Witness statement dated 17th September 2001.

⁹² *Ibid.*

⁹³ Prior to the raised alert state, two soldiers would have been assigned to this gate and any prowler patrol would have been conducted by a sole soldier. Warrant Officer CC's statement to the RMP dated 17th September 2001 stated that prior to 9/11: "... there has to my knowledge, only been a static guard at the gate and no Prowler patrol has been mounted." At the inquest, Squadron Sergeant-Major(f) BZ was asked by the Coroner to clarify a point raised by Mrs Gray as to whether, prior to 9/11, a single soldier would normally conduct a prowler patrol. Her reply was: "I couldn't say a hundred per cent sir but generally when the alert state are at a lower ebb we reduce the figures, because we reduce the number of people on guard and that doesn't allow us to double man every sentry post that we have got there will also be two people on there and if there are orders and I couldn't say again before then, if their orders were to patrol then one person would have had to stayed on the gate, obviously to allow access in and out the camp for the personnel driving in and out."

⁹⁴ Witness statement dated 9th October 2001.

- 10.72 According to these times, from 19.00hrs to 21.00hrs Geoff was in the guardroom on a rest period and spent some of his time on his mobile phone and having conversations with his fellow guard members. After his death, the RMP subsequently took possession of Geoff's mobile phone from the clothing taken to the mortuary and, in co-ordination with the civilian (Surrey) police and the Coroner's officer, downloaded the contact details of over 50 entries from his mobile's SIM card. The content of three text messages received on 22nd May, 2nd June and 3rd June 2001 were also captured. The Surrey Police re-investigation has resulted in a substantially fuller picture of the conversations Geoff conducted on his mobile that evening than was available by the time of the inquest in March 2002. Witnesses subsequently interviewed revealed that Geoff was using his mobile around 19.00hrs on 16th September 2001.
- 10.73 It seems that Geoff may have left his mobile phone in the guardroom when he started his first stag at 21.00hrs, as his friend, and fellow trainee from the under-18s accommodation block, Private BY, phoned him on it and has stated that he spoke to another trainee on guard duty, Private CN, who was on a rest period. Mr and Mrs Gray doubt that Geoff would have lent his phone to someone else.⁹⁵ The evidence known at the time of the inquest on this issue was dealt with by the questioning of the Coroner's officer. She noted that the last call that Geoff's mobile received, that was answered that night, was at 21.23hrs. She had spoken to the person who had called, Private BY, and he said that he had phoned up for a chat with Geoff but didn't speak to him. All further calls were directed to voicemail and did not show up on the phone.
- 10.74 During their re-investigation in 2002, Surrey Police interviewed Private BY, no previous statement having been taken from him, who estimated he had called Geoff at 22.00hrs. He stated that he had spoken to Private CN, the colleague on a rest period, who told him that Geoff was out on guard duty at the time of the call. In the opinion of this Review, the evidence of Private BY is consistent with and confirms, rather than undermines, Geoff's guarding sequence. One potential explanation for Private CN answering Geoff's mobile, rather than Geoff himself, may be that Geoff left his phone behind in the guardroom in error and, once the first call was answered, the phone was switched off. Whatever the explanation, Geoff certainly had his mobile with him on his second stag that night. The evidence of Private CN is considered later.⁹⁶

The incident with a civilian during the first stag

- 10.75 During his first stag from 21.00hrs to 23.00hrs, Geoff and his two colleagues, Private(f) CE and Private CF, were on duty at the 'rear' gate, used as the main entry to the Officers' Mess rather than the ornamental 'front' gate.⁹⁷ In his statement to the RMP dated 21st September 2001, Private CF recalled that Geoff seemed quite happy but was annoyed at having to be on guard. He stated that Geoff was apparently frustrated that, as he had been on guard "*without a day off*", he had not been able to prepare for his course at Leconfield and that his request for time off to organise himself had been refused.⁹⁸

⁹⁵ See Appendix A4/11.047 B – C.

⁹⁶ See paragraph 10.122 below.

⁹⁷ Confusingly, it appears that, since the 'rear' gate was used as the 'main' entry to the Officers' Mess, a number of witnesses in their statements to the RMP refer to the 'front' ornamental gate by a variety of names: "*the back gate*" (see statement of Private CJ dated 26th November 2001); "*the rear gate*" (see statement of Private CH dated 6th November 2001); "*the rear ornamental gate*" (see statement of Private CI dated 8th November 2001); and, even, "*the main gate situated to the rear*" (see statement of Warrant Officer CC dated 9th January 2002).

⁹⁸ From the guard duty rotas it would appear that Geoff was not on guard duty on Saturday 15th September 2001. As noted, he had been on daytime guard duty from Monday 10th to Friday 14th September. Indeed, the evidence of Private CN confirms that Geoff was not on guard from the evening of Friday 14th until the evening of Sunday 16th September 2001. See paragraph 10.127 below.

According to Private CE, Geoff was very serious while he discussed these frustrations but then shrugged his shoulders and said *“‘Oh well’ and he instantly became his usual, easy going self.”*

- 10.76 At some time after 22.00hrs, Geoff and his two colleagues had to deal with an incident where a civilian instructor, who was a member of the Ministry of Defence (MOD) Fire Service, sought admission to the Officers’ Mess where he alleged he was living. This individual presented an identity card, which the guards correctly noticed was not a military ID card.⁹⁹ The civilian was the worse for alcohol and, when not immediately allowed to enter, was repeatedly verbally abusive, most notably towards Geoff. Private(f) CE called the guardroom to check the validity of the ID card and Lance Corporal CD, the Second-in-Command of the guard, came to the scene. He asked the civilian to keep his ‘profanities’ to himself and remembered Geoff smiling at this when Lance Corporal CD looked over at him. As the Officers’ Mess reception phone was engaged, Lance Corporal CD and Geoff escorted the civilian to the Officers’ Mess where his identity was satisfactorily established.
- 10.77 According to Private(f) CE, in her RMP statement dated 21 September 2001, this incident happened around 22.50hrs. According to Lance Corporal CD, he was made aware of the issue with the civilian fire officer around 22.00hrs to 22.15hrs. Private CF described their first stag as between 19.00hrs and 21.00hrs and the incident happening between those two times. He repeated this assertion at the inquest and this was the source of confusion, referred to earlier,¹⁰⁰ about the timings of Geoff’s stags. The correct time was ultimately clarified towards the end of the inquest, following an adjournment, by reference to the Guard Commander’s contemporaneous manuscript guardroom daily occurrence log, which recorded 01.15hrs as the time that shots were reported. From that timing, it could then be deduced that Geoff’s second stag started at 01.00hrs, that his first stag, therefore, started at 21.00hrs and that Private CF was clearly mistaken.
- 10.78 The guardroom daily occurrence log also recorded the call from Private(f) CE regarding the civilian as being logged by Sergeant CB, the Guard Commander, at 21.45hrs and Lance Corporal CD’s return being logged at 22.15hrs. Warrant Officer CC, the Barrack Orderly Officer, gave two statements to the RMP dated 17th September 2001 and 9th January 2002. In his first statement he stated that he had been told by Sergeant CB of the incident with the civilian fire officer at 21.45hrs. While there is some discrepancy in the recorded name of the civilian, it is clear only one such incident occurred that night. After the civilian fire officer had been escorted to the Officers’ Mess, a Major - Major CG - who had witnessed the incident from his front garden, informed Lance Corporal CD that he and the guards had handled the situation well. Shortly thereafter, the stag concluded and Geoff and his comrades were driven back to the guardroom for their two-hour rest period. Lance Corporal CD passed on the Major’s praise, and specifically congratulated Geoff on his conduct.
- 10.79 There is no evidence that this incident with the civilian caused Geoff any lasting concern. Private CF noted that Geoff looked a bit nervous during the incident. However, Private(f) CE described to the RMP how, once the incident was resolved, she was talking to Geoff:

⁹⁹ It is understood that accommodating MOD Fire Service civilian officers within the Officers’ Mess has been common practice since at least 1990, however, due to the modest number involved, those on guard are likely to have been unfamiliar with this practice and would similarly be unlikely to recognise an MOD civilian ID card.

¹⁰⁰ See paragraph 10.69 above.

"I recall he was teasing me about the fact that he was due to go to Leconfield on the following Friday. He seemed to be in high spirits and looking forward to commencing training and was telling me of his plans for the week prior to leaving."¹⁰¹

Indeed, at the inquest, the Coroner asked Private(f) CE whether Geoff was upset at all when he returned from having escorted the civilian to the Officers' Mess and she replied that he was not and that they joked about how the civilian had woken everyone up. Private(f) CE also added that Geoff was seen as a bit of a 'hero' when the incident was described to everyone else on their return to the guardroom at the end of the stag.

- 10.80 After the events of the first stag, the second rest period from 23.00hrs to 01.00hrs does not seem to have been particularly eventful. It can be assumed from Private(f) CE's evidence at the inquest that the incident with the civilian was the subject of some discussion amongst the guard members. In his statement to the RMP dated 9th October 2001, Lance Corporal CD recalled that, during the second rest period, Geoff was keen to know what the training was like for the Commando Course and what exercises he could do to improve his strength and stamina. Lance Corporal CD noted that:

"Throughout our conversation he appeared happy, and was laughing and joking with me. I had previously noted that Pte Gray took great care over his appearance and would straighten his trousers when he got out of the wagons and always checked himself off prior to starting his watch, he was a keen and well turned out soldier even at this hour of the night."¹⁰²

- 10.81 The civilian MOD fire officer has received attention in the reporting of Geoff's death, as this individual is the only person identified who had an argument with him and, therefore, a possible animus against Geoff around the time of his death. Surrey Police's re-investigation subsequently revealed that this civilian, having been escorted to the Officers' Mess, was assisted to his room after the arrival of the Provost staff. He was checked in his room around 23.00hrs and was asleep. He was subsequently checked again by Major CU¹⁰³ after gunshots had been heard in the early hours of the morning. Major CU was off duty in his quarters on camp watching a film. He heard the sound of gunshots and went outside. He appears to have gone to the gate by the Officers' Mess where he met Lance Corporal CD and learned of the incident earlier that evening with the civilian fire officer. He thought it appropriate to check on the civilian to satisfy himself that he had not caused any further problems. Major CG went to the civilian's room and saw him in underwear and a dressing gown and believed he was alone in his room and in bed when visited. He estimated this check to have been sometime after 01.00hrs.¹⁰⁴

- 10.82 In the opinion of this Review, there is no reason to believe that the civilian fire officer had any connection with the tragic events of the early hours of 17th September 2001. Surrey Police were satisfied that he was not a suspect during their re-investigation. The Review has not seen or heard anything to challenge that conclusion. However, a more thorough investigation into this should have been conducted at the time. The discrepancy between Private(f) CE and Private CF as to the timing of the stags should have been picked up. Sergeant CB, the Guard Commander, should have been interviewed about the entry in the guardroom daily occurrence logs. The civilian fire officer should also have been

¹⁰¹ 21st September 2001.

¹⁰² 9th October 2001.

¹⁰³ Not to be confused with Major CG who had witnessed the civilian's behaviour earlier in the evening from his front garden.

¹⁰⁴ Paragraph 5.6.38-40 of the Surrey Police report to the Coroner.

interviewed, with a view to inculpating or excluding him, as well as those who could account for his movements. The early failure to provide a consistent and coherent narrative has, understandably, been one of the concerns of Mr and Mrs Gray.

The journey to the second stag

- 10.83 Private CP, whose evidence of primary interest is considered below, gave a statement to Surrey Police during their re-investigation. He was on the same two-hour stag/rest period rotation as Geoff and recalled getting on the minibus for the beginning of the second stag starting at 01.00hrs:

"I remember getting on the bus and looking at Geoff. He did not look happy. He had no smile on his face. He look completely different. I remember the Fijian female¹⁰⁵ said to him 'what's up'. Geoff said 'Nothing'."¹⁰⁶

- 10.84 After the first rest period, Private CM, a friend of Geoff's whose evidence of primary interest is also discussed later, did not see Geoff again that evening until the same journey in the minibus on the way to the second stag. In his statement to the RMP, given in the hours after Geoff's death, he said:

"About ten to one on the morning of Monday 17th September, we got back on the minibus to go back out on guard duty. Again, Geoff was with us. I sat next to Geoff on the bus on the five minute journey. Geoff was very quiet but this is not unusual for Geoff. His three man patrol got out first at the Officers' Mess. As we drove off, I saw Geoff just staring off into an abyss, not focusing on anything. He looked quite down, but I did not think much of it."¹⁰⁷

Geoff Gray's lone prowler patrol and the hearing of shots

- 10.85 Although this Review is satisfied that the civilian encountered earlier in the evening was not involved in the events that followed, it may be that the incident itself did play an indirect role in events of the second two-hour stag that evening. The Review accepts that the second stag would have been from 01.00hrs to 03.00hrs on 17th September 2001. Private(f) CE¹⁰⁸ states that at about 01.15hrs, shortly after the stag commenced, Geoff told her that he was going to do a foot patrol (a prowler patrol). She asked him if he wanted her to go with him. He replied that she should stay with Private CF because of what had happened earlier – she took that to be a reference to the earlier incident with the civilian. Geoff told her that he was going to do a fast foot patrol and then return to his comrades.¹⁰⁹ Between three to five minutes later she heard a burst of shots, she estimated four – she thought a single shot followed, a split second later, by automatic fire.

¹⁰⁵ A misdescription for Private(f) CE. See paragraph 10.71 above.

¹⁰⁶ See Appendix 6, entry 5; 24th July 2002.

¹⁰⁷ 17th September 2001.

¹⁰⁸ 21st September 2001.

¹⁰⁹ Lance Corporal CD's statement of 9th October 2001 states that a patrol of the perimeter of the Officers' Mess compound would take approximately 15 minutes, being roughly 1km in length.

- 10.86 Private CF's statement dated 21st September 2001, as noted above, was given on the basis that the first rest period was between 21.00 and 23.00hrs and that the second stag started thereafter. As discussed, this Review believes that he was mistaken. He recalls that, on his timings, at about 00.30hrs Geoff said he was going to do a quick patrol on foot. He says that he told Geoff he should go with Private(f) CE in accordance with their earlier briefing, but Geoff declined the offer of assistance from her and from Private CF. Both Private CF and Private(f) CE recall that there was a period of silence, when nothing was said between the three of them, before Geoff announced he was going to do his patrol. Like Private(f) CE, Private CF also stated that between three to five minutes after Geoff left he heard a burst of automatic fire – a first shot sounding rapidly followed by about four others.
- 10.87 There are two matters as to guard procedure to be noted from this account. First, it will be seen that Geoff performed his second stag at the same location as the first. One of the recommendations of the Board of Inquiry formed after the death of Sean Benton was that stags should be altered as to posts.¹¹⁰ Lieutenant Colonel Josling says these recommendations were implemented.¹¹¹ By contrast, Lieutenant Colonel Laden thought that in 2001 this was considered impractical.¹¹² It may be that Geoff and his colleagues were assigned the same location because of the introduction of the 'additional guard', due to the heightened alert state following 9/11, to permit prowler patrol. In any event, the tedium of repetition, at least in relation to location, does not appear to be a feature in this case. The first stag had been quite eventful and there were two soldiers to talk to rather than the normal one.
- 10.88 The second feature is that Geoff should not have gone out on a lone prowler patrol. According to his comrades, this was at Geoff's insistence. Lance Corporal CD's statement is not precise as to who was armed for the second stag at 01.00hrs - one reading suggests that the same soldiers had loaded weapons as before, which according to him, was Geoff and Private(f) CE. However, it is apparent from what he observed later, which is discussed below,¹¹³ that Private CF was armed for the second stag. If that is correct, it should have been Private(f) CE who accompanied Geoff, as she was unarmed at that time.
- 10.89 The written standing orders were not informative as to who should do what, as they had not been updated after the atrocities of 9/11 to reflect that there were now three guards assigned. They were subsequently changed so that the guard at the gate was left unarmed, while the two armed soldiers went out on prowler patrol together. Sergeant CB, the Guard Commander, said that he explained in great detail, at his original briefing when the guard paraded, that there should be one armed soldier at the gate and that the other armed guard should be accompanied by the unarmed guard when on prowler patrols. Private CF clearly recollected Sergeant CB's briefing. Private(f) CE's statement simply noted that they were informed that patrols had to be conducted by two personnel, but she later made the observant point, noted in the subsequent RMP report,¹¹⁴ that, as the unarmed guard, whoever she went with, she would be leaving one armed guard alone.
- 10.90 The Review cannot now assess why Geoff was assigned an armed rifle on both stags when he was the only one of the three guards under 18. It may be that the policy that prevented females from being alone with a weapon had some influence on this. Geoff was, in any event, over the minimum age under the local policy, if this was, indeed, in force at the time, and, was also over the Army minimum age for armed guard duty. Perhaps he had

¹¹⁰ See Appendix A9.008 para 28(g).

¹¹¹ See Appendix A4/9.016 B - C.

¹¹² See Appendix A4/11.006 E - F.

¹¹³ See paragraph 10.92 below.

¹¹⁴ Summary of Investigation, paragraph 13.

greater experience of guard duty. The Review understands that the requirement for prowler patrols to be conducted in pairs is based on a military assessment that it is more dangerous for a lone soldier on prowler patrol to be armed and to confront a potential enemy than for two soldiers to do so. In the absence of a clear rationale, on 16th–17th September 2001, as to why prowler patrols with a weapon and ammunition should be accompanied, but duty at the gate with a weapon and ammunition need not, and notwithstanding the apparent breach of their original briefing, the Review is not of the opinion that either Private(f) CE or Private CF were negligent for failing to ensure that Geoff was accompanied. As noted earlier, after Geoff's death, the Review understands that the standing orders were changed so that the person at the gate was left unarmed but the two prowlers were both armed. This arrangement was designed to ensure that no trainee, of whatever age or gender, was left alone with a weapon. In any event, Geoff's death cannot be said to have been caused by the apparent confusion on 16th–17th September 2001 and the failure to adhere to instructions. Indeed, it would appear he refused any company and was insistent that he conducted the prowler patrol alone.

- 10.91 The entry under Sergeant CB's name in the guardroom daily occurrence log records 01.15hrs as the time of a report of shots being heard by guards at other gates and 01.30hrs as the record of a report that Geoff was missing. Sergeant CB – the Guard Commander – told the RMP, in his statement dated 17th September 2001, he heard three loud bangs of gunshot himself at 01.15 hrs. He also stated that, as a fully qualified weapons instructor with 18 years' experience in the Army, he knew the shots were of an automatic burst and were live rounds. Lance Corporal CD's statement to the RMP dated 9th October 2001 says that from about 01.10hrs he recorded three separate calls in to the guardroom of reports of shots being heard. Again, the rest of the events of this night, and the alerts sent out later, make sense if these are the accurate timings, as the Review considers them to be, rather than Private CF's.

The search for Geoff Gray

- 10.92 On hearing the shots, and receiving the reports into the guardroom, Sergeant CB, the Guard Commander, tasked Lance Corporal CD, the Second-in-Command of the guard, to attend the Officers' Mess with two armed guards from the guardroom, Private CH and Private CI. Private CH and Private CI had recently finished their stag and were outside having a cigarette. They both stated that they heard three shots. All three travelled to the Officers' Mess. It is plain that there was considerable anxiety as to what might have happened, with the events of 9/11 fresh in the mind of all concerned. In the absence of any reason to believe that Geoff would self-harm, the shots, combined with Geoff's absence, must have resulted in a belief of a possible terrorist attack. On arrival at the guard post at the Officers' Mess, Private CF, the other male on guard duty at the Officers' Mess with Geoff, was found to have made his weapon ready.¹¹⁵ According to Lance Corporal CD, Private CF was in an agitated state and was saying that he was 'ready to kill'. Lance Corporal CD ordered Private CF to clear the weapon and put the rounds back in the magazine that was fitted once more to his weapon. At the inquest Private CH confirmed this account.

¹¹⁵ That is to say the weapon had been cocked ready for firing and a round entered the chamber from the magazine. This incident also confirms that Private(f) CE was not issued with a weapon and that Private CF and Geoff were.

- 10.93 Lance Corporal CD's statement to the RMP is dated 9th October 2001. He appears to have been away in Plymouth some time after Geoff's death and arrangements were made to interview him on 3rd October, before a statement was taken. He stated that he, Private CH and Private CI conducted a slow clockwise search inside the perimeter fence with no 'white light', being no more than a metre away from the fence at any time. This initial search was unsuccessful in finding anything. It was repeated twice more, without success. Prior to the third search, Lance Corporal CD radioed for more manpower and for the civil police to be informed. If any of these searches had been done to the full extent of the perimeter fence, Geoff's body would have been found, if it was at all times in the place where it was subsequently discovered.¹¹⁶
- 10.94 Private CH was to ultimately find Geoff's body. He gave a different account to that of Lance Corporal CD in his statement to the RMP dated 6th November 2001. He stated that, whilst conducting a search of the perimeter fence area of the Officers' Mess with Lance Corporal CD and Private CI, they encountered a small mound about 25 metres from where Geoff's body was ultimately to be found by Private CH. Private CH stated that Lance Corporal CD alone went on to the mound and that they did not proceed beyond it down to the fence near where Geoff was to be found: *"It is fair to say that we did not stay within an arm's distance of the perimeter fence, near this hill. I can also state that we did not conduct a check of the area where I later found Pte Gray's body."* As a matter of military training, Private CH's account makes sense. At a time of heightened alert and anxiety, a soldier would not want to expose himself as a target on the top of a mound where he might be silhouetted against whatever light emerged from the windows of the Officers' Mess (see Figure 10.2). Indeed, Private CH noted such concern in his statement.

Figure 10.2: A photograph of the view from the area where Geoff Gray's body was discovered looking towards the small mound and corner of the HQ RLC Officers' Mess



¹¹⁶The Surrey Police Scenes of Crime Officer (SOCO) who arrived on the scene was to note in his sketch that Geoff's body was found nine inches from the perimeter fence.

- 10.95 Private CI's statement of 8th November 2001 supported Private CH's account with respect to which areas were searched by the group. He says visibility was poor, that they had no torches and that he concentrated his vision on the area outside the perimeter fence. He states that he and Private CH took up defensive positions while Lance Corporal CD did a check from the mound, and that all three cut out this corner of the grounds in their check of the perimeter fence: *"I believe because we cut the corner to avoid the hill, we did not check the area where Pte Gray's body was later discovered."* He estimated the search lasted 25 minutes without success and that assistance arrived with torches about 30 minutes after he had arrived at the scene. He and another Private, Private CJ, were instructed by Lance Corporal CD to blow on a whistle if they found anything. Whilst Private CI and Private CJ crouched down near the front ornamental gate that was not in use, Private CI heard what he thought sounded like chains rattling and saw what he understood to be a person sprinting across the cricket field beyond the fence 50 metres away: *"The person, who was just a silhouette, appeared to run through a fence at the opposite end."*
- 10.96 Private CI gave evidence at the inquest into Geoff's death and was questioned by the Coroner about this figure he thought he had seen. He was asked what he was expecting to find when his assistance was first required:

Ans.: Don't know I could see I had butterflies in my stomach I was nervous

Qn.: Were you expecting to find some somebody who had intruded or were you expecting to find Private Gray?

Ans.: All sorts of kinds of ideas not something that has ever happened before to me so."

The Coroner then asked Private CI to describe in more detail the figure he said he saw:

Qn.: And what was he dressed in?

Ans.: I couldn't tell you just black

Qn.: How fast did he run?

Ans.: He just sprinted it was just a sprint fast

Qn.: What noise if any did he make as he ran?

Ans.: Nothing I couldn't hear nothing

Qn.: So it was a silent run was it?

Ans.: Yes it was too far away to spot clothing or sound

Qn.: You say he came from the woods, was that near the perimeter fence?

Ans.: It was a fair way oh yer

Qn.: And was it from the direction then that Private Gray was found in?

Ans.: No."

In response to questioning by Geoff's father, Private CI explained that he believed the fence had been checked and that no holes had been found. The Report from Surrey Police to the Coroner following their re-investigation of Geoff's death noted that Detective Constable CL who attended the scene, and is discussed later in this Chapter, checked the perimeter fence and found that there were no breaks in it. Furthermore, he noted that there was a heavy dew on the grass of the cricket field and he noticed that there were no footprint impressions in the dew.¹¹⁷ The Coroner's officer was also to note that there was dew on the grass and that she saw no footprints or disturbance on the grass of the cricket field.¹¹⁸

¹¹⁷ Paragraph 5.7.15 of the Surrey Police Report.

¹¹⁸ *Ibid*, paragraph 5.7.36.

- 10.97 Private CJ made a statement to the RMP on 26th November 2001. He was one of a number of members of the guard whose rest period was interrupted to form a further wave of the search party. As noted, he accompanied Private CI to the front ornamental gate and, although it was quite windy, he thought he heard a fence rattle in a way that was stronger than merely the wind. He asked Private CI if he had heard this and they decided that they should blow on the whistle. It was at that point that Private CI said he thought he had seen someone in the area but Private CJ did not see anyone.
- 10.98 Lance Corporal CD has subsequently stated on more than one occasion in the media that he is convinced Geoff's body was not where it was found when he did his initial searches.¹¹⁹ Since no further gunshots were heard following the shots that caused the alert, the suggestion is that Geoff must have been shot somewhere else and moved by someone to where he was found. Apart from the blood stain evidence at the scene strongly suggesting that Geoff was shot where he was found, there is the inherent improbability that someone would have shot Geoff somewhere inside the perimeter fence, left the body hidden or undiscovered within the perimeter when the alert was sounded minutes later, and succeeded in moving the body to where it was subsequently found, also inside the perimeter fence. This would have had to have occurred sometime between Lance Corporal CD's initial search and the final successful search, at a time when there were at least three armed guards searching a confined area with more reinforcements arriving.
- 10.99 An alternative explanation is that Lance Corporal CD and all the members of the search party were in an understandably emotive and anxious state, believing that a comrade may have been attacked, and that they were all both cautious of exposing themselves to fire and highly sensitive in reporting anything that had the appearance of being suspicious. Surrey Police's re-investigation has identified a number of other witnesses suggesting that Lance Corporal CD was in an understandably emotional state at the time he was asked to recall these events, and the descriptions he gave to his comrades of where he actually searched are more consistent with the accounts of Private CH and Private CI, than his assertion in his witness statement to the RMP or his subsequent statements to the media.
- 10.100 Warrant Officer CC – the Barrack Orderly Officer – gave a further statement to the RMP on 9th January 2002. In that statement, he gave the time he was alerted on his bleeper by Sergeant CB, the Guard Commander, as 01.10hrs and his arrival at the scene of the Officers' Mess as 01.25hrs, at which time he was told by Lance Corporal CD that Geoff was missing. The statement reveals no basis for this time estimate. If Warrant Officer CC had attended in response to Lance Corporal CD's request for assistance, or when the guardroom logs state that he was notified, this recollection must be wrong and too early by 20 or 30 minutes. On arrival Warrant Officer CC met Lance Corporal CD and was in the process of assembling the soldiers when he heard Private CI's blow on the whistle and heard a shout that someone had been seen running. Warrant Officer CC, Lance Corporal CD and another soldier he could not identify (Private CH) went to the front ornamental gate, where Private CI and Private CJ were, but Warrant Officer CC did not see anything. He then heard someone (Private CH) claim that they could see something. Warrant Officer CC and Lance Corporal CD then approached an area inside the perimeter fence whereupon they came upon Geoff's lifeless body with a weapon nearby.

¹¹⁹Lance Corporal CD did not give evidence at Geoff's inquest because he was on an Army exercise.

10.101 The person who claimed he could see something and who first spotted Geoff's body was Private CH, one of the two Privates who had been with Lance Corporal CD on the initial unsuccessful searches. In response to Private CI's whistle, Private CH had approached the area with Lance Corporal CD and Warrant Officer CC and had started to search. It will be recalled that, taking Private CH and Private CI's consistent description of the initial searches, Lance Corporal CD did not see Geoff's body when he looked from the mound towards the direction where it was later to be found. In a comment that may provide a possible explanation for this, Private CH described the visual conditions when he was actually looking in the near vicinity where Geoff was found (see Figure 10.3):

"I recall that the area was poorly lit and a tree next to the perimeter fence made the whole area very difficult to see clearly, as I conducted a search."

Figure 10.3: A photograph showing the area where Geoff Gray's body was discovered



10.102 Private CH continued to describe that, as he approached the tree that was making visibility very difficult, he noticed something shining on the ground (he later realised it was Geoff's cap-badge) that made him examine the ground more closely. As Private CH came to within about two metres of the base of the tree (again an indication of how limited visibility was), he saw Geoff's weapon lying to the left of Geoff's motionless body. He called for Lance Corporal CD who arrived, followed by a Warrant Officer (Class 2) whose name Private CH could not remember (Warrant Officer CC).

10.103 Lance Corporal CD approached Geoff's body and saw he was lying on his back with his head about 30 cms away from the fence with his feet up near the large tree. Geoff's weapon was about 50 cms away from his feet at the base of the tree. Lance Corporal CD could see two holes to Geoff's forehead and blood on the ground. Warrant Officer CC arrived and tried to feel for a pulse while Lance Corporal CD cleared Geoff's weapon and made it safe. Warrant Officer CC was unsure whether he could feel a pulse because his adrenaline was so high, so he asked Lance Corporal CD to double check. Warrant Officer CC noticed black residue on Geoff's face near his nose, blood on the back of his head area and also on the ground. Later, as it became light, he saw what appeared to be body tissue on a cricket sightscreen, located two to three paces from Geoff's body, about seven and a half feet from the base of the screen.¹²⁰ At the inquest, Warrant Officer CC timed the discovery of the body to between 20 to 30 minutes after he arrived at the Officers' Mess.

10.104 The guardroom logs contain the following running entry in response to the recording of shots at 01.15hrs:

"Log book opened. 2 i/c sent to investigate. 0130 hrs A4 reported 25127287 Pte Gray 86 Sqn was missing. 0140 hrs 2 i/c requested extra men to search area. 0200 hrs civil police informed BOO [Barrack Orderly Officer] + BDO [Barrack Duty Officer] informed. 0213 hrs RMP Aldershot phoned to say they were on their way there. 0220 hrs guard found Pte Gray. Ambulance phoned. 0340 hrs SIB [Special Investigations Branch] took control of situation. 0350 hrs Pte Gray confirmed dead."

The arrival of Surrey Police

10.105 During their re-investigation, Surrey Police identified the full sequence of arrivals at the scene from their records. It demonstrates a considerable police presence was called out:

*"0220hrs Search party find body
 0234 hrs Surrey Police Armed Response vehicle 1
 0234 hrs Surrey Police Armed Response Vehicle 2
 0235 hrs Royal Military Police Officers [three Corporals]
 0240 hrs Surrey Police Duty Inspector
 0255 hrs RSM [Regimental Sergeant Major]
 0305 hrs Cordon officer [Police Constable]
 0330 hrs Surrey Police CID [Detective Constable CL]
 0330 hrs Army Special Investigations Branch (SIB) [Sergeant(f) CK and a Corporal]
 0350 hrs Police doctor
 0425 hrs Surrey Police CID [Detective Sergeant]
 0426 hrs Surrey Police inner cordon [two Police Constables]
 0429 hrs Coroner's Officer
 0430 hrs Surrey Police SOCO
 0435 hrs Surrey Police photographer
 0529 hrs Army Padre
 0536 hrs Regimental Field Officer [Captain]
 0610 hrs Undertakers*

¹²⁰ The Surrey Police Scenes of Crime Officer recorded in his sketch of the scene that there were two cricket sightscreens – one located directly behind Geoff's body.

0626 hrs *Body removed to the mortuary."*

10.106 Sergeant(f) CK attended the scene from the RMP SIB and made enquiries. From the RMP case diary it is known that the civilian (Surrey) police were already on the scene. At the inquest, the Coroner's officer stated she arrived at about 04.00hrs at which time the RMP SIB and the civilian police were present and Geoff's weapon had been made safe but was bloodstained.¹²¹

The continuity of Geoff Gray's weapon

10.107 In a statement he gave to the RMP for continuity purposes, the Surrey Police Detective Constable from Woking Criminal Investigations Department (CID), Detective Constable CL, stated that he took possession of Geoff's weapon at 06.15hrs on 17th September 2001 at the scene and conveyed it to Woking Police station along with five brass cartridges and a bullet.¹²² Some questions have been raised about the continuity of carriage of Geoff's weapon after his death. The RMP statements record that it was subsequently returned to the RMP, at their request, at 10.45hrs on 20th September 2001, when it was inspected by an Armourer who concluded in his report that there was no fault with its mechanical safety that could have caused an accidental discharge. Thereafter, the weapon, having been returned at 12.40hrs that same day, remained in RMP Sergeant(f) CK's custody until 3rd October when it was handed to a colleague from the RMP to facilitate its examination by another expert on 9th October 2001.¹²³ Sergeant(f) CK was present at that examination at the Firearms Unit of Hampshire Constabulary, Southampton when Geoff's weapon was examined by a civilian expert who recorded its satisfactory functioning and it was returned to her to be available for the inquest. According to Sergeant(f) CK's statement dated 30th January 2002, the weapon was still in her possession on that date and given that that statement was made in support of the final report by the RMP dated 4th February, the continuity evidence from RMP then ceases. However, it is known that the weapon was available for subsequent forensic analysis by Surrey Police, that will be referred to below, and that it was collected from the RMP on 16th May 2002 and is understood to still be in the possession of Surrey Police.¹²⁴

An early indication of how Geoff Gray died

10.108 It is clear from the RMP files, and Geoff's casualty file, that a decision was promptly reached by all those attending the scene that Geoff's death was not suspicious. The best contemporaneous evidence of this is from the signals sent out by the Training Regiment to all interested persons, as required under standing orders. The Review understands that the signals would have to be composed from information then available, then sent to the communications centre at Aldershot for transmission and then transmitted, recording the time of the transmission in Greenwich Mean Time (GMT) – an hour before British Summer Time (BST), that would have been applied in September. Accordingly, it is not surprising that the signals describe, as about to happen, things that have already happened on the evidence of the guardroom logs.

¹²¹ This Coroner's officer was also present at the scene of Sean Benton's death but only as an observer accompanying the then Coroner's officer.

¹²² It appears from the RMP file that on 20th September 2001, the single bullet retained was explained as the round from the chamber of the weapon released on clearing the weapon at the scene. The entry records that four rounds were in the magazine recovered on 17th September, thereby accounting for all ten issued to Geoff.

¹²³ The RMP case file diary contains an entry dated 21st September 2001: "*Weapon held at Armoury Buller Bks for safe keep.*" See also footnote 129 below in relation to the inspection of the weapon on 20th September.

¹²⁴ The last date was provided to the Review by the Adjutant General's Headquarters at Upavon.

10.109 A signal sent at 02.45 GMT (03.45 BST) states that the civilian police have been called for. A signal at 04.35 GMT states that the civilian police have jurisdiction and are awaiting the arrival of a Scenes of Crime Officer (SOCO). At 04.40 GMT a signal states that the death is subject to police investigation. At 08.50 GMT a signal states:

“Suspected to have taken his own life according to Surrey CID who are dealing with the incident.”

10.110 The Adjutant General’s Headquarters were clearly well versed in statistics on deaths, as a minute generated on 17th September by Personal Services (PS4(A)) and sent to the Adjutant General’s military assistant, sets out the total number of Intentionally Self-Inflicted Deaths (ISIDs) from 1997 to 2001 – including whether the death occurred on peacetime duties (including training), on operations or on leave/AWOL, as well as the method used. Although the minute notes the circumstances of Geoff’s death was subject to further civilian police investigation, the writer refers to Geoff’s death as ‘intentionally self-inflicted’.

10.111 The RMP diary may indicate why such an early view was taken. First, according to the earliest of the 101 entries in a manuscript case file diary, civilian police were already on the scene when RMP Sergeant(f) CK arrived.¹²⁵ She then recorded in the diary the following at the second entry (also dated 17th September):

“Establish a [Private CM] had a conversation with the deceased about 2000 hrs that day (Sun 16 Sep) during which Pte Gray stated he was intending to shoot himself. Info passed to civpol [civilian police] and statement recorded from him at the scene.”

Such a statement was, indeed, taken there and then and Private CM subsequently gave evidence in accordance with it at the inquest. His evidence is considered later in this Chapter.¹²⁶

10.112 Secondly, Warrant Officer CC, the Barrack Orderly Officer, was asked to check whether any weapon or ammunition was missing from the armoury, and a swift response came back that it was not. Thirdly, the RMP and the Surrey Police SOCO together accounted for five used cartridges by Geoff’s body, and five live rounds recovered from his weapon and magazine.¹²⁷ Geoff had been issued ten rounds to perform guard duty, so no bullet or spent cartridge was unaccounted for.

10.113 The likelihood that Geoff had died from automatic gunfire inflicted at the scene where his body was found was supported by the finding of the spent cartridges there and the body tissue to the cricket sightscreen behind the body, observed by Warrant Officer CC. It appears that the cricket sightscreen was later dismantled by grounds staff in October 2001 and may have been subject to cleaning. During Surrey Police’s re-investigation in 2002, the sightscreen was reassembled but forensic tests conducted for any relevant stains have proved negative. However, in November 2002, Surrey Police did discover a piece of human skull in the vicinity where Geoff’s body was found which does suggest that any wider forensic examination at the scene was not particularly thorough in September 2001.

¹²⁵ There is both a manuscript and subsequently typed up version of the RMP case file diary.

¹²⁶ See paragraph 10.129 below.

¹²⁷ See paragraph 10.107 above.

Responsibility for the investigation in 2001

- 10.114 The Review has noted the late date at which Private CH and CI, who both helped with the initial search of the perimeter fence with Lance Corporal CD, had a statement taken from them by the RMP (6th and 8th November 2001, respectively). It seems that, after discussion with Detective Constable CL of Surrey Police on 20th September 2001, responsibility for statement taking was divided between the RMP and Surrey Police. The RMP were specifically tasked with taking statements from the guards on duty with Geoff, Private(f) CE and Private CF, while Detective Constable CL stated he would speak to Private CN. Following Lance Corporal CD's statement, dated 9th October 2001, the question of where the search for Geoff had been conducted had then become an issue. There was a discussion with Detective Constable CL on 11th October and with the Coroner's Officer on 25th October, resulting in attempts to trace Private CH and Private CI and interview them once they could be located. This Review has observed that the tracing of Private CI appears to have been prompted by a call from Geoff's father on 22nd October, after he had spoken to Private CI himself.
- 10.115 The entries in the RMP case file diary and the signals noted earlier are entirely consistent with the Army's understanding that the RMP were assisting Surrey Police and the Coroner's officer in any further enquiries conducted into Geoff's death. This was on the basis of an earlier Surrey Police decision that Geoff's death was not suspicious and, therefore, a full murder investigation was not established. There is no evidence to suggest a cover up by the Army. Indeed, as noted below, the RMP were to discover evidence and initiate tests unprompted by Surrey Police.
- 10.116 The question of primacy has already been discussed in general in Chapter 3, and with respect to the deaths of Sean Benton and Cheryl James in Chapters 5 and 6, respectively. It is unfortunate that lessons had not been learned as to how investigations into 'sudden' deaths generally, as opposed to 'suspicious' ones, should be conducted. In Geoff's case, it would seem that a civilian police SOCO attended and did a cursory examination of the scene, drew a plan and took photographs. In October 2002, after Surrey Police had decided to re-investigate Geoff's death, the RMP conducted an audit of the original investigation into Geoff's death, for which they believed Surrey Police had primacy, and noted a number of failures of capture of evidence at the scene from Surrey Police. This document indicates that no Surrey Police officer attended the post-mortem, called for scientific investigations or followed, what RMP considered to be, best practice at the time.
- 10.117 The most striking demonstration of the consequences of this concerns Geoff's post-mortem. From the RMP case file diary, it seems that an SIB Corporal attended the post-mortem on 17th September 2001 for training purposes. The Coroner's officer's evidence at the inquest was that two SIB personnel were, in fact, present at the post-mortem. In any event, in the course of the post-mortem Geoff's mobile phone was discovered in the pocket of his uniform and handed to the SIB personnel who in turn notified civilian police.¹²⁸ Clearly, the civilian police officers should have checked Geoff's body for relevant evidence and ensured that there was attendance at the post-mortem to direct the pathologist to any issues of interest to the investigation. The RMP feels strongly that it was not responsible for these shortcomings.¹²⁹

¹²⁸ It appears that Geoff's clothing, like Sean Benton's, was subsequently ordered to be destroyed as it represented a biological hazard. Unlike in the case of Sean Benton, however, that order was carried out and the clothing destroyed, meaning no subsequent testing of any clothing has been possible, other than of Geoff's beret which has yielded significant results. See paragraph 10.120, point (iv) below.

¹²⁹ A further example of the RMP being proactive in their support of Surrey Police may be in relation to Geoff's weapon. The RMP case file diary includes the following entry for 19th September 2001: *"Telcon with [Detective Constable CL] and establish no examination of weapon has been conducted. Request that he bring weapon to Aldershot so that we can nominate Class 1 Armourer to conduct check..."*

10.118 The Review is aware that relations between the RMP and Surrey Police over responsibility for the weaknesses in the initial investigations into the first three deaths have been tense.

The Surrey Police re-investigation in 2002

(i) The expert evidence

10.119 A full account of the Surrey Police re-investigation into Geoff's death is neither necessary nor possible, given its interconnection with the investigation into the death of James Collinson.¹³⁰ However, the independent experts consulted by Surrey Police were able to examine the post-mortem photographs, the witness statements and (unlike in the deaths of Sean Benton and Cheryl James) the weapon and the cartridges found next to Geoff's body, as well as his damaged beret found nearby. From all this evidence, the BKA (the Forensic Institute of the German Federal Crime Bureau or Bundeskriminalamt, Kriminaltechnisches Institut), who once again assisted, and the other British forensic experts, were able to reach some firm conclusions.

10.120 The Review is satisfied that this careful work demonstrates the following:

- (i) The cartridges found by Geoff's body were fired by the weapon also found near him when in automatic mode.
- (ii) The site of the two bullet wounds to the head is consistent with an elective site for self-harm.
- (iii) The photographs and post-mortem indicate powder marks to the head,¹³¹ and the nature of the marks is indicative that the weapon that fired the bullets was held at close range to the head.
- (iv) Forensic analysis of Geoff's beret shows that it contains chemical traces of gunshot residue consistent with close contact with a weapon. The tears in the beret, and the displaced cap-badge, suggest Geoff was wearing the beret at the time he was shot, contrary to initial belief.¹³²
- (v) An SA80 weapon fired in automatic mode at close range may well lead to bullets being ejected that miss the head.

¹³⁰ See paragraph 1.7 above.

¹³¹ The doctor who carried out the post-mortem gave evidence at the inquest that *"there was sort of powder marking to the upper lip, the right cheek and the right side of the nose, bridge of the nose and indeed the upper slant of the mid line forehead."*

¹³² The Coroner's officer gave evidence at the inquest that the beret had two large tears, one at the back and one at the front, that the cap-badge had been dislodged and that, as there was minimal blood spotting on it, it was likely that Geoff was not wearing the beret when he was shot.

(vi) None of those who examined the exhibits provided found any evidence indicative of third party involvement. There were no injuries to Geoff's body suggestive of a struggle.¹³³

(vii) The BKA found that the resulting pattern of evidence is totally consistent with a series of shots fired with suicidal intent from an SA80 weapon.

10.121 While compelling, this does not mean that third party involvement can be excluded on the scientific evidence alone. As noted in the discussion of Sean Benton's and Cheryl James's deaths, science alone can rarely do this. However, it would strongly negate any expert opinion that the evidence was inconsistent with self-infliction. It also does suggest that no further tests are now available to produce any more emphatic results. Further, anyone reviewing Geoff's death would need to consider it possible, or of equal probability to the hypothesis of self-harm, that a killer mimicked self-inflicted injury by taking Geoff's weapon off him, without a struggle, and firing automatic shots at near point blank, missing with some rounds, before disappearing without leaving any trace.

(ii) The telephone call with an old girlfriend

10.122 The RMP case file diary, composed by Sergeant(f) CK, has been referred to earlier at paragraph 10.111 above. It has been noted that the second of the 101 entries referred to a Private CM and this will be discussed in more detail later. The 14th entry, also inserted on 17th September, the day Geoff died, notes that the RMP were notified by Squadron Sergeant-Major(f) BZ that a Private CN:

"stated he was present when Pte Gray had spoken to a 'girlfriend' on the telephone and was 'quiet' following the call."

It will be recalled that it is now known that Private CN was the individual who Private BY stated answered Geoff's phone when Private BY, a friend of Geoff's, tried to call him at 21.23hrs on 16th September 2001. The RMP case file diary records that on 19th September Private CN was discussed with Detective Constable CL of Surrey Police. Following a later call with the Coroner's officer, the diary notes:

"discussed requirement for Civpol [civilian police] to conduct further investigation & spk to witnesses – i.e. those on guard and [Private CN]."

10.123 As noted at paragraph 10.114 above, an entry on 20th September records that Detective Constable CL agreed that he would make arrangements to speak to Private CN, while RMP would interview the two trainees on guard with Geoff, Privates(f) CE and Private CF. At some point it is clear, from comments made in the margin to the RMP case diary for 17th September, that the name originally assigned to Private CN is incorrect. It is not clear when this mistake was realised but in the RMP's final report, 'Final Investigation Summary', dated

¹³³ The doctor who carried out the post-mortem gave evidence at the inquest and when asked by the Coroner whether there were any marks or other signs that Geoff may have been assaulted in any way replied: "No, no there were not, there were some bruises, there was old or fading yellowish bruise on front of the right shoulder, there was an old scar on the back of the left wrist and there was a healing graze a centimetre in diameter on the upper left shin, there was a minor old pale scar on the left forearm. Really these were minor marks and did not indicate to me that he had suffered any form of assault ... it would be normal to expect to find some bruising particularly to the arms if there had been some form of struggle and restrained. This was a young and fit man and I would expect some form of struggle or restraint if that indeed has occurred." When asked by the Coroner whether there were any marks on Geoff's hands to suggest that he had for example been defending himself, the doctor's answer was "No." The Review is aware that Mr and Mrs Gray's evidence to the House of Commons Defence Select Committee included reference to the fact that, when viewed after the post-mortem, Geoff's body was covered in bruises and he had a black eye. The Review has not seen any evidence to support that recollection.

4th February 2002, it is stated that further enquiries were being made by Surrey Police CID at Woking at that time to interview Private CN on his return from an Army exercise in March 2002, after which the inquest could proceed.

- 10.124 From the transcript of the inquest into Geoff's death, there is no reference to Private CN's evidence, written or oral. However, Surrey Police did interview Private CN during their re-investigation and his evidence, and that of others, not discussed before the Coroner at the time of the inquest, established that Geoff was speaking to a former girlfriend in the evening of 16th September 2001.
- 10.125 Miss CO was a former girlfriend of Geoff's and someone for whom it is apparent he still had strong affections. She was one of the girls on whom it was later discovered Geoff had kept a file and she attended his funeral. Geoff's mother was to note that Miss CO "*was the girl he had the softest spot for and liked the most. She was also his first girlfriend.*"¹³⁴ Miss CO gave evidence about the night of Geoff's death for the first time in 2002, to Surrey Police. She recalled that at about 19.00hrs she received a call from Geoff but because she was at work she could not answer. A few minutes later, she received a text from Geoff which said: "*IF YOU DON'T WANT TO TALK TO ME JUST TELL ME TO FUCK OFF, LOVE GEOFF*". She noted that it was unusual for Geoff to swear in a text message and to appear to be annoyed that she hadn't answered but she replied: "*DON'T BE SILLY CALL ME BACK LATER*".¹³⁵
- 10.126 At about 19.30hrs, Geoff did call back and they spoke for about ten minutes. Geoff mentioned a number of things during the call: that he had been in a fight that weekend;¹³⁶ that he was due to do his HGV driving course the following week; and the possibility of him visiting her in Dorset, now that he had his driving licence. At the end of the call, Geoff said: '*I love you*'. As far as Miss CO was concerned, it was usual for Geoff to say this and she would normally have reciprocated the same feelings, but because the call took place in the presence of her then boyfriend, she did not.
- 10.127 Surrey Police were able to locate and obtain evidence from a number of trainees who witnessed this call between Geoff and Miss CO. They corroborate the topics discussed in the conversation and recall that some of the other trainees gave Geoff some stick for talking to a girl and saying "*I love you*". As noted earlier, Private CN, who was recorded in the RMP diary after Geoff's death as being present when Geoff was on the phone to a girlfriend, does not appear to have been interviewed until much later, July 2002, once Surrey Police had decided to re-investigate Geoff's death.¹³⁷ His evidence was that he and Geoff had been out in the evening of Friday 14th and Saturday 15th September and that he had seen Geoff over the weekend, thereby, confirming that Geoff was not on guard from the evening of Friday 14th until the evening of Sunday 16th September. They met for lunch on Sunday 16th September and Geoff had been in a good mood, apart from expressing some frustration at being on guard duty again, having been on day duties the previous week. Private CN was also part of the guard force on the evening of Sunday 16th but was on duty on the front desk in the guardroom booking people in and out, rather than forming part of an armed guard at a gate. He recalls Geoff being on his mobile phone in the back of the guardroom and assumed he was on the phone to his girlfriend. When they next spoke, Private CN noticed a change in Geoff's mood. Private CN asked him if his

¹³⁴ Paragraph 5.2.19 of Surrey Police's report to the Coroner.

¹³⁵ Surrey Police were to commission a Behavioural Investigative Advisor's Report during their re-investigation. That report noted that Geoff's uncharacteristic swearing could suggest that his mood was poor prior to contacting Miss CO.

¹³⁶ Surrey Police were unable to find any evidence to support the suggestion that Geoff had been involved in a fight.

¹³⁷ It appears that Private CN may have gone AWOL for some time.

girlfriend had dumped him which Geoff denied, adding that he was fed up with guard duty, particularly as he did not consider those he was assigned to do guard with that much fun to talk to.

- 10.128 After his death, as noted earlier, Geoff's mobile phone was examined and, as well as the list of names and numbers in his address book, three text messages were retrieved with details of the calls made and received on the handset.¹³⁸ One of the texts was from a recent girlfriend wishing Geoff luck in the Army. The two other texts were from Miss CO. The first, dated 22nd May 2001, discussed meeting up in the following week and ends "love u". The second is dated 2nd June 2001. The contents are very personal and elicited an emotive response from Geoff consistent with strong feelings for her. He kept the text in his phone. He mentioned the content of the message to his mother. He also showed the contents of the text to other trainees.

(iii) Evidence of Geoff Gray's intention to self-harm

- 10.129 It will be recalled that the second entry dated 17th September 2001 in the RMP case file diary noted Private CM as having heard Geoff say that he "was intending to shoot himself." Private CM gave a statement to the RMP on 17th September 2001, the day Geoff died. He and Geoff, while not close friends, got on well and had done their Phase 1 training at Pirbright together and would socialise in the NAAFI. They lost contact after Phase 1 when Private CM was posted elsewhere, but he was to return to Deepcut in September and saw Geoff on 12th September 2001, as Geoff was coming off guard and Private CM was going on. They next saw each other on 17th September when they were both on guard on the same two-hour stag rest period rotation, though on different guard posts. Accordingly, they both had a two-hour rest period from 19.00hrs to 21.00hrs before their first stag.

- 10.130 Private CM recalls that, at about 20.15hrs, he and Geoff were both alone out the back of the guardroom having a cigarette. Geoff talked about how he had been out on the weekend with Private CN and, despite their various activities, Private CM and Geoff both noted that they had plenty of money left. Private CM then described what happened next:

"Geoff said, "Guard is really depressing." I said, "Yeah it is." He said, "I've done two twenty-four hour shifts in the weekend."¹³⁹ I feel like shooting myself." I just laughed. He said, "If I shoot myself first will you shoot yourself second?" I said, "Yeah," and laughed. I did not take him seriously. He was not laughing or smiling when he said this. I said, "Yeah, whatever," and then went back inside the guardroom because it was cold. Geoff stayed outside a while. I did not talk to Geoff again that night."

During their re-investigation, Surrey Police were to speak to two trainees who recalled Private CM telling them about the conversation with Geoff after his death, one noting that he was told of it by Private CM at around 04.00hrs.

- 10.131 Private CM gave evidence at the inquest into Geoff's death and was questioned by Geoff's parents. At the inquest, he added that Geoff had mentioned that he was looking forward to his forthcoming driver training at Leconfield the following Friday and that he 'hated'

¹³⁸ See paragraph 10.72 above. The Surrey Police report to the Coroner following their re-investigation notes at paragraph 7.17 that Geoff's mobile phone "has provided evidence that confirms the conversation he had with [Miss CO] and the call from [Private BY]."

¹³⁹ This does not appear to be accurate. See *supra*, footnote 98.

doing guard duty. He noticed Geoff's mood change while talking and there was a pause before Geoff then mentioned shooting himself. When questioned, Private CM reiterated that he did not think anything of it at the time:

"no, I didn't think anything of it. I just thought he might have had a row with his girlfriend or something might not have been quite right ... something you're just thinking about, know what I mean. I didn't think he was that serious whatever it was."

10.132 During their re-investigation, Surrey Police were to take a statement from another trainee, Private CP.¹⁴⁰ He was also on the same two-hour stag rest period rotation as Geoff and, whilst those on the first shift went to get their weapons, Private CP went to the back of the guardroom to what he described as the 'bunk room'. There were some Fijian trainees in the room and Private CP was aware that Geoff was there talking to some other trainees, whose names he cannot recall. Private CP was trying to get some sleep. He described what then happened:

"At some stage, I recall Geoff saying 'I wonder what it is like being shot in the head' – he mentioned this out of the blue. The others just laughed. He said it again, I didn't take any notice. I took it as a joke and never got up. I remember a male replying 'It would probably hurt' and someone else saying 'You wouldn't feel a thing you would be dead.' There was then laughter. A group of people then got up and left the bunk to go out back and have a fag. This included Geoff."¹⁴¹

It appears this comment was made before Geoff's conversation with Private CM.

(iv) Teasing during the first rest period

10.133 It appears that Geoff may also have been the subject of some teasing in the early hours of the evening before his first stag started at 21.00hrs, as a result of an incident that occurred the previous month. A number of trainees recall Geoff telling them about a sexual encounter he had with a young woman he met, when with some fellow trainees, who was deaf.¹⁴² At the time, some of the other trainees teased Geoff but *"Geoff took the ribbing about the girl well and it became a bit of a joke."*¹⁴³ In their report to the Coroner after their re-investigation, Surrey Police were to note that, after some initial bravado about this incident, Geoff may have become ashamed of his actions once he became the subject of further teasing.¹⁴⁴ This incident was to become the subject of some further teasing on the night of 16th September.

10.134 Private(f) CQ was on guard the night Geoff died and recalls that during the first rest period a male Private mentioned the incident with the young deaf woman. Private(f) CQ could see that it was upsetting Geoff. She asked him if he was alright and he said he would be in a little while. Despite Geoff's request that she did not, Private(f) CQ spoke to the male Private who had mentioned the incident and berated him for not realising it might have upset Geoff. The male Private did not reply but went into the room where Geoff was and

¹⁴⁰ Appendix 6; entry 5.

¹⁴¹ 24th July 2002.

¹⁴² Appendix 6; entries 10 and 28 (who was present when they met).

¹⁴³ *Ibid*, entry 28; 15th May 2003.

¹⁴⁴ Paragraph 5.3.14 of Surrey Police's report to the Coroner.

stayed there for around five minutes before returning. Geoff then came to where Private(f) CQ was, wanted to give her a hug and said he was tired and wanted to go to sleep, but did not appear depressed or down.

(v) The entry in Geoff Gray's mobile

10.135 It has been noted at paragraph 10.117 above that Geoff's mobile was recovered at the post-mortem by the SIB personnel in attendance. Surrey Police were notified and they requested SIB assistance in analysing the mobile's SIM card. A list of the entries in the mobile was downloaded on 2nd October, and the RMP notes record that Geoff's parents requested, and were provided with, a copy in order to make funeral arrangements. The Coroner's officer and the family, therefore, had the list of Geoff's contacts well before the inquest in March 2002. One entry in the phone is of particular interest and does not appear to have been the subject of any further comment or discussion. Entry number 16 in the mobile phone's memory is recorded as "Date Died" with the number recorded as "1744".

10.136 During their re-investigation, Surrey Police sent Geoff's mobile to computer forensic specialists. They concluded that it is not possible to determine the time or date that the entry was made or whether whoever made the entry deliberately intended to insert it at entry 16. It is possible to record an entry in a specific memory number, such as 16, which would suggest that, if the entry was made on the day of Geoff's death, it could have been placed at number 16 deliberately.

10.137 It will be recalled that Geoff's phone was out of his possession for a period of time on 16th September, though it was in his possession when he died. Surrey Police have emphasised the risk of placing any importance on the entry at memory number 16. The Review agrees but notes that, if it was inserted by Geoff, it provides further support for a morbid state of mind on the night of the 16th September 2001.

(vi) The sketch and other evidence

10.138 Surrey Police's re-investigation was to uncover further evidence worthy of note. It appears that in December 2001, Mrs Gray gave Miss CO the file that Geoff had kept on her containing cards, letters and other mementos of their relationship. Within the folder was a print out of an e-mail to Miss CO from her then boyfriend dated April 1999. On that e-mail, in what Miss CO recognised was Geoff's handwriting, was a rough sketch of a gun being fired at a head and details of weapons and prices. Miss CO was unable to explain how Geoff had come to obtain a copy of the e-mail.

10.139 It is clear that Geoff was a popular young man and widely viewed as easy going. However, there does appear to have been a more sensitive side to Geoff that perhaps was not apparent to all those who came into contact with him. Surrey Police were to speak to a female trainee who was a friend of Geoff's. She made the following statement:

"I found that I could confide in Geoff and he likewise with me. I found that there were two sides to Geoff's character, one that was the way he was with his mates, and another that was the way he was with me. By this I mean that when he was with his mates he acted as if he didn't have a care in the world as if was just 'one of the lads'. When he was with me he was just the opposite, I believe I saw the true side of him, in that was sensitive and far less outgoing. He confided to me that he really missed his girlfriend and family

*and was homesick. He told me that his girlfriend was from his home town, I don't know if this was from up North or in London. I've no idea what her name was but I know that he'd been going out with her for 7-8 months. As far as I'm aware this was his only girlfriend and he appeared to be very loyal to her. Regarding Geoff's family I got the impression that he was very close to his mother and missed his home comforts. I got the impression that he would have like to have been able to go home every 3-4 weeks for that reason. At some stage in August both Geoff and I decided that we were going to leave the Army. Mine was for personal reasons but Geoff's was for the reason I've stated and the fact that he didn't like Deepcut. However I wouldn't have said Geoff was depressed. We spoke about this together and decided that we would support each other and remain in the Army and review the situation again in 3-4 weeks time."*¹⁴⁵

Conclusions on the death of Geoff Gray

- 10.140 The death of Geoff Gray is perplexing. It is very difficult to understand why a healthy, enthusiastic and popular young man of 17 years, seven months who had enjoyed his military career to date, and was looking forward to his driver training, should want to turn his weapon on himself and fire it.
- 10.141 On the other hand, it is even more perplexing why a third party would have the animus, or the opportunity, to ambush Geoff whilst he was alone, take possession of his weapon without an apparent struggle, shoot him from close range, and therefore within the perimeter of the Officers' Mess, and disappear without leaving any evidential trace at all.
- 10.142 Of the two alternative hypotheses, this Review considers the first much more probable in explaining how Geoff died, although the available evidence to explain why he did so is fragile. It is understandable why the Surrey Coroner returned an open verdict in 2002. In the absence of any evidence of a third party involved in Geoff's death, and on the balance of probabilities noted above, this Review seeks to draw what conclusions it can from these events.
- 10.143 First, no one had any inkling that Geoff might self-harm. He had not done so in the past and did not fit any of the criteria previously noted by the Army, save for his age. As an individual, therefore, there was no apparent need to apply special protective measures to him and no reason to remove him from the roster of available armed guards at a time of heightened alert. It is likely that the occasion of his having to perform guard duty was dictated by the heightened alert state and not discriminatory selection. It was an unwelcome chore but there is no reason to believe it had particular risks for Geoff.
- 10.144 Secondly, there is no evidence at all to suggest that Geoff had been the victim of abuse by NCOs or others at Deepcut. He had many friends, both male and female, and NCOs were aware that he was a keen soldier.
- 10.145 Thirdly, even if Lieutenant Colonel Laden was seeking to tighten discipline and improve morale in the Training Regiment, this is no evidence that this had any adverse impact on Geoff. He had never been in trouble for breach of the rules and there was no reason to believe he had anything to fear from such a clampdown.

¹⁴⁵ Paragraph 5.3.19 of Surrey Police's report to the Coroner.

- 10.146 Fourthly, the Review has already noted that Geoff's comrades on guard with him at the Officers' Mess cannot be held accountable for his going on lone prowler patrol. It should not have happened but they were both willing to accompany him and he refused their company. In any event, the logic of the policy at the time, prowler patrols should be performed by one armed and one unarmed guard, always left one individual alone with a weapon and there is no reason to believe that anyone from the Commanding Officer to Guard Commander or trainee thought that self-harm might be a consequence of a lone prowler patrol.
- 10.147 Fifthly, although there are weaknesses in the original RMP investigation, these are fewer than those of the earlier deaths. Again, it is clear that, within a few hours of being called out, the RMP were investigating a non-suspicious death according to the assessment of Surrey Police and the Coroner's officer. There is no evidence of a cover up or collusion in the evidence. The RMP were to uncover relevant evidence at the post-mortem, the pictures from the scene where Geoff's body was discovered were actually taken by the Surrey Police SOCO and all the RMP documents relevant to Geoff's death were available to Surrey Police when they decided to re-investigate in July 2002.
- 10.148 For this Review, the principal lesson to be learned from the death of Geoff Gray is precisely that such a death by such a means is not foreseeable and cannot be anticipated by the spotting and reporting of danger signs. A too precise profile of who is at risk may, therefore, be counter-productive.¹⁴⁶
- 10.149 Instead, this death, as with the deaths of Sean Benton and Cheryl James before it, suggests that the assigning of armed guard duty to young trainees, not under the immediate supervision of more experienced NCOs, affords an opportunity for potential self-harm that is, itself, a source of risk to the welfare of the young soldier. Statistically, this risk may not be significant, but a regime for young people to be trained to become effective soldiers cannot depend on mere statistical probability of loss. For Geoff, it would appear that he was also excited by the prospect of Leconfield, where fewer guard duties and more free time awaited but, at the same time, somewhat dismayed by the prospect of some nights of guard duty that stood in his way. Geoff had already performed five day duties, had been frustrated that he felt he had not had enough time to prepare for going away and was now facing five nights of guard duty where there was plenty of time to be left alone with his thoughts.
- 10.150 A plausible explanation of Geoff's death is that, despite outward appearances to some, he was a serious minded young man with some personal issues to face in his private life. The Review notes that Cheryl James may have found herself in a similar situation in relation to turmoil in her private life. Unsurprisingly, hopes and fears about sexual partners feature high in the issues of concern to young people.
- 10.151 Whether it was the curiosity to know what it is like to shoot oneself¹⁴⁷ with the powerful and lethal weapon in his possession, this Review cannot speculate. If someone decided on the spur of the moment, or in a passing mood of anxiety and low spirits, that painless exit from the problems and challenges of life seemed a preferable course, then guard duty at night with a loaded weapon gave a clear opportunity to put any such thought into effect. For this Review, it is precisely because Geoff's death was not foreseeable or predictable that it poses the fundamental question as to why young people were performing guard duty in the way that they were: isolated and unsupervised.

¹⁴⁶ See House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev 74 for the evidence of Professor Hawton of the Centre for Suicide Research and Professor of Psychiatry, Oxford University.

¹⁴⁷ See paragraph 10.132 above.

Part 3

11 Guard Duty Policy and the Death of James Collinson

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The death of James Collinson

- 11.1 James Collinson was found dead on the evening of 23rd March 2002 within the perimeter fence of the HQ Royal Logistic Corps (RLC) Officers' Mess. This was four days after the inquest into the death of Geoff Gray, whose body had been found in the grounds of the same Officers' Mess, had returned an open verdict. James was 17 years and three months at the time of his death. As noted in Chapter 1, the circumstances of his death, including how he came to be on guard duty that night, are matters for investigation by the Coroner and, therefore, will not be addressed in detail in this Report. However, the Review has had the benefit of seeing the Surrey Police report to the HM Coroner, for Surrey, following their investigation of James's death. Further, the Review has met with Mr and Mrs Collinson,¹ and received a written submission from them,² and also met with the Coroner, and, therefore, has had some idea of the issues to be considered at that inquest.
- 11.2 For present purposes, it is sufficient to note that James represented yet another death by gunshot wound of a young Phase 2 trainee at Deepcut whilst performing guard duty. According to local policy at Deepcut, he should not have been assigned a weapon on account of his age. It appears that he may have acquired possession of a weapon and ammunition from another trainee on guard. If so, how and why this happened will have been explored at the inquest.
- 11.3 James Collinson has the sad distinction of being the youngest of the four trainees who died at Deepcut. Coming so soon after the death of another, Geoff Gray, who was also under 18, it poses the question, yet again, of why trainees were left in unsupervised possession of lethal weapons? The local policies adopted at Deepcut have already been noted in connection with the death of Geoff Gray.³
- 11.4 This Chapter will first examine Army-wide policy with respect to guard duty and trainees, and will consider, in particular, whether there was a minimum age for armed guard duty and, if so, what it was and the rationale behind it. It will then examine practical problems encountered in applying Army-wide and local policy at Deepcut. It will then consider how the experience of James Collinson's death led to a revision and change of policies and how those policies have been implemented at Deepcut today.

Army policy on armed guard duty

- 11.5 The question of the circumstances as to employment of armed guards at defence establishments, their rules of engagement and such like are matters of understandable security sensitivity. The Review has had access to a wide range of sensitive documents that deal with this topic, and has also had the opportunity to read reports and discuss armed guarding policy and practices at Deepcut with a number of officers and soldiers employed there throughout the seven years covered by this Review.
- 11.6 In the section of this Chapter that follows, the Review will briefly examine the most significant policy documents at national level to see how armed guard policy interrelated with changes brought about by Single Entry.

¹ See Annex B for the list of meetings and key visits conducted by the Review.

² See Appendix 2.

³ See paragraph 10.48 ff above.

(i) The policy in 1990

- 11.7 The earliest armed guarding policy document seen by the Review, provided by the Ministry of Defence (MOD), is titled 'The Carriage of Arms by Service Personnel and Ministry of Defence Police on General Security or Policing Duties outside Northern Ireland and the Falkland Islands in Peacetime' issued on 10th September 1990.⁴ The aim of this paper was:

*"... to review the policy for issuing firearms and live ammunition to Service personnel engaged on general security duties (both in and around Defence installations and in HM Ships alongside and at anchor) outside Northern Ireland and the Falkland Islands in peacetime, and to recommend how this policy should be redefined in light of recent developments."*⁵

- 11.8 The paper outlined the arming posture in place at the time for all three Services, as well as for the Ministry of Defence Police (MDP), and recommended a revision to the guarding policy to reflect the then increased threat posed by the Provisional IRA on the mainland (the "recent developments"). This stipulated that Service personnel on armed guard would always be issued with ammunition, with the individual Service Commanders-in-Chief having discretion to order how ammunition was to be carried: in a charged magazine on a made-safe weapon, or carried in a pouch (as was the case in 1995 at the time of the deaths of Sean Benton and Cheryl James).

- 11.9 With respect to the selection of guards to be armed, the paper noted that decisions on which guards were to be armed must be left to local discretion, taking account of, amongst other things:

*"... the standards of training and maturity of the guards to be armed."*⁶

- 11.10 The paper went on to say:

*"As to age limits, the RAF [Royal Air Force] does not propose to allow personnel under the age of 18 to serve as armed guards. The RN [Royal Navy], RM [Royal Marines] and Army requirement is to arm personnel who have reached the age of the adult entry, which is 17 years. This is the practice already followed by the Army and RM for the arming of service personnel on general security duties outside NI."*⁷

The minimum age for armed guarding was, therefore, set as 17 years, although the RAF had unilaterally adopted a minimum age of 18 at this time.

- 11.11 It is clear from this paper that each of the Services had, as they do today, a different approach to armed guarding. The paper stated:

*"There is no need for complete uniformity, nor is it practicable."*⁸

In the same paragraph, however, it acknowledged that:

"... significant differences should be kept to a minimum and should be explicable."

⁴ CDS 21/90.

⁵ *Ibid*, paragraph 7.

⁶ *Ibid*, paragraph 37(c).

⁷ *Ibid*, paragraph 48.

⁸ *Ibid*, paragraph 49.

The issue of different policies for armed guarding is one of concern to this Review, particularly given the trend today towards greater joint working between the three Services and the risks that this may pose in light of different understandings of basic issues such as age, suitability and circumstance.

11.12 The paper included counter-arguments to arming, including:

*"... the risk of undermining the concept of the unarmed society, the risk of killing or injuring innocent people, the need for expensive and time-consuming training programmes, and the risk that armed guards at some installations could increase the threat where guards cannot at present be armed."*⁹

The paper expanded on these points in some detail, noting:

*"There could be a risk of innocent people being killed or injured through negligent discharge,¹⁰ through poor aiming or wrong decisions made in split seconds. However good the training, this risk cannot be totally eliminated."*¹¹

Indeed, the paper noted that there were 28 negligent discharges affecting Service personnel and six affecting the MDP in the period 1st April 1988 to 1st April 1990 with two fatalities resulting.

11.13 However, although due consideration was given to the risk in terms of negligent discharge, both to Service personnel and civilians, there was no similar consideration of the risk of intentional self-harm occasioned by unsupervised access to firearms. Similarly, although there was recognition of the need for adequate training (including in weapons handling, marksmanship, weapon safety and rules of engagement) there was no acknowledgement of the increased risk resulting from arming the young, including recruits and trainees, and the question of maturity of judgement in the light of age. The paper stated:

*"Servicewomen are not excluded from armed security duties. Nor is there any reason why recruits and, subject to the general legal and constitutional limitation on their employment, Territorial Army (TA) personnel and other reservists should not serve as armed guards, provided that they have received the necessary basic and refresher training and reached the specific standard."*¹²

11.14 Although the resource implications of armed guarding were considered in the paper, the impact on training establishments and their ability to find sufficient numbers to satisfy the number of guards required was not.

11.15 The paper acknowledged that armed civilian guards are employed in many European countries but not in mainland United Kingdom. It notes that *"it should be possible for selected elements of any new [civilian] MOD Guard Service to be armed"*¹³ but this approach was not pursued, and an alternative to arming service personnel was not to emerge until the creation of the Military Provost Guard Service (MPGS) some years later.¹⁴

⁹ *Ibid*, paragraph 72(e).

¹⁰ The accidental discharge of a firearm.

¹¹ *Supra*, footnote 4, paragraph 29(c).

¹² *Ibid*, paragraph 48.

¹³ *Ibid*, paragraph 69(b).

¹⁴ See paragraph 11.113 below.

(ii) The Single Entry Implementation Plan, June 1993

11.16 The Single Entry Implementation Plan has been noted earlier in Chapter 4.¹⁵ It dates from June 1993 and includes reference to the arming of ‘sentries’:

“Rules for the arming of sentries are contained in UKLF [United Kingdom Land Forces] Anti-Terrorist Security Instructions. Soldiers will not be armed for sentry duty under age 17. Recruits will not mount guard at ATRs [Army Training Regiments].”¹⁶

This document, therefore, set out intentions in two important areas. First, soldiers at Army Training Regiments (ATRs), and therefore in Phase 1 training as ‘recruits’, were not to be used as armed guards, irrespective of age. This precluded any contact with weapons for this purpose. Secondly, those under 17 years would not be armed for sentry duty, irrespective of whether they were undergoing training at an ATR or whether they were in a Phase 2 training establishment (and therefore a ‘trainee’), or even in the field army. A minimum age was established therefore. As will already be apparent, this Review has concerns as to whether the right age was identified for this purpose and whether an appropriate risk assessment had been made. Further, there were no restrictions on using those under the age of 17 as unarmed guards within a mixed armed/unarmed guard force at a Phase 2 establishment. The document does not consider how under-17s could be prevented from obtaining access to weapons in such circumstances. It noted, however, that the rules for armed guard duty were laid down in United Kingdom Land Forces (UKLF) instructions.

(iii) United Kingdom Land Forces Anti-Terrorist Security Measures, 1994

11.17 Each of the three Service Commanders-in-Chief issue their own Arming Directive, which sets out the policy and regulations as they relate, among other things, to armed guarding for their Service. These Arming Directives are required to meet minimum standards agreed by Ministers. For the Army, the Arming Directive was the United Kingdom Land Forces Anti-Terrorist Security Measures (UKLF ATSM).

11.18 The earliest edition of this document obtained by this Review dates from July 1994. This document was issued by HQ UKLF to ‘All Units and Establishments in UKLF’, which would have included both the RLC Training Group at Deepcut, and the Training Regiment & Depot within it. Section 1 stated:

“These instructions are primarily designed to provide Unit COs [Commanding Officers]/Heads of Establishments with an anti-terrorist handbook to assist them in the production of local plans and operating procedures.”¹⁷

11.19 Section 5 of the UKLF ATSM dealt with ‘Guarding Requirements and Guard Forces’, with Annex D of Section 5 detailing the ‘Rules for the Carriage of Arms by Service Personnel’. It is this Section which subordinate units should have drawn upon when drafting their own more detailed set of instructions, or local standing orders, for guarding and it sets the minimum standards to apply. Although some elements of this document provide

¹⁵ See Chapter 4, paragraph 4.30 ff.

¹⁶ Single Entry Implementation Plan dated 15th June 1993, paragraph 32.

¹⁷ UKLF ATSM OPS2(UK) 4303 dated July 1994, section 1, paragraph 1.1.

guidelines, rather than definitive instructions, this is not the case with Section 5. The covering letter that accompanied the issue of the document stated clearly that “Red pages contain mandatory measures” and Section 5 is issued on red paper.

11.20 The opening paragraph of Annex D to Section 5 stated:

“COs/Heads of Establishment are directly responsible for security inside perimeters and therefore should personally participate in all security planning.”¹⁸

The issue of Commanding Officers being personally responsible for security is reinforced throughout the document. In practice, the administration of security is often delegated to the Second-in-Command, who works with the Regimental Sergeant-Major to implement and maintain security standards.

11.21 With respect to eligibility for armed guarding, Annex D stated:

“(1) Regular Adult Soldiers. Regular adult soldiers must have completed Phase 1 training of CMS(R) [Common Military Syllabus (Recruit)]. Exceptionally, recruits may be armed and employed once they have met the minimum weapon training standards set out in Appendix 1, but then only when dispensation has been granted by the Division/District GOC [General Officer Commanding].

“(2) Apprentices. Apprentices may be armed and employed on the same basis as adult soldiers once they have reached the age of 17 years and are judged by their CO [Commanding Officer] to be sufficiently mature.

“(3) Servicewomen. Servicewomen may be armed and employed on the same basis as adult male soldiers. The only proviso is that, where possible, armed Servicewomen should be accompanied by male personnel. If this is not possible, Servicewomen are to be employed in ‘pairs’.”¹⁹

11.22 It will be seen that this instruction fails to implement the general policy, previously set out in the Single Entry Implementation Plan in 1993, that under-17s would not be subject to armed guard duties and neither would recruits at ATRs.²⁰ It could, perhaps, be inferred that under-17 year olds were to be equated with Apprentices rather than adult entry soldiers, but this is not clear from the text, and it is more likely that non-Apprentice recruits would be grouped with regular adult soldiers.

11.23 In the opinion of this Review, this important instruction at a senior level was imprecise in its language, inconsistent with the policy adopted for Single Entry and caused confusion at local level where standing orders sought to give effect to it. If Annex D was to be consistent with policy adopted on Single Entry one year previously, it should have read as follows:

- (i) Recruits are not to perform guard duty. In wholly exceptional circumstances, recruits over 17 who have received the appropriate training and are considered sufficiently mature may be called on to perform this function.
- (ii) Trainees and Apprentices over 17 but under 18 may be called on to perform armed guard duty if they are trained for it, and are considered sufficiently mature to perform it.

¹⁸ *Ibid*, Annex D to Section 5, paragraph 1.

¹⁹ *Ibid*, paragraph 8(a).

²⁰ See paragraph 11.16 above.

- (iii) Women soldiers over 17 may perform armed guard duty but only in pairs, if possible when accompanied by a male soldier over 18.

(iv) Land Command Standing Order 1108, October 1996

- 11.24 The UKLF ATSM was replaced, in October 1996, by a revised document, issued by Land Command (formerly UKLF), Land Standing Order 1108 (LANDSO 1108) and titled 'Land Anti-Terrorist Security Measures.' The revised LANDSO 1108 follows the format of the earlier UKLF ATSM, and Section 5 remained the primary source for information on armed guarding policy for the Army. Once again it is a mandatory instruction.
- 11.25 Although some measures were revised, the issues of primary interest to the Review were not, and the text quoted at paragraph 11.21 above from the 1994 UKLF ATSM remained extant. It is, therefore, clear that no wider lessons relating to guard duty were learnt as a result of the deaths of Sean Benton or Cheryl James in 1995 at Deepcut or, indeed, from deaths elsewhere.
- 11.26 In the opinion of this Review, a paragraph excluding those whose previous personal histories had placed them on a risk register might have been considered appropriate as well as emphasising that women should not be on armed guard duty unaccompanied, as was the case with Cheryl James.
- 11.27 The October 1996 LANDSO 1108 was amended on 19th May 1997 but, again, none of the changes impacted on the issues of interest to the Review. It is, perhaps, noteworthy that amendments to this key document were to be made in manuscript, which are difficult to decipher and can contribute to confusion, and misreading. A similar problem bedevilled the local standing orders at Deepcut in 2001 and 2002.²¹
- 11.28 In the opinion of this Review, Army policies on issues such as the requirements for guard duty should be unambiguous, consistent and communicated in writing. The date of adoption of the policy should be noted. Amendments to the text and the date of the amendment should be noted in new versions produced. There should be a separate record kept of the reasons for the amendment. Policies should be reviewed at least annually in light of any experience indicating that improvements could be made. If no change is considered necessary, this should, itself, be noted. When policies are replaced from time to time, a copy of the old policy should be kept centrally in Army records for future reference. This is further considered in paragraph 12.78 below.

(v) A Minimum Age?

- 11.29 In the opinion of this Review, therefore, there has been a lack of clarity in the formation, expression and understanding of the minimum age of those being put on armed guard. Such confusion is clearly demonstrated by an entry in the guardroom daily occurrence log at Deepcut on 22nd January 1999. Serial 792 stated that:

"It was brought to our attention that there was a 16 year old carrying a weapon on guard. We informed the Adjt [Adjutant]. He stated that if he's carried out Phase I training he is qualified to carry a weapon."

²¹ See paragraphs 11.71-72 below.

- 11.30 It is noteworthy that the Guard Commander queried this point on becoming aware that a soldier under 17 was armed on guard. It is significant that he was unsure and queried it with the Adjutant (who is, among other things responsible for issuing standing orders, including those covering guarding). Further, the Adjutant was wrong in his assertion that the 16 year old soldier was permitted to be armed on guard, according to the policies adopted in June 1993 in the Single Entry Implementation Plan. As to the text of LANDSO 1108, in the opinion of the Review, the soldier in question above was neither a regular adult soldier, nor an Apprentice. Further, if an Apprentice has to reach the minimum age of 17, has to be trained in weapons handling and has to be judged by his Commanding Officer to be sufficiently mature, then it is nonsensical if a 16 year old undergoing trade training who is *not* an Apprentice is treated differently. Indeed, it has been stressed that Apprentices are likely to have higher intellectual qualifications and skills and may, therefore, have greater maturity.²² They are also more likely to be better known to their supervisory staff.
- 11.31 The failure to clearly state the minimum age for armed guard in LANDSO 1108, other than for Apprentices, clearly contributed to the confusion. It is unlikely that the minimum age would have been any more clearly expressed within the Training Regiment's own standing orders, although the Review has not seen these as they have not been retained.²³ The failure to specifically cater within the rules for those under 17 who were not Apprentices was a significant oversight, and probably borne of the limited number of under-17s who were not Apprentices.
- 11.32 Although none of four soldiers who died at Deepcut were under 17, it is the opinion of the Review that appropriate consideration had not been given to the implications of Single Entry for young people entering Phase 2 training with respect to unsupervised access to weapons when on guard. It is a concern that this continued to be overlooked even when the risks to young trainee soldiers should have been apparent from the deaths of Sean Benton and Cheryl James, in 1995, alone.
- 11.33 In June 2000, the LANDSO 1108 was revised and released to units. Annex D to Section 5 continued to contain the mandatory rules for the 'Carriage of Arms by Service Personnel', and the detail concerning minimum age remained unchanged, being only specifically expressed in relation to Apprentices, as quoted earlier.²⁴

(vi) Communications from ATRA

- 11.34 Further evidence of the consequence of lack of connection between Single Entry and the policy for armed guarding is to be found in another document. On 11th December 2001, nearly three months after the death of Geoff Gray at Deepcut, the Army Training & Recruiting Agency (ATRA) issued a letter to its Phase 2 operating divisions (including the RLC Training Group at Deepcut) concerning the supervision of soldiers under the age of 17 years.²⁵ The letter covered a number of issues, including armed guarding:

²² See paragraph 4.15 above.

²³ It is understood by the Review that such orders are frequently amended and do not warrant permanent or long-term retention. It is only through the retention of unit standing orders by the RMP during their investigations that certain contemporaneous standing orders of relevance have been kept (see footnote 66, paragraph 10.48 above).

²⁴ See paragraph 11.21 above.

²⁵ D/ATRA/20/551/1 dated 11th December 2001.

"5. Guard Duties and Weapons Handling. All soldiers, regardless of age, have been trained to handle weapons to a basic but competent standard by completion of Phase I training. They may ... be deployed on guard duties with live ammunition. Clearly, common sense must be exercised when selecting a guard force to ensure a spread of ages but there is no legal obstruction to employing soldiers under 18 years, or indeed 17 years, on guard duties ..."

11.35 This statement shows a clear lack of grasp of the previous policies outlined above. Alarming, it shows a lack of understanding by ATRA, the organisation primarily concerned with, and directly responsible for, the recruitment and training of young soldiers. The minimum age requirement set as early as 1990, and re-affirmed in 1993, was never rescinded. However, the policy was misapplied due to the failure to cater for non-Apprentices under 17 within the main source document for Army policy on armed guarding requirements (the UKLF ATSM, then superseded by LANDSO 1108). The ATRA letter also covered Apprentices, but importantly missed the vital reference to a minimum age and the need for an individual assessment of maturity, thereby confusing an already grey area still further.

11.36 ATRA subsequently issued a correction on 22nd March 2002 to the text concerning Apprentices in their 11th December letter, which added:

*"... once they have reached 17 years and are judged by their COs to be sufficiently mature."*²⁶

This brought the text back into line with the wording of LANDSO 1108, albeit still not addressing the issue of armed guarding for an under 17 year who was not an Apprentice.

11.37 In the opinion of this Review, it is of concern that ATRA took over three months to acknowledge this significant error and that, even then, ATRA still did not question the wisdom of the erroneous distinction between under 17 year old Apprentices and under 17 year old non-Apprentices. This concern is compounded by the events considered in Chapter 9 that would have been known to ATRA, namely: statistical evidence of higher than expected rate of self-harm, by misuse of weapons, for young people in the Army; and the inability to address the poor supervisory ratios noted by the Haes Report.²⁷

(vii) Amendments after the death of James Collinson

11.38 On 15th August 2002, four months after James Collinson's death, Headquarters Land Command issued an amendment to LANDSO 1108. The opening text of this amendment reads:

*"In response to recent high-profile incidents involving young soldiers on armed guarding duties the following changes to LANDSO 1108 Sect 5 are effective forthwith."*²⁸

There is no doubt that the high-profile incidents were the deaths of Geoff Gray and James Collinson, both aged 17, at Deepcut.²⁹

²⁶ D/ATRA/20/551/1 dated 22nd March 2002.

²⁷ See paragraph 9.74 ff above.

²⁸ Land/Cts/Int/Sy/CT/4027 dated 15th August 2002.

²⁹ Due to the investigations by Surrey Police, no Board of Inquiry (the usual process by which the Army seeks to learn lessons) has yet been convened into either death. For current practice, see Appendix A16.004, paragraph 7.15 ff.

(a) Accompanied armed prowler patrols

11.39 The amendment changed the requirement for singleton daytime prowler patrols to being unarmed only. It added a new sub-paragraph, which read:

“Soldiers aged under 18 years may carry out armed patrolling duties but they are to be accompanied at all times when carrying out such duties. It is acceptable for two soldiers aged under 18 to constitute an armed patrol.”³⁰

11.40 In the opinion of this Review, such a general instruction was long overdue, and ought to have been anticipated in the July 1994 UKLF ATSM. Even so, the difficulties of precisely enforcing this instruction if there was to be no supervision by an NCO remained, as the circumstances of the deaths of both Geoff Gray and James Collinson show. In the opinion of the Review, the wisdom of allowing two unsupervised trainees under 18 to police the rule, designed in part to protect under-18s from the follies of immature judgement and understanding, seems highly questionable.

(b) Supervision of isolated detachments

11.41 The amendment also introduced a new requirement of direct supervision of isolated guard posts:

“A detachment isolated from the main guard is to be commanded by a NCO. The detachment commander will be responsible for implementing the orders for that detachment. A sensible judgement taking account of local circumstances is to be made by the Commanding Officer as to what constitutes a ‘detachment’.”³¹

11.42 The RLC HQ Officers’ Mess, where both Geoff Gray and James Collinson died, was to be defined as a “*detachment isolated from the main guard*” thereafter and would, therefore, attract direct supervision by a NCO.

11.43 In the opinion of this Review, it is regrettable that this decision was not made much sooner and, again, that the vulnerability of young people under 18 years of age was not anticipated.

11.44 In practice, the requirement to provide supervision caused logistical difficulties in Deepcut from August to December 2002, doubtless because a number of the gates could be considered ‘detached’. As a consequence, Lieutenant Colonel Laden has explained that officers were used as a short-term expedient, before a temporary exception was granted for armed guard duty at certain times and places to be suspended.³²

(viii) Current general statements of policy

11.45 In July 2003, a revised policy paper was issued to the Commanders-in-Chief of the Royal Navy, the Army and the Royal Air Force. This paper, titled ‘The Carriage of Arms By Service Personnel and MOD Police on General Security Duties other than on Operations’ superseded the September 1990 policy paper.³³ This revised policy paper states that:

³⁰ Land/CTS/Int/Sy/CT/4027 dated 15th August 2002.

³¹ *Ibid.*

³² See Appendix A4/11.031 A – C.

³³ CDS 21/90. See paragraph 11.7 above.

*"Only suitably trained male or female Service guards aged 17 or over, in accordance with single Service regulations, are to be armed."*³⁴

Whilst a clear statement of minimum age is welcome, the policy merely reiterated the requirement first identified as long ago as 1990. In the light of all that had happened and had been learned since 1990, one might have thought that the joint service position on minimum age should have developed somewhat beyond this by 2003.

- 11.46 In February 2004, a second revised version of LANDSO 1108 was issued. Paragraph 5.11 of the revised Section 5 says:

"CinC [commander-in-Chief] authorizes the carriage of arms and ammunition by suitably trained and qualified Service personnel aged 17 years old or over for general security details."

Annex D, 'Guarding Level Guidelines' specify that by day:

*"Armed or unarmed Prowler sentries over 18 years old may operate singly."*³⁵

and that:

*"Soldiers aged under 18 years may carry out armed patrolling duties but they are to be accompanied at all times when carrying out such duties. It is acceptable for two soldiers aged under 18 to constitute an armed patrol."*³⁶

It also allows for unarmed soldiers under 18 to operate singly, including as prowler sentries.

- 11.47 This is the first time we see the minimum age of 17 years clearly specified in the Army's primary armed guarding policy document, even though this had been mandated for all three Armed Services since at least 1990. Considering the critical nature of this policy, it is surprising that subsequent entries within the Annex, which provide guarding guidelines, refer to those under 18, when what is meant is under 18 *but over 17*.
- 11.48 In light of the evidence reviewed above of the minimum age being misunderstood, it is regrettable that the language used is not more explicit and reinforcing. A quick check of the rules in response to a query from a Guard Commander³⁷ could potentially result in a misreading and consequent misapplication of the rules. Reading Annex D in isolation, one could wrongly conclude that soldiers under 18, with no minimum age, are authorised to be armed for general security duties, albeit accompanied.

(ix) The Review's conclusion on a minimum age for guard duty

- 11.49 It is apparent from all the conversations that the Review has had with the Commanding Officers that none were particularly concerned about the age of trainees assigned to guard duty.³⁸ The general message each gave was that if a trainee was sufficiently mature to have passed Phase 1 training and their weapons handling tests, they were of sufficient age and

³⁴ D/DDefSy/31/6 (128/03) dated 25th July 2003.

³⁵ Annex D to Section 5 LANDSO 1108, February 2004, paragraph 3(b).

³⁶ *Ibid*, paragraph 3(c).

³⁷ See paragraph 11.29 above.

³⁸ See for example Appendices A4/5.038 A – B and A4/11.017 C.

capacity to perform armed guard duty,³⁹ unless something was known about their mental state that made them unsuitable. As noted, there was nothing in LANDSO 1108 or ATRA instructions to suggest otherwise.

- 11.50 “*Common sense*” was referred to by ATRA in its letter of 11th December 2001⁴⁰ and Brigadier Elderton, Commander of the Defence Logistic Support Training Group at Deepcut from 2002, took this as a veiled reference to an individual assessment of maturity.⁴¹ In reality, how is a Commanding Officer to make this assessment, particularly in a training regiment such as that at Deepcut with a substantial transient trainee population and limited NCOs? In discharge of the duty of care and responsibility to their soldiers, the Commanding Officer would inevitably rely on the experience and judgement of their NCOs to make the call as to individual suitability. But if the NCO does not have an opportunity to get to know the trainees, through under-manning or the trainees’ absence on trade training, how is this to be achieved? Further, the more complex and nuanced the policies, the more likely there will be mistakes. Who is to know which individual trainees within a group have been assessed suitable? If someone is not assessed suitable for *armed* guard duty, by reason of age, maturity or for some other reason, but is deemed eligible for *unarmed* guard, alongside an armed guard of similar age, who is to prevent them swapping roles?
- 11.51 It has been pointed out to the Review that chronological age and maturity and sound judgement are not the same thing.⁴² Certainly there are sensible 17 year olds and unwise 18 year olds, as anyone who has dealt with young people will be aware.
- 11.52 It has further been pointed out that the distinguishing feature of the profession of soldier is the ability to carry a weapon.⁴³ That is the very badge of membership of the Army and unless a soldier is used to looking after, carrying and deploying his weapon safely and competently he will not be able to function as a soldier. It has been further stressed that guard duty will be a part of the soldier’s duties when deployed on operations abroad and that it is better that they get used to it in a more benign atmosphere, such as a Barracks in Surrey, than somewhere considerably more hostile.⁴⁴
- 11.53 There is also the utilitarian argument that if under-18s are excused armed guard duty, the burden on others will increase. A further observation that has been made is that it would be wrong to marginalise under 18 year olds from membership of a cohesive unit by preventing their participation in a regular chore of military units.⁴⁵ The object of training is, in part, to develop a collective discipline and cohesion.
- 11.54 These arguments, of varying weight, are acknowledged. Ultimately, they do not convince this Review that such an approach was, or is, sufficient. If the Army are to recruit minors, i.e. those under 18, the necessary predicate is that special attention and care must be given to such young people precisely because they are *minors* and deserving of special protection due to the fact they are under the age of adult responsibility. Chronological dividing lines, whether for sexual activity, driving a vehicle, purchase and consumption of

³⁹ See Appendix A4/11.018 B – G.

⁴⁰ See paragraph 11.34 above.

⁴¹ See Appendix A4/3.020 B – E.

⁴² See Appendix A4/15.024 E – F.

⁴³ See Appendix A4/11.018 C – D where Lieutenant Colonel Laden describes the responsible handling of arms and ammunition as “*the number one tool of their trade.*”

⁴⁴ *Ibid.*, A – B where Lieutenant Colonel Laden pointed out that it is “*better they learn to guard in Surrey than Afghanistan.*”

⁴⁵ See Appendix A4/11.075 B – F.

alcohol, gambling or using a dangerous piece of machinery may be somewhat arbitrary with respect to individual maturity, but they are not to be diminished in importance for that reason.

- 11.55 It may be that mere chronological age is not sufficient to determine suitability for armed guard duty. If so, what is necessary is a policy that addresses a minimum age requirement *and* ensures an informed assessment of individual maturity and capacity added in as an additional safeguard. The difficulties of making such an assessment cannot be underestimated, as each of the deaths of Sean Benton, Cheryl James and Geoff Gray show. Age is one clear unambiguous test that can, and should, be applied to reduce risk.
- 11.56 In the opinion of the Review, the appropriate minimum age for armed guard duty, outside the context of training that is directly supervised by an experienced adult soldier, should be 18 throughout the Armed Forces. This is generally recognised as a milestone in the passage from minority to adulthood and is most likely to be understood by all concerned.
- 11.57 The argument that any distinction is discriminatory and that under 18 year olds need to be knit into the same operational duties as older soldiers does not sit easily with the consistent recognition that special policies were needed on access to alcohol or knowledge of movements away from the base. Further, soldiers under 18 are no longer automatically eligible for participation in hostilities and so there is a necessary sensible distinction made on age grounds.
- 11.58 It seems to this Review that, in relation to armed guard duty for young people, the tension between assimilation of training and protection of minors is evidence of a continuing failure to address, with full understanding, the implications of a Single Entry, as opposed to an age divided, training regime.
- 11.59 It may be that earlier thinking was based on a practice when guarding did not necessarily mean the issuing of a weapon and ammunition. If so, it has been overtaken by a less secure world with heightened security alerts, and a permanent requirement that guards should be armed.
- 11.60 Whatever the reason may be, the convenience of the Army cannot predominate over the best interests of the minor. Single Entry and co-location of training may be the most effective use of current resources, and may give a training benefit. If so, then a special regime is needed for those under 18 with respect to any practice or activity that it might be more dangerous a minor to undertake.
- 11.61 It does not follow from this conclusion that young people under 18 should not be permitted to join the Armed Forces or to start their training in military skills. This issue will be addressed further in Chapter 12, the final chapter of this Report.
- 11.62 If young people are to be trained as soldiers, they will need training in guard duty that will form a significant part of their likely duties on operation. There would seem to be little need for them to be armed, and in possession of ammunition, while performing such duties in order to understand what a guard may have to do. However, if the training programme does require periods where young people are to become familiar with performing guard duty with a weapon, and ammunition, such activity should strictly be for training purposes and at all times closely supervised.

- 11.63 There is a difference between guarding assigned as part of a young soldier's training for the acquisition of military skills, and guarding as an indeterminate chore that may, indeed, interfere with the acquisition of trade skills or final posting.⁴⁶
- 11.64 It may be that a similar policy is already in place in some establishments. Lieutenant Colonel Strutt explained, in conversation with the Review, that at the Infantry Training Centre in Catterick, infantry trainees are only now required to do guard duty as part of their training.⁴⁷
- 11.65 The Review understands that such an approach means: supervision – guarding within eyesight of a more experienced soldier; planning – so guarding is part of the training timetable, rather than a potentially extraneous intrusion into it; and, further, developing a close relationship between instructor and trainee – so that there is an awareness of any particular vulnerabilities.
- 11.66 Under such circumstances, there is no reason why a trainee should not handle a weapon. It is the absence of supervision by experienced soldiers which generates risk.
- 11.67 The conclusions on age, as well as restrictions that ought to be in place for Phase 2 trainees generally, are informed by the practical considerations in enforcing any policy of more complexity. These practical difficulties are illustrated by further examination of the events at Deepcut in 2002.

Guard policy at Deepcut

- 11.68 Having seen how national policy for armed guarding evolved from 1990 through to 2004, and the Review's concerns in respect of it, it is necessary to return to Deepcut to see how this issue related specifically to guarding policy and practice there.
- 11.69 It has been established in the previous Chapter that there were a number of entrances and detached facilities to guard at Deepcut, and that trainees were under-stimulated by the nature of the regime and that their supervision was lacking. In itself, those are significant differences from the operational environment to which trainees will be exposed to when older.
- 11.70 It has already been noted in Chapter 10 that the evidence to the Review, accepted by the Commanding Officer Lieutenant Colonel Laden,⁴⁸ suggests that he approved an amendment in local policy at Deepcut increasing the age for armed guard duty to 17½, some time after July 2001. It remains unclear whether this change had been implemented by the time Geoff Gray died, but it certainly seems to have been in existence by the time of James Collinson's death.
- 11.71 In the course of their investigations, Surrey Police obtained a copy of the Training Regiment's standing orders in force at the time of James's death. These contained amendments by hand to include a reference to a minimum age of 17 years. Clearly, this reflected national policy, but undermines the local policy of 17½ years which the Review is satisfied had been adopted at Deepcut by this time.

⁴⁶ See Appendix A4/3.022 B – C, where Brigadier Elderton makes this point in conversation with this Review.

⁴⁷ See Appendix A4/14.032 C – E.

⁴⁸ See Appendix A4/10.001 D – F.

- 11.72 The manuscript amended order is the only copy of that contemporaneous standing order that the Review has seen. Brigadier Elderton was surprised that the age requirement should have been noted by a manuscript amendment.⁴⁹ Lieutenant Colonel Laden was not surprised, given the shortage of administrative support available at Deepcut.⁵⁰ There is also some evidence that a sign noting the age requirement existed in the guardroom at the time. Some of the trainees interviewed by Surrey Police were aware of reasons why someone as young as James Collinson should not be in possession of a weapon, but there were differences of recollection as to what the precise policy was.
- 11.73 Further, in an internal minute dated 28th March 2002, responding to the death of James Collinson, the Adjutant General's Secretariat, themselves, were misinformed or wrongly stated the policy:

"Following the earlier death of Pte Gray, Deepcut Standing Orders were amended to prevent under 18 year-old soldiers from carrying weapons on patrol."⁵¹

- 11.74 There has, thus, been continued confusion at local level as to what the policies were, why they were adopted, how they changed and how any changes were disseminated. The Review's observations on the need for clarity and a written record of what policies are, and when and why they are changed, have already been noted at paragraph 11.28 above. These comments are equally applicable to problems at the local level, whatever the pressure on resources may have been.

Adherence to the local policy and standing orders

- 11.75 Whatever the policy was, and whenever and however it was implemented, are likely to be matters of interest for the Collinson inquest, but there is a secondary question of how any policy was to be effectively applied.
- 11.76 Lieutenant Colonel Laden, the Commanding Officer of the Training Regiment at Deepcut, provided a quarterly management report in April 2002 to Brigadier Elderton, the new Commander of the Defence Logistic Support Training Group. Lieutenant Colonel Laden made the following notable conclusion:

"Adequate Supervision of Trainees. The recent death of Pte Collinson, the second death in similar circumstances just over 6 months, has drawn much attention from all levels in the chain of command. Inevitably we have faced many questions. I note that if the Permanent Staff enhancements suggested by an application of the ATRA Working Time Regulations had been available, then closer supervision of armed detachments would have been possible. This conclusion may be a stark and unpopular, but is a probable consequence of a resource shortfall."⁵²

- 11.77 The Review has already noted the connection between supervisory ratios and guard duty.⁵³ It has noted the comments of a succession of Commanding Officers regarding supervisory ratios. It would appear to be a fairly basic proposition that the Training Regiment at Deepcut needed sufficient staff to have a better understanding as to which trainees should not, for whatever reason, handle a weapon. With more staff, an NCO could be provided

⁴⁹ See Appendix A4/3.031 A – C.

⁵⁰ See Appendix A4/10.014 C – E.

⁵¹ Loose minute D/AG Sec/113/5 dated 28th March 2002.

⁵² Paragraph 2 dated 5th April 2002.

⁵³ See paragraph 9.19, 9.31-9.33 and 9.44 above.

to supervise guarding at detached locations to ensure orders were being enforced, although this was not, to the knowledge of the Review, ever put forward as justification for supplementing the supervisory staff at Deepcut. If there is no supervision, trainees can wander off alone or acquire weapons from their comrades who are armed. The events at Deepcut show that such policies cannot be regarded as being implemented merely because young people have been told about them.

- 11.78 Indeed, in discussion with the Review, Brigadier Elderton added his own pertinent comment on the link between effective supervisory ratios and the enforcement of standing orders:

“Because the indications were in both the cases, Collinson and Gray, and then of course when you look back, in the case of Sean Benton, that there were positive indications that orders had been disobeyed. So therefore, it didn’t matter how fool-proof your orders were. If they were going to be disobeyed, you’ve got a problem. You can’t just say “OK, the orders were disobeyed.” Why were they disobeyed? How were they able to be disobeyed? And then you get into the supervision and so on.”⁵⁴

- 11.79 The Review notes that a number of changes were made to the standing orders at Deepcut following each of the deaths. It would appear that at some point after 1995, and, therefore, after the deaths of Sean Benton and Cheryl James, the standing orders were amended to include a specific order that a weapon issued to one person should not be handed over to another.⁵⁵
- 11.80 After Geoff Gray’s death, the standing orders for the guards on the HQ RLC Officers’ Mess gate were amended so that the guard who was left alone, when the other members went on prowler patrol, was to be left unarmed.⁵⁶ Both soldiers carrying out the prowler patrol were to be armed, although, under Army-wide policy, both could be under-18.⁵⁷
- 11.81 Following James Collinson’s death, the order prohibiting the handing over of weapons was emphasised in bold. This rather suggests that it had not been hitherto, although the Review accepts that, as a matter of general military training, soldiers are responsible for their own weapon. Nonetheless, the weapons used for guarding at Deepcut were ‘pooled’ and only issued to trainees for temporary use. The Review understands that long-term personal issue of weapons does not take place until soldiers complete their training and join their first field army unit. The trainees mounting guard at Deepcut did not, therefore, have the same sense of personal ‘ownership’ of, and accountability for, their weapons as might be expected of those who have been issued a weapon for long term use.

The response to the death of James Collinson

- 11.82 However, the death of James Collinson, so soon after Geoff Gray’s, was to have wider implications for Army policy on armed guarding. As noted, a special instruction on supervised guarding at detached locations was brought into effect in August 2002.⁵⁸ By

⁵⁴ See Appendix A4/3.028 B – C.

⁵⁵ See *supra*, footnote 174, paragraph 5.169 above.

⁵⁶ See paragraph 10.91 – 92 above.

⁵⁷ See paragraph 11.46 above.

⁵⁸ See paragraph 11.38 above.

December 2002, much more radical measures were proposed for Deepcut itself, although the Review would be concerned if they were not replicated throughout Phase 2 training generally.

- 11.83 The outline narrative of events has already been set out in Chapter 1 and it is not proposed to set out a detailed account here of the events leading to the Deputy Adjutant General's (DAG's) final report in December 2002,⁵⁹ or the factors that lead Surrey Police to issue its Fifth Report in March 2004.
- 11.84 The important questions are whether the Army has sought to fundamentally address the issues behind the Deepcut deaths since March 2002? If they have, how and why have they done so, and will such change be short-term or enduring?
- 11.85 It is important to recognise the role of the media. The Review has noted in Chapter 1 that ill-informed and sensationalist reporting has not been helpful in identifying the real issues and addressing them fairly and effectively. The media spotlight on Deepcut and the Army over the issue of the deaths was intense, and may well have influenced Surrey Police's decision to retain primacy in relation to the death of James Collinson and to re-investigate those of Sean Benton, Cheryl James and Geoff Gray.
- 11.86 Although much of this media reporting was exaggerated, ill-informed and unfair to some individuals, the Review has no doubt that the media's sustained focus on Deepcut after 2002 has, nevertheless, had the salutary effect of requiring the Army to focus on the issues that have been the central themes of this Review: supervisory ratios; the recruitment and training of young people into the Army; the selection of instructors; improvements to RMP investigations; procedures to effectively supervise and enhance the welfare of trainees; and the reduction of the burden of guard duty.
- 11.87 Indeed, Brigadier Elderton acknowledged, in an interview with the Review, that a significant factor that kept the response swift and high profile was the media scrutiny.⁶⁰
- 11.88 The other catalyst for change was the Learning Account, discussed early on between Surrey Police and the Army, and formally adopted in August 2002.⁶¹ Again, the Review considers this to have been a worthwhile and helpful initiative of Surrey Police that brought senior Army personnel into the process.
- 11.89 Even before the establishment of the Learning Account, however, the Adjutant General's HQ was aware of the significance of the events and the need to respond to them. The minute from the Adjutant General's Secretariat of 28th March 2002 (previously quoted at paragraph 11.73 above) noted the recent statistics:

*"There have been 119 cases of ISIDs [Intentional Self-Inflicted Deaths] since 1 Jan 1996. Ten of these cases have involved soldiers aged 18 years of age or under, of which eight have resulted in deaths from gunshot wounds to the head. More specifically, the death of Pte Collinson represents the sixth ISID of an 18/under 18 year-old soldier since Jul 01; all of these deaths have resulted from gunshot wounds to the head and four of these incidents have involved soldiers under 18 years of age."*⁶²

⁵⁹ See Appendix 15.

⁶⁰ See Appendix A4/3.050 D – E.

⁶¹ See paragraph 1.13 above.

⁶² See *supra*, footnote 51. The Review has also considered the statistical evidence in Chapter 9.

11.90 Brigadier Elderton, in his Quarterly Report to ATRA of April 2002, himself noted that the shortfalls in the supervisory ratios, combined with the concerns as to whether under-18s should be performing guard duty, required a speedy response.

11.91 The response from ATRA to this report shortly afterwards is of interest:

*"The issue of U18 soldier and security duties is also being re-examined in the light of recent events and the impending ratification of the UN Convention on the Rights of a Child."*⁶³

11.92 As has been noted in Chapter 4, the United Kingdom had been party to the main body of the Convention on the Rights of the Child since 1992, and inspiration for a best interest centred policy towards minors could have been drawn from this document. The impending ratification, noted in the quote above, refers to the Optional Protocol that the United Kingdom ratified in June 2003. In October 2002, the United Kingdom announced that, pursuant to its intention to ratify, it would not be sending under-18s to hostilities where it was practicable to avoid doing so.⁶⁴ The Review notes, first, that the international instrument was being considered to promote policy, irrespective of its status in domestic law. Secondly, those responding were making the link between armed under-18s on guard duty and hostilities.

11.93 In July 2002, an ATRA-convened meeting on the events at Deepcut noted that amongst the longer term issues that needed addressing were: Army support for families following such deaths; the Deepcut regime and the manning level; the duty of care (including support mechanisms, recruit selection and indications of unsuitability); training to recognise those at risk; as well as issues relating to the media strategy, and clarifying the issue of the primacy for the previous investigations of the deaths.

11.94 As noted in Chapter 1, on 13th September 2002, the Deputy Adjutant General, Major General Charlton-Weedy, was tasked by the Adjutant General to assist Surrey Police by conducting a supporting military investigation in order to identify the lessons to be learned from all four deaths and to make recommendations.⁶⁵ An interim report was produced in October 2002, in which the work of the Army Suicide Prevention Working Group⁶⁶ was linked with concerns about trade training at Deepcut, access to weapons and the priority use of MPGS⁶⁷ guards there. The question whether the Army should be recruiting under 18 year olds at all was considered because the basic Department of Health research suggested, unsurprisingly, that limiting access to the means is the most effective suicide prevention measure:

*"This is especially the case in the male 17-21 age group, in which the risks of spontaneous acts are most pronounced. These considerations present the Army with a serious dilemma, since military training and operations unavoidably require young soldiers to handle weapons. Furthermore manning imperatives make it essential for the Army to continue to recruit and train young men and women from the age of 17."*⁶⁸

⁶³ See paragraph 4.41 ff for previous discussion of the Convention.

⁶⁴ See paragraph 4.41 ff above.

⁶⁵ See paragraph 1.14 above.

⁶⁶ See paragraphs 9.12 and 9.22 above.

⁶⁷ See paragraph 11.113 below.

⁶⁸ Loose minute D/AG/1700 dated 11th October 2002.

The Deputy Adjutant General's final report, December 2002

11.95 However, by far the most important document to emerge from the Army in response to the four deaths at Deepcut was DAG's final report on the Deepcut Investigation issued on 3rd December 2002.⁶⁹ Surrey Police, in their evidence to the House of Commons Defence Select Committee (HCDC), described DAG's final report (along with the Learning Account) as a watershed in the Army's dealings with the issues.⁷⁰ This Review agrees with that assessment.

11.96 Although Surrey Police's investigations were not yet complete and the inquest into the death of James Collinson had not been heard, DAG proceeded on the basis that there was no evidence of third party involvement and that the soldiers concerned may, therefore, have inflicted death by their own hand. The report was therefore:

*"... primarily concerned with the environmental factors that may have influenced the soldiers' behaviour, and with any systemic failures of prevention and protection."*⁷¹

11.97 The Report proceeded to link the Army's adverse suicide rates for the 16 to 25 year group compared with civilians, access to weapons and the rates of incidence of ISIDs in the different cap-badges to see if patterns emerged. It then analysed the Deepcut-specific factors that have been central to this Review. At paragraph 14 it stated:

*"The investigation found several sources of adverse stimulation at Deepcut. They are all related, and thus tend to be mutually reinforcing. Most of them are inadvertent, in that they are owed to externally generated factors, processes and policies that are beyond the control of local commanders. This situation creates additional requirements for restraints. Only limited evidence was found of current internal processes and policies that were likely to produce adverse stimulation. This was not, however, the case in 1995-6, as described below. Nevertheless, it is essential to be aware of the dangers of trying to attribute incidents to specific singular stimuli. Cause and effect are not directly and logically connected; different people react in different ways to common experiences."*⁷²

11.98 The problems of Soldiers Awaiting Trade Training (SATT) and under-stimulation are noted, as are the problems of supervisory ratios. This led to the findings:

*"As a result, the military ethos inculcated in Phase 1 declines in proportion with the time spent on training and SATT. This can leave trainees ill-prepared for their arrival in the entirely military environment of a service unit."*⁷³

11.99 Although isolated, the physical environment was found to be no worse than elsewhere in ATRA. As for the staff:

⁶⁹ See Appendix 15.

⁷⁰ House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Chief Superintendent Denholm's response to Question 670. See also Ev 455, 'Memorandum from Surrey Police', paragraph 4.

⁷¹ See Appendix A15.001, paragraph 3.

⁷² See Appendix A15.008, paragraph 14.

⁷³ See Appendix A15.009, paragraph 19.

*"The training, supervisory and welfare staff are well led and motivated, despite the magnitude of the challenges that are beyond their power to resolve. They make every possible effort to counter the adverse factors described above, but an established military staff: trainee ratio of 1:60 is a pervasive handicap on their effectiveness."*⁷⁴

11.100 Elsewhere, it was noted that these ratios were worse than any other establishment in ATRA. Altogether, the conclusion was reached that:

*"The range and combination of mutually reinforcing stimulants at Deepcut is especially adverse. They exist at a level well above that found anywhere else in the ATRA during this investigation. Although the majority of the trainees are content and well motivated, the risks are concentrated amongst the weakest and least competent, and especially those with underlying problems, which such a psychological environment would exacerbate. The earlier analysis underlined that this group may include those most likely to take their own lives."*⁷⁵

11.101 Such general conclusions would be of little help in understanding all of the particular deaths at Deepcut where psychiatric evidence, intellectual limitations, poor disciplinary record or history of self-harm do not provide a complete or consistent explanation. However, it is when DAG's final report analyses the opportunity for unsupervised guard duty, inherent in each of the deaths, that it really breaks new ground in reaching an understanding of the problem.

11.102 The conclusion at paragraph 24 is striking in its overall assessment and is therefore quoted in full (with emphasis added by this Review):

"Guard Frequency, Size and Supervision. *It is axiomatic that generally the risks increase with the frequency with which someone who is inclined to take their own life by predisposition and stimulation is presented with both the means and the scope for opportunity. In this respect the investigation found that the frequency, size and limited supervision of guards at Deepcut created those circumstances. Research into those factors showed that the number of soldiers employed on guard at Deepcut at night and weekends, the greatest risk periods, was until recently as high as 26. This alone set it apart from all other training establishments, where the equivalent average is only 8. Furthermore, the size and shape of the barracks involved significantly more detached guards than anywhere else, and hence produced a lower level of direct supervision. The compounding of these factors suggests a level of opportunity risk at least 6 times greater than the norm. Two additional exacerbating factors were identified. First, trainees were able to exchange duties with others with minimal restriction. Second, soldiers subject to SATT, who were previously identified as a potential risk category, inevitably carried out more guards than others, owing to the length of their stay in the barracks and their ready availability. This led to the conclusion that the guarding regime at Deepcut inadvertently created an extraordinarily high level of opportunity risk. Moreover, the simplicity, objectivity and extremity of this factor led to the ultimate conclusion that it may have been the most significant in these 4 deaths.*"⁷⁶

⁷⁴ See Appendix A15.010, paragraph 20.

⁷⁵ *Ibid*, paragraph 21.

⁷⁶ See Appendix A15.011, paragraph 24.

11.103 The Review has had the opportunity to speak to Major General Charlton-Weedy (formerly DAG, and the author of the final report). He stressed that the computation of risk is a multi-faceted task with no single element predominating. It is a complex mixture of events with no single causative factor. It is necessary to look at predisposition, means of self-harm, opportunity to self-harm, stimulus to self-harm and the absence of restraints. His conclusions were based in statistical analysis of self-inflicted deaths in the Army over a 20-30 year period.

11.104 However, *“the simplicity, objectivity and extremity”* of the opportunity of self-harm that unsupervised armed guard duty presented would appear to have been a constant theme in the four Deepcut deaths, as well as the deaths of Sapper Alfie Manship and Private CR (that have been noted in Chapters 3 and 9 respectively).⁷⁷

11.105 Once the central factor linking the Deepcut deaths had been identified, the solutions were not far behind. At paragraph 28, DAG recommended that with immediate effect:

- “a. The establishment at Deepcut should be revised in order to provide a supervisory ratio of approximately 1:38, and the resultant requirement for an increment of up to 12 officers and 50 NCOs be funded in STP [Short Term Plan] 03 (£2.2M).*
- “b. The supervisory ratios across the entire ATRA should be reviewed and brought to appropriate levels in line with a clearly defined and endorsed policy for all training establishments and which can be carried forward into DTR [Defence Training Review].*
- “c. Performance Indicators and Targets placed upon the ATRA should be reviewed and reordered to prevent inconsistency with the best interests of the trainees and the reduction of SATT.*
- “d. The routine security and guarding of the Deepcut site should be taken over by MPGS as soon as practicable at a cost of £1.7M.*
- “e. A common induction training package for ATRA Phase 2 instructors and supervisors should be implemented in order to raise standards towards those prevailing in Phase 1.*
- “f. The detailed observations and taskings in Annex A [the Learning Account] should be implemented forthwith.”⁷⁸*

11.106 For the Review, DAG’s final report and its conclusions and recommendations was the first to grapple with the interconnection of all the issues noted in the previous Chapters of this Report. It achieved what the suicide prevention strategy did not and identified the opportunity for unsupervised access to weapons as the central most important factor, as opposed to compliance with a model of a typical trainee susceptible to self-harm who could be recognised in advance.⁷⁹

⁷⁷ See paragraphs 3.36 ff and 9.24 ff above.

⁷⁸ See Appendix A15.012 paragraph 28.

⁷⁹ The Review takes account of the evidence of Professor Hawton, Professor of Psychiatry, Oxford University, and Director of the Centre for Suicide Research at Oxford, to the HCDC – See Vol II Ev 73, 7th July 2004 – to the effect that prediction of who is a risk is difficult, making screening out at the recruitment stage impractical. See footnote 19 in Chapter 7.

- 11.107 The report addressed the link between poor supervisory ratios and self-harm in a more direct and thorough way than the Haes Report did.⁸⁰ Unlike ATRA's response to the Haes Report only 15 months earlier,⁸¹ it concluded that the *status quo* with regard to both supervisory ratios and trainees performing guard duty was unacceptable as a matter of risk.
- 11.108 By contrast with the Evans Report in 1995,⁸² DAG's final report was commissioned at a senior level in the Army with the intention of learning wider lessons that could be applied throughout ATRA. As the report was commissioned by the Adjutant General, he could ensure that the report's recommendations, and the financial commitments required to deliver them, could be implemented.
- 11.109 The Review has pressed Major General Charlton-Weedy on whether ATRA could have reached conclusions similar to his own earlier than he did. Some of his responses have been noted in Chapter 9, where he pointed out that Lieutenant Colonel Haes' Report was not underpinned by scientific assessment of risk and that ATRA did not, therefore, have sufficient material to make a compelling case to address the inevitable budgetary and resource concerns.⁸³
- 11.110 The Review recognises that until DAG's final report, the Army had not analysed the available data in the way this Report has done. However, the data was, by and large, there and waiting to be analysed and drawn together. Various initiatives over the previous years had sought to address distinct component parts of the problem. The problem of sufficient supervisory ratios had been a regular theme of the Army's response to issues of bullying and self-harm.⁸⁴
- 11.111 Clearly, DAG's recommendations could not be implemented overnight. It takes time to find staff and extra resources to make the changes. The Review has not sought to examine competing budgetary requirements for 2003 to see whether the Deepcut reforms could have been implemented more speedily than they were. It notes that Surrey Police, in their Fifth Report, considered the implementation of DAG's recommendations at Deepcut to have been substantial by March 2004, although it had other concerns as to whether the Learning Account had led to Army-wide implementation by then.
- 11.112 The Review is satisfied from its visit to Deepcut in March 2005 and from the reporting of others, such as the Adult Learning Inspectorate (ALI), that Deepcut is a significantly different place by comparison to 1995 and 2001/2002.

Deepcut today

- 11.113 The most notable change, of most immediate relevance to the deaths, is in respect of guard duty. The occasion for unsupervised access to weapons has been greatly reduced by the introduction of the MPGS in sufficient numbers to reduce the requirement for trainees to undertake armed guarding. The MPGS is part of the Provost Branch of the Adjutant General's Corps. Its personnel are all over 18 and have served at least three years in the Armed Forces, or Reserves, before joining. The MPGS are armed and replace military

⁸⁰ See Appendix 13. See also paragraph 9.74 ff above.

⁸¹ See paragraph 9.100 above.

⁸² See Appendix 11. See also paragraph 7.2 ff, and in particular 7.6, above.

⁸³ See paragraph 9.116 above.

⁸⁴ See paragraph 4.102, 4.104 and 7.9 above.

personnel for security duties. They were first used in the Armed Forces in 1997 and first appeared at Deepcut in March 2001, but not in sizeable numbers until after the implementation of the recommendation in DAG's final report.

- 11.114 The Review understands that the only Phase 2 trainees performing armed guard duty at present are trainees assigned to the front and rear gate to the Barracks, under direct supervision at all times. The intention is that the use of Phase 2 trainees for guarding at Deepcut will be discontinued altogether when the numbers of MPGS personnel available are sufficient.
- 11.115 ALI noted in its initial visit to Deepcut in December 2004 that *"some under-18's and inexperienced recruits carry out guard duty together which is inappropriate."*⁸⁵ By the time of the follow up visit in January 2005, it noted that guard duty takes better account of *"recruits"* at risk. The Review understands that armed guard duty is limited to the two locations described above, where one trainee has a weapon and is under the constant supervision of an NCO, or MPGS, to ensure the rules are enforced. Trainees do not perform armed prowler patrols. It seems to the Review that this greatly reduces the burden on trainees and reduces the risk of inappropriate use of a weapon.
- 11.116 The trainee profile appears to have changed from 1995. There is a significant percentage of Commonwealth trainees who tend to be older, more settled and less likely to give disciplinary problems of the sort particularly associated with the young. Younger trainees can benefit from a calmer, more focused and disciplined atmosphere. The disadvantage of splitting training into Phase 1 and Phase 2, from the point of view of getting to know the trainee, is mitigated by improved supervisory ratios, better systems to promote throughput of trainees, and a better disciplinary environment. Success in this respect is regularly monitored by satisfaction surveys.
- 11.117 The problems of SATT are being addressed as best they can by more sophisticated computer technology to load trainees on to courses, by better medical facilities to rehabilitate those who suffer injury and by the implementation of fair, rather than equal, treatment of trainees of different physical attributes and strengths when it comes to physical exercise and endurance. Improved gym and sporting facilities, as well as the maintenance and development of non-alcoholic recreational facilities, are designed to enable the trainee to develop his or her fitness for military life during Phase 2 rather than stagnate, as may previously have been the case. It seems that there is better throughput to, and earlier notification of, the final unit of allocation so soldiers can identify with, and prepare for their move to, their future field army posting. All these are relevant adjustments to maintain morale and purpose.
- 11.118 The medical problems of trainees are also being addressed more strategically. The Review understands that at the recruitment centres, GP case files and notes are now obtained, so a medical history can be passed to the Deepcut Medical Centre for action if medical questions arise during Phase 2 training. People who may have particular problems can then be targeted for monitoring and special attention. Rehabilitation platoons in Deepcut, and other training organisations the Review visited, are designed to enable trainees to make rapid progress to rejoin the course, rather than linger on for lengthy periods without direction and purpose.
- 11.119 The depot function has now been considerably reduced at Deepcut. Those who are facing discharge for whatever reason are now retained and administered by their originating unit, unless safety reasons require a transfer, rather than ending up in a sink unit capable of

⁸⁵ Adult Learning Inspectorate: 'Safer Training – Managing risks to the welfare of recruits in the British Armed Services', pp 84-86, March 2005.

affecting the morale and welfare of trainees (as was previously the case when Deepcut retained the depot function for the RLC as a whole). This does not completely resolve the problems of unsuitable soldiers, whom the Army must accommodate and look after pending discharge, but it significantly reduces this aspect of the Deepcut phenomenon.⁸⁶

- 11.120 It seems that the definition of what disciplinary sanctions can be imposed by NCOs is considerably more precise now than it was in 1995. Significantly, the trainees are given induction training in what they can expect by way of sanction and how to complain if they do not get it. It may be that there are some Army-wide needs for greater transparency in this process and greater information available to the parents, but it seems, from casual conversations members of the Review team have had, that discipline is not a substantial concern for the recruits and trainees of today.
- 11.121 The staff seem better informed as to the layered issues relevant to training that affect young people and the equal opportunities issues arising from gender, race or cultural background. If there are problems, there seems to be a recognised mechanism for reporting through the chain of command.
- 11.122 The Review has not engaged in any form of audit of how Deepcut is functioning in 2005. The impressions noted above are based on the briefings and encounters when the Review team visited the Barracks, as well as cross-checking with the experience of others who have visited. It would also be unfair to imagine that all the improvements have resulted solely from the efforts of the present Garrison Commander and Commanding Officer, or are simply the product of extra resources following DAG's recommendations. No doubt Deepcut was learning the lessons from the previous deaths and seeking to do what could be done within existing resources and commitments. There is now a greater sense of an overall coherent understanding of factors that may make the place an unhappy experience for some and what can be done to mitigate these consequences.
- 11.123 The physical accommodation for trainees could do with some expenditure of resources. A number of informants have suggested that planning blight has played its role in the Deepcut story, with no strategic decisions being made on training, relocating or rebuilding for the modern era, and that this, in turn, affected the ability to make medium term investment decisions for training.
- 11.124 The Review cannot assess for itself such sensitive socio-economic questions as to whether the site should be relocated to allow for more training to be provided in one place to further reduce SATT and enhance the morale and welfare of staff and trainees alike. It notes, however, that the human and social needs of trainees and staff must be identified and fairly addressed in any future strategic initiatives, including the on-going Defence Training Review. These will include the privacy rights of individuals who may want to maintain a personal life during extensive periods of training, but find that barracks dormitories preclude this. There is a balance to be achieved between training soldiers to live and work in close quarters to each other, and precluding them from having a private life over extended periods. This was an issue mentioned by trainees to some of the Review team and, given the importance that sexual relations has had in the narrative of events, it is a factor to be considered in any future planning of accommodation.

⁸⁶ See also paragraph 4.67 above.

- 11.125 The Review heard from Lieutenant Colonel Strutt that, at Infantry Training Centre, Catterick, the policies on alcohol appear to be tightening where, for health and safety reasons, the camp is effectively dry from Monday to Friday when soldiers may be called on to handle weapons as part of their training.⁸⁷ Conversely, lightening sexual regulations enable Privates to sign in guests into their rooms at appropriate times so they are treated equally when compared with married soldiers or officers.⁸⁸ At some point in the combined training cycle, future policy ought to consider revamped accommodation permitting such freedom of choice. Regulated and supervised responsibility sounds more encouraging than merely disciplinary repression without a decent and practical alternative, particularly as this approach has proven ineffective in the past.
- 11.126 As a result of Deepcut's high profile, it may be that it now represents one of the more effective and safe training establishments in ATRA's estate. The Review has not itself been able to make detailed comparisons, but notes the round of inspections now routinely undertaken by the ALI, so good practice can be promoted and bad practice highlighted and addressed. Some general observations of what good practice requires in terms of recommendations to address the events at Deepcut will be considered in the final Chapter.
- 11.127 It should, of course, be noted that, notwithstanding the considerable work that has been done to improve matters at Deepcut since 2002, the risk of future self-inflicted deaths cannot be wholly eradicated. However, the opportunity for self-harm has undoubtedly been significantly reduced, and such measures as have so far been taken will be further enhanced by the implementation of recommendations contained in this Report.
- 11.128 It is sufficient to conclude this commentary on Deepcut today with the observation indirectly communicated to the Review by a trainee in Phase 2 training in 2005, that he felt mollycoddled by all the briefings, reviews of his welfare and monitoring of experiences that has been going on. It is unlikely that a similar comment would have been made in 1995. ALI noted that trainees *"under 18 are well cared for. They are closely monitored by duty staff."*
- 11.129 Although questions of SATT remain to be managed, and the physical state of the accommodation is poor and lacking in privacy overall,⁸⁹ the impression given of the place and its people in 2005 was somewhere where trainees wanted to get on with the learning the lessons they need to take on board in order to be effective and capable soldiers in the field army of today.

The Director of Operational Capability's Report

- 11.130 The Review has considered DAG's final report into Deepcut in some detail, as it directly addresses the factors that may have contributed to the deaths. However, this has not been the only initiative adopted by the Army in response to the joint Learning Account with Surrey Police and the broader issues of training and recruitment.

⁸⁷ See Appendix A4/14.005 B – F.

⁸⁸ See Appendix A4/14.006 E – G.

⁸⁹ *Supra*, footnote 85, p. 85.

11.131 The RMP has contributed its own reflection on where and why best practice was not adopted in the investigation of these deaths.⁹⁰ A new and unambiguous protocol has been drawn up with the civil police⁹¹ that should prevent misunderstandings of the sort that have undermined the investigative process into the deaths of Sean Benton, Cheryl James and Geoff Gray.

11.132 In addition, the MOD's Director of Operational Capability (DOC) produced a report on 18th December 2002, following an appraisal of the initial training of non-officer recruits across the Armed Forces.⁹²

11.133 The executive summary at paragraphs 3 and 4 notes the broad conclusions:

"3. Firstly, the Department as a responsible employer needs to ensure that its young people are managed proficiently and provided with effective duty of care at all stages of Initial Training. Therefore,

"a. In order to minimise risks during training, every recruit and trainee should have absolute, and confidential access to an experienced, empowered officer (as opposed to Non Commissioned Officer) to highlight any issues of concerns that affect his/her welfare or well-being.

"b. All recruits and trainees should complete and sign a questionnaire about his or her experiences during Initial Training.

"c. A formal training covenant should be established, laying down the precise responsibilities of both the recruit and the training system.

"d. Realistic supervisory ratios should be determined, established and resourced by each Service, as a duty of care issue, including an appropriate balance of male and female Service supervisory staff.

"4. Secondly, in terms of corporate governance, the Department requires more rigorous assurance mechanisms, to provide regular monitoring, to expose risk and to promote best practice. In this context, the Report concludes that an Assurance authority should be established outside the single-Service chains of command. It is suggested that this body could also administer the Questionnaire and Trainee Covenant proposed in the Report."

11.134 All this is sound policy, although it is disappointing to find such measures are discussed almost as new ideas in 2002 when they should clearly have been built in to the 1993 proposals concerning the implementation of Single Entry. Thus, paragraph 29 of the report notes the obvious consideration recognised back in 1993:

"There are also sufficient grounds to place a higher duty of care on the MOD in relation to the welfare of recruits and trainees under the age of 18."

From this, the rather unspecific recommendation is drawn:

"Major Recommendation: The legal and moral obligations relating to the MOD's duty of care to under-18s should be reviewed and, where necessary, translated into practice."

⁹⁰ Reference D/MP/A1110/6/2 Deepcut Learning Account, 16th December 2002.

⁹¹ See Appendix A16.

⁹² D/DOC/10/64 – 'Directorate of Operational Capability: Appraisal of Initial Training' dated 18th December 2002.

- 11.135 The overall analysis of the transition from Phase 1 to Phase 2 in the Army appears to be a particular apposite reflection on Deepcut;⁹³ as were the passages on: supervisory ratios;⁹⁴ staff training;⁹⁵ reporting on bullying;⁹⁶ and sexual liaisons.⁹⁷
- 11.136 The Review is somewhat concerned that DOC's report may not have grasped the difficulties of obtaining effective evidence against bullying or harassment by training staff in its references to administrative action taken following complaints. In light of the events at Deepcut outlined in Chapters 7 and 8, the Review is by no means certain that formal disciplinary action on the criminal standards of proof suffices to ensure a safe and fair training environment. In principle, the Review accepts that demonstrably malicious complaints should be the subject of sanction, as these may undermine the safety of others. However, it can readily be imagined that an unscrupulous instructor could use the threat of such sanctions to deter genuine complaints that may be difficult to prove. On the whole, the Review concludes that the Army's problem, historically, has been under-reporting of unacceptable behaviour rather than over-reporting of innocent behaviour. In a Training Regiment, the duty of care rather suggests that the responsible employer who has fairly investigated a complaint of inappropriate treatment and has good reason to consider the allegation is well founded but may have difficulty in proving this to the satisfaction of a Court Martial, ought to be able to take administrative action to ensure that the welfare of the trainees is assured, whether by transfer out, or short-term suspension from duties.
- 11.137 The events surrounding the career of Leslie Skinner (discussed in Chapter 7) show that the "*presumption of innocence*" should not be used as a failure to take necessary action to remove from contact with trainees those accused of serious wrongdoing. The actions of Sergeant BB (discussed in Chapter 8) also demonstrate that an influential NCO can deter reporting whilst he or she remains on the scene.
- 11.138 Ultimately, trainees have both to recognise and have the confidence to report conduct that is a clear abuse of power by any objective standard. The RMP must be the rigorous and effective agency of investigation of such abuse, deploying all means available to obtain reliable evidence from victims, whilst ensuring that those complained against have a fair investigation of allegations against them. Even a failed formal investigation may have evidential significance if repeat conduct is to be alleged. Current developments in civil rules on evidence would permit evidence of propensity, or similar fact, to be admitted in proceedings to prove a disputed point. If the investigation is informal, conducted by the unit itself and not the RMP, if it does not employ best practice in terms of taping or aids to vulnerable witnesses to capture an accurate account of the misconduct alleged, or access wider information than that held by the unit, none of this will be possible.
- 11.139 The acknowledgment in DOC's report of the role of Commanders and Commanding Officers in engaging with parents of trainees,⁹⁸ especially in the tragic event of a death, is particularly necessary in the light of the varying experiences of the parents of the four trainees with whom this Review is primarily concerned.

⁹³ *Ibid*, paragraphs 42-43.

⁹⁴ *Ibid*, paragraphs 45-46.

⁹⁵ *Ibid*, paragraphs 57-64.

⁹⁶ *Ibid*, paragraphs 71-76.

⁹⁷ *Ibid*, paragraphs 78-83.

⁹⁸ *Ibid*, paragraphs 90-94.

- 11.140 The Review was pleased to be able to arrange, under its auspices, meetings between Mr and Mrs Gray and Lieutenant Colonel Laden⁹⁹ and between Mr and Mrs James and Colonel Josling.¹⁰⁰ It was particularly disconcerting for both parties that the latter meeting, held late in the life of the Review, was the first opportunity for any detailed exchange between the parents and the Commanding Officer in the ten years since the death of their daughter.
- 11.141 The need for open communication in such case has been stressed by Fiona Murphy in her report commissioned by the Review.¹⁰¹ Her comments on the Casualty Notification Procedure and the need for a liaison officer, as well as to the reference to comparative police and Home Office practice with respect to deaths in custody, may be a further useful source of information to fine tune these measures.¹⁰²
- 11.142 Overall, the problem with DOC's report may be the speed with which it can be turned from aspiration into precise delivery on the ground. Surrey Police expressed a cautionary note that follow-up work in 2003 revealed some cynicism as to when and how it would be delivered. It would be fatal to the standing of the Armed Forces if a public perception was allowed to develop that these reports were public relations exercises designed to take the issues out of media prominence, but without an urgent agenda of finding the funds, the personnel and the other resources to implement the recommendations contained within them.
- 11.143 The Review has been impressed by the willingness of very senior staff in the Army to frankly discuss these issues and reflect on what may have gone on. Some of these conversations have been recorded and are reproduced in Appendix 4. Others were conducted in less formal ways, or ranged over topics no longer of central importance to the Review. Whilst they have helped inform policy and particularly apposite comments are noted in the body of the Chapters, they have not been formally appended as a matter of judgement by this Review.
- 11.144 The commitment by the Army to this independent Review itself is further evidence of an honest and open desire to learn, improve and advance. The tragic events that have occurred to prompt this learning experience demand that the task of implementation is not distracted by rival budgetary attractions or memory fade. Action by the Army to implement the recommendations contained in this Report will be the ultimate demonstration of good faith in this regard.

⁹⁹ See Appendix 4/11.

¹⁰⁰ See Appendix 4/8. Colonel Josling was a Lieutenant Colonel in 1994/95 when Commanding Officer of the Training Regiment & Depot and has since been promoted to full Colonel.

¹⁰¹ Fiona Murphy's opinion is reproduced at Annex C to this Report.

¹⁰² *Ibid*, paragraphs 4.4 ff. and 14.

12 Conclusions and Recommendations

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Introduction

- 12.1 This Chapter serves three purposes. First, it summarises the conclusions reached in Chapters 5, 6, and 10 about the immediate circumstances of the three deaths the Review has examined.¹ Secondly, it notes the broader circumstances relating to all four deaths that appear to the Review to be relevant. Thirdly, it presents the recommendations that it considers appropriate having regard to the matters considered previously and in the first two sections of this Chapter.

Section 1: Conclusions as to the responsibility for the deaths

The responsibility for the deaths

- 12.2 The Review has concluded, on the balance of probabilities, that the deaths of Sean Benton, Cheryl James and Geoff Gray were self-inflicted² and that the opportunity for self-infliction was afforded by the policy of frequently assigning Phase 2 trainees to armed guard duty at Deepcut, unsupervised by experienced soldiers or members of the Military Provost Guard Service (MPGS).³
- 12.3 Each death needs to be treated separately, on the basis of what was known, or should reasonably have been known, by the time of the death in question.

(i) Sean Benton

- 12.4 Sean Benton was known to have become emotionally distressed and had engaged in at least two attempts at self-harm in the months before he died. It was Sean's own insistence that he wanted to stay in the Army, coupled with the absence of any medical evidence of psychiatric disorder, that led the Officer Commanding B Squadron to give him another chance to make a success of his military career.⁴ The Squadron had previously taken measures to deny Sean access to a weapon on guard duty. On the night before Sean's death, Squadron staff sought to ensure that he did not become drunk and did not perform armed guard duty after he had been notified that his discharge from the Army was being applied for. Until the normal closing hours of the NAAFI, at least, he was under the regular supervision of an NCO. The full circumstances of Sean Benton's death are dealt with in Chapter 5.
- 12.5 The opportunity for self-harm was, therefore, created by Sean when he acquired a weapon from another trainee on false pretences and took the chance to be by himself. He then used the weapon on himself with fatal consequences. These acts were pre-planned only hours before his death. There was no opportunity for anyone else to have become aware of them or alert those in authority of the risk of harm to Sean.
- 12.6 There is no evidence that Sean had been bullied shortly before his death, nor that he had ever complained of bullying to his close friends or anyone in authority in the frequent meetings he had with officers about his future. There is no consistent and reliable evidence that over-harsh discipline caused him to become depressed. Any over-harsh discipline to

¹ See paragraph 1.30 ff for an explanation as to why the Review could not examine the immediate circumstances of the death of James Collinson.

² For the Review's conclusions on the deaths of Sean Benton, Cheryl James and Geoff Gray, see paragraphs 5.197 ff, 6.181 ff and 10.140 ff, respectively.

³ For an explanation of the MPGS, see paragraph 11.113 ff.

⁴ See paragraphs 5.174-175.

which he may have been subject during his military career did not cause him to take his life. The conclusion of the Review is that he was neither bullied to death nor was his death caused by the negligence or breach of duty of the Army.

(ii) Cheryl James

- 12.7 Cheryl James was not known by anybody in authority in the Army to have been unhappy, or to have had a pre-disposition to self-harm. Any conversations she had with her friends or others about self-harm were insufficient to alert them to a risk and nothing was passed on to anyone in authority. There is no reliable evidence that she had been the victim of sexual harassment by NCOs or officers during her training. There is no reason to believe that any such treatment was affecting her mind on the day of her death. There is no evidence that bullying was a factor in her death. The full circumstances of Cheryl James's death are dealt with in Chapter 6.
- 12.8 Whatever may have caused her to self-harm cannot be identified with certainty.⁵ It would appear to include personal factors during a period of unresolved complications in her private life, at a time when she may have been vulnerable and lacking in self-esteem. This was not an aspect of her personality that was apparent to those who did not know her well.
- 12.9 Cheryl should not have been assigned the lone static guard duty at a remote post that she volunteered for, but this failure to apply Army policy only created the opportunity for her to be by herself. The circumstances of the other deaths show that this opportunity could easily have been created by anyone in unsupervised possession of a weapon and ammunition. In the conclusion of the Review, this failure did not cause her death.

(iii) Geoff Gray

- 12.10 There was nothing in Geoff Gray's past to suggest to anyone that he posed a risk of self-harm or that he might misuse his weapon. There was nothing in his conduct or his treatment by the Army that would suggest he was at risk of self-harm. There is no reason to believe bullying was a factor in his death. The full circumstances of Geoff's death are considered in Chapter 10.
- 12.11 Although Geoff was under 18, he had performed armed guard duty successfully before and was fully trained in the use of a weapon.⁶ Army policy permitted trainees over 17 to perform armed guard duty unsupervised by an experienced person in authority. Assuming that a local policy had been adopted and implemented at Deepcut by the time of his death, assigning Geoff to guard duty would not have been in breach of it as he was over 17¹/₂.⁷
- 12.12 Geoff should not have gone off on an unaccompanied prowler patrol with his weapon whilst on guard duty. He had been instructed to that effect a few hours earlier and both his comrades on guard with him volunteered to accompany him. The decision to proceed on a sole prowler patrol was his alone. In the conclusion of the Review, neither the Army nor his comrades caused his death.

⁵ See paragraphs 6.189-190. See also paragraph 6.97.

⁶ As were Sean Benton and Cheryl James.

⁷ See paragraphs 10.48 ff and 11.70-74.

Section 2: Conclusions as to the circumstances surrounding the deaths

Factors contributing to the deaths

- 12.13 In the cases of Cheryl James and Geoff Gray, frequent armed guard duties at remote locations unsupervised by an NCO, or experienced person in authority, afforded them the opportunity to self-harm. In both cases, the frequency of guard duty in the weeks before their deaths may have contributed to their unhappiness and, combined with other personal factors, may have made them more susceptible to self-harm on the occasions of their deaths.⁸
- 12.14 In the case of Sean Benton, his prolonged progress through Phase 2 training, together with attendant disciplinary penalties, informal sanctions (including extra guard duties), and possible restrictions on weekend home leave added to factors that made him unhappy.⁹

The training environment

- 12.15 Low morale can be induced by factors in the physical environment at Deepcut. Concerns noted by the Review include: the quality of the accommodation blocks, and particularly the sanitary and washing facilities there;¹⁰ the delicate balance between effective security denying unauthorised access to the dormitories and the ability of responsible adults to lead a private life;¹¹ the limited range of recreational activities provided on site;¹² and the practical ability to leave the Barracks in off duty hours.¹³ The extended configuration of the camp and the additional demands it imposed for guard duty have been noted throughout this Report.¹⁴
- 12.16 Added to the physical environment there is the psychological one, best described as the indeterminate and unpredictable length of Phase 2 training at Deepcut. The effect this has had on trainees has been considered throughout this Report.¹⁵
- 12.17 These general aspects of the Deepcut regime may have contributed to making any one of those who died unhappy. They need to be addressed in any future planning of military training.¹⁶ They are reflected in some of the more general recommendations made below. A number of specific factors deserve attention.

Unsupervised access to weapons

- 12.18 In all three cases considered in detail by this Review, the regime for unsupervised armed guard duty for inexperienced soldiers afforded an opportunity to either acquire a weapon or to move with it to an isolated spot to use it. While after each death some changes were made to local orders regarding the handing over of weapons, it is clear that the orders

⁸ See paragraphs 6.21, 10.44 and 10.75.

⁹ See paragraph 5.150 ff.

¹⁰ See paragraphs 4.76-77, 7.55, 8.44, 8.53, 9.71-72 and 11.123. However, note paragraph 11.99.

¹¹ See paragraphs 4.89-92, 6.9, 6.129, 7.16, 7.24, 7.89 ff, 8.7 ff, 10.13, 10.29 and 11.124-125.

¹² See paragraphs 4.95-96, 5.192, 8.22 and 9.57 (including Figure 9.2).

¹³ See paragraph 5.194

¹⁴ See for example paragraphs 6.55, 9.120, 10.52, 10.58, 10.68, 11.44 and 11.102.

¹⁵ See paragraphs 4.71-72, 5.10, 5.111, 10.31 ff, 11.98 and 11.117. See also footnote 166 in Chapter 5.

¹⁶ See paragraph 11.124.

could be easily disobeyed.¹⁷ From the evidence given at the inquest, this also appears to have been a factor in James Collinson's death. In summary, James was under 17^{1/2} and not issued a weapon when he was assigned to guard duty at the Officers' Mess. He acquired a weapon from a fellow guard member in breach of standing orders. According to the guard member, James asked for a weapon so that he could have an excuse to go for a smoke. The third member of the guard at the Officers' Mess post has stated that he was making a call on his mobile phone at around this time. The Coroner noted in his summing up to the jury that it was now clear that several military orders had been breached: the handing over of the weapon; the use of a mobile phone whilst on guard duty; smoking whilst on duty; patrolling alone; and failing to inform someone in authority that a patrol was taking place.

- 12.19 With hindsight, it appears that for each of the four young people who died there were factors in their lives troubling them that may have prompted thoughts of self-harm. In James Collinson's case there was some evidence at the inquest that he had told other soldiers of an intention to harm himself if he had access to a weapon, although there was no clear evidence of a motive to self-harm and the jury returned an open verdict on 10th March 2006. There is evidence to suggest that Cheryl James and Geoff Gray both expressed intentions to self-harm before their deaths.¹⁸ The personal histories of Cheryl James and Sean Benton revealed factors that objectively made them more vulnerable to self-harm.¹⁹ For the Review, age itself is also a relevant factor. Geoff Gray and James Collinson were under 18. Cheryl James had just turned 18. Sean Benton was older but had been recognised by medical staff as having an immature personality.²⁰ Further, there are a number of factors to be considered that diminished the ability of the Army to predict such susceptibility to self-harm and prevent it from occurring on guard duty.

Supervision

- 12.20 Apart from Cheryl James, none of the four young people had completed their Phase 2 training. None were part of closely supervised Troops with a structured support system and good working relationships with NCOs who knew them well.²¹ Geoff and Cheryl were both dealing, to different degrees, with complications in their personal lives, as many young people do. Sean Benton was known to have self-harmed in the recent past and had been considered doubtful or unsuitable by way of temperament for a military career, before his discharge was ultimately applied for.²²
- 12.21 The Army appears to have been slow to have analysed all the data in its possession about the nature and scale of the risks posed to young trainees by unsupervised armed guard duty, particularly in remote locations.²³ When it did analyse this data under intense public scrutiny, it took measures to invest in Deepcut by way of alternatives to trainees performing armed guard duty by greater use of the MPGS.²⁴ Where trainees continued to perform armed guard duties, the Army also provided more staff to directly supervise them. The provision of more staff to supervise trainees generally, thus, resulted in the adoption of recommendations that had previously been suggested by senior officers over the preceding eight years.²⁵

¹⁷ See paragraphs 5.169 (particularly footnote 174), 10.88-90 and 11.79-81.

¹⁸ See paragraphs 6.98 ff and 10.129 ff. See also footnote 172 in Chapter 5 in respect of Sean Benton. See also paragraph 9.14.

¹⁹ See paragraphs 5.4 and 6.99, respectively. See also paragraphs 6.104 and 12.50.

²⁰ See paragraphs 5.14 and 5.21.

²¹ See paragraphs 4.72-75, 5.119, 5.191-192, 6.6 and 11.99.

²² See paragraphs 5.4, 5.14, 5.16 and 5.21.

²³ See paragraphs 6.191, 7.4-6, 9.42-9.47, 9.119-120 and 10.56-57.

²⁴ See paragraph 11.113 ff. See also paragraphs 9.78-79.

²⁵ See paragraphs 9.122-123 and 11.106-11.110.

12.22 On the basis of these factors, the Review considers that, although the Army did not cause any of the deaths, there were institutional failures to identify potential sources of risk and address them. Those failures increased as more information became available but the factors creating risk were still not comprehensively identified and, therefore, not addressed adequately.²⁶

Discipline, bullying and informal sanctions

12.23 In only one of the three deaths reviewed, that of Sean Benton, might bullying or over-harsh discipline have played any role in undermining the morale of the trainee. There is insufficient reliable evidence to conclude that it did so. There is no evidence that any of the trainees were bullied to death.

12.24 Nevertheless, the evidence obtained by Surrey Police and this Review suggests that from 1995 to 2002 a number of trainees at Deepcut had, at various times, experienced, or claim to have experienced, harassment, discrimination and oppressive behaviour from NCOs, as well as from other trainees.²⁷ Such claims may well only be from a small minority of trainees, but such experience cannot be dismissed as non-existent or not a cause for concern.

12.25 Resentment of informal sanctions (particularly guard duty),²⁸ denial of weekend leave in the context of prolonged exposure to a tedious regime awaiting trade training, and the behaviour of fellow soldiers are also likely to have made a number of trainees disillusioned and unhappy.²⁹ Throughout this period, trainees had self-harmed or threatened self-harm and some of those who had were subsequently to explain that they were unhappy with the military regime at the time.³⁰

Ventilation of grievances

12.26 Some of those who were unhappy about their treatment or their situation as Phase 2 trainees complained to the chain of command. Others, who subsequently expressed their unhappiness to Surrey Police during their investigations, did not complain at the time. A number of those who did not complain explained they had little confidence that the system could or would redress their grievance.³¹

²⁶ See paragraphs 9.119-120.

²⁷ See the Surrey Police Duty of Care Schedules reproduced as Appendices 5 and 6 to this Report.

²⁸ See, for example, paragraphs 4.109, 5.152-155, 6.22, 6.28, 6.125, 6.175 ff and 8.33.

²⁹ See paragraphs 5.195 and 10.31 ff.

³⁰ See paragraphs 6.72-75 and 9.48-57 (including Figure 9.2).

³¹ See paragraphs 5.99 and 10.38. See also paragraphs 6.162, 6.170 and 6.173-174.

- 12.27 In at least some cases considered by the Review, it can be said that such concerns clearly had substance. Many of those who were undoubtedly the victims of indecent assaults by Leslie Skinner, whose conduct is considered in Chapter 7, did not complain until a long time after the event.³² Similarly, the events described in Chapter 8 demonstrate, to the satisfaction of this Review, that there was reluctance by trainees to complain against NCOs; those who did complain about a senior NCO were vulnerable to reprisals and received an ineffective response by their immediate superiors.³³
- 12.28 The efficacy of the military complaints system and any other measures for independent oversight of the welfare of recruits, trainees and young soldiers, is, therefore, an issue that arises from the circumstances surrounding the deaths and requires further consideration in this Chapter.

The efficacy of the investigations into the deaths

- 12.29 The issue as to who had primacy for investigation of sudden deaths on military property has already been noted in Chapter 3. A new protocol between the Secretary of State for Defence and the Association of Chief Police Officers (ACPO) dating from September 2005 (see Appendix 16) re-affirms that primacy for investigating all such deaths rests with the civilian police. Even so, as noted at paragraph 3.17 above, an internal Surrey Police policy document seen by the Review in late 2005 referred to them having primacy in cases of 'suspicious', rather than 'sudden', deaths. Clear and unambiguous language should be used to accurately reflect the Protocol and avoid confusion that could diminish the scope and nature of future investigations.
- 12.30 Where the Royal Military Police (RMP) has primacy for an investigation, the quality of the investigation may vary according to resources, training and the context of the investigation. In the case of Leslie Skinner, considered in Chapter 7, the Review has noted occasions when the scale and persistence of his misconduct was not revealed by RMP investigations. The question of how best practice and high standards of investigation can be maintained by the RMP will be the subject of recommendation later in this Chapter.

Issues relating to instructors

- 12.31 There is some reason to doubt that a number of those put in charge of training and supervising the trainees at Deepcut had the requisite personal skills or training to successfully achieve this task.³⁴ The challenge for these instructors was increased by the decisions related to Single Entry in 1993,³⁵ and the phenomenon of delayed throughput in trade training.³⁶ Poor supervisory ratios exacerbated this problem and reduced opportunities to detect unhappiness or ventilate grievances.
- 12.32 The system for selecting and vetting instructors, and other members of the permanent staff, for training posts, reporting on their progress and recording concerns that reflect their suitability to perform such a challenging task appears, to the Review, to be in need of revision and improvement.³⁷

³² See paragraphs 7.65, 7.68 and 7.78.

³³ See paragraphs 8.50, 8.75 ff and 8.103 ff.

³⁴ See, for example, paragraphs 5.196, 6.131 ff, 6.160 ff, 6.169 ff, 7.31 and 8.24 ff.

³⁵ See paragraph 4.30 ff.

³⁶ Described elsewhere in this Report as SATT, Soldiers Awaiting Trade Training. See paragraph 4.72.

³⁷ See in particular paragraphs 6.133, 7.92 ff, 8.20, 8.24-25 and 8.112.

Selection of recruits and parental involvement

- 12.33 Other issues arising from the narrative of the Deepcut events include whether recruit selection is sufficiently rigorous and well-informed and whether parents are sufficiently involved in the selection and training of their son or daughter in the Army.³⁸
- 12.34 The Review has also highlighted the need for parents to be well-informed and briefed in the tragic event of their son or daughter meeting a sudden death, particularly where there is uncertainty as to how or why they died.³⁹

Section 3: Recommendations

- 12.35 In the light of these matters, the Review will now proceed to make recommendations for consideration by the Minister of State for the Armed Forces, and others, before finally considering whether there is a need for a public inquiry.

The age of recruitment

- 12.36 There is a case for restricting the recruitment of soldiers into the Army to those who are over 18 on enlistment or commencement of training. There is simplicity about such a proposal that makes it attractive. Problems of access to alcohol or *in loco parentis* welfare obligations to trainees⁴⁰ would be replaced by a single duty of care – to protect soldiers from foreseeable harm not inherently connected to their role as soldiers. Although being over 18 is no guarantee of individual maturity, it is the formal moment of transition from the status of minor to adult. It could be argued that employment in the Army, with its particular features, is inappropriate for minors.
- 12.37 The Army in 1993, in its consideration of Single Entry and, more recently, in the Deputy Adjutant General's interim report in October 2002, was unwilling to lose the capacity to recruit those under 18.⁴¹ There is no doubt that such a move would diminish the present ability of the Army to recruit the numbers it needs to perform the tasks the government asks of it.
- 12.38 The case to move to an adult only Army might be compelling if the only justification for recruiting those under 18 rested on the Army's manpower needs, particularly if those needs could be said to be inconsistent with the principle of the best interests of the child. Such a principle should be a prime consideration for all public authorities in the United Kingdom.⁴² However, the Review is satisfied that a military career is an exciting and challenging career for many young people who otherwise may not have an opportunity to lead structured and fulfilling lives.
- 12.39 Civilian society has not been notably successful in providing the opportunities for rewarding life-long careers for young people whose talents are not in the field of GCSEs and higher academic qualifications but lie, rather, in the technical trades or other careers offered by the Army. To deny these young people the chance to start training for such a career when they are of school-leaving age may deprive them of the opportunity they need

³⁸ For examples of the Army's previous acknowledgement of the importance of involving parents see paragraphs 4.40 and 4.54. See also paragraphs 4.52, 8.21 and 11.139.

³⁹ See paragraphs 2.9, 2.17 and 2.38. See also Annex C for the opinion of Fiona Murphy.

⁴⁰ See paragraph 4.36 ff.

⁴¹ See paragraph 11.94.

⁴² See paragraphs 4.41-44 and 4.51 (see also footnote 29 in Chapter 4).

to get away from difficult social circumstances and acquire new skills, and social discipline, before it is too late to adapt. As the Review has noted in Chapter 4, although the Army is not designed as an agency to improve the quality of life of young people, it does offer broad opportunities for the acquisition of new skills and career development that schools and colleges may not.⁴³ For many young people the 'boarding' experience may provide an effective chance to develop self-discipline and independence.

- 12.40 Unless and until educational opportunity for 16 to 18 year olds in the United Kingdom becomes so diverse and well-resourced that it provides everyone the opportunity of acquiring better life skills in civilian society, this Review is of the opinion that there is not a sufficient case to prevent the recruitment to the Army of those over 16 but under 18. There is a mutual benefit to individual recruit and the Army alike to continue to permit those of this age to have the chance to start a military career and acquire a range of new skills. However, such recruitment and training must take place in an appropriate environment where there are sufficient staff skilled in understanding and addressing the particular vulnerabilities of young people in general, as well as being alive to any specific issues any individuals may have.

RECOMMENDATION 1

Young people with suitable qualities for a military career should continue to be able to enlist at 16, with a view to fully participating in all aspects of military duties from the age of 18, so long as their training takes place in a suitable environment dedicated to the needs of such young people, and particular care is taken for their welfare.

The training environment for minors

- 12.41 For the Review, the regime offered at the Army Foundation College (AFC) in Harrogate is certainly an appropriate environment for 16 year olds. There is good accommodation, recreational and training facilities and the 42-week long course provides an opportunity for acquiring enhanced educational skills and personal self-discipline, as well as purely military and technical ones.⁴⁴ In the opinion of the Review, AFC Harrogate offers the best model for enlisting young people into the Army. It means that young people will not start Phase 2 training until they are at least 17 years old and, depending on the length of their trade training, even the youngest trainee would only join the field army shortly before their 18th birthday. Soldiers need to be 18 before they can be deployed on operations.⁴⁵
- 12.42 The Review is aware that resources do not, at present, permit the universal implementation of the best practice at AFC Harrogate throughout the Army Training and Recruiting Agency (ATRA). Further, it has been pointed out that some of the educational and technical input AFC Harrogate provides is not always appreciated by the recruits, or is, indeed, necessary for all trades.
- 12.43 As an alternative, the Army Training Regiment (ATR) in Basingstoke is a dedicated facility for those who are recruited under 17 but who do not meet the entry requirements of AFC Harrogate. It has many of the features that make it a suitable environment for young people to learn to become soldiers.⁴⁶

⁴³ See paragraphs 4.8-10.

⁴⁴ See paragraphs 4.10 and 4.60 ff.

⁴⁵ See paragraph 4.41 ff.

⁴⁶ See paragraphs 4.10 and 4.60 ff.

The duration of training for minors

- 12.44 The Review believes that the present balance between fast-track throughput and setting a pace for the training regime that allows the young people who pass through ATR Bassingbourn to develop the skills, fitness, and robustness of personality needed for a successful military career, should be revisited. The length of the Army Development Course there in 2005 (17 weeks) seems, even with the proposed increase by one week, too short to achieve all the added value that may be necessary for a smooth transition into Phase 2 training.⁴⁷
- 12.45 There should be sufficient time to address any deficits in basic functional numeracy and literacy skills,⁴⁸ and sufficient time to adjust to living away from the home environment, as well as learning about the military one. The Review believes that the Phase 1 course at ATR Bassingbourn should be at least 26 weeks to achieve all these functions.⁴⁹ First, this is the period needed for a young person to become accustomed to living away from home and to the disciplined life of the Army. Secondly, the young person will have some opportunity to enhance their basic educational skills. Thirdly, it will reduce the number of minors in Phase 2 training and in the field army. No trainee should arrive at a Phase 2 training establishment under 17 years of age.

Provision for minors during Phase 2 training

- 12.46 For the Review, it would be preferable for the Army not to mix adults and minors at all in either Phase 2 training or in the field army. Such a scheme would require either Phase 1 training for minors to be prolonged or some structured delay in starting their training after school-leaving age is reached. The Review is not convinced that any such deferral of training would be fatal to the Army's future prospects of attracting sufficient numbers.
- 12.47 However, if minors are to continue to start Phase 2 training in a Single Entry regime, the physical environment, the supervisory ratios, the selection of instructors and other factors affecting the psychological environment must be designed to reflect the particular needs of young people.
- 12.48 The Review appreciates that any recommendation it makes about the improvement of the regime for young people in the Army makes greater demands on the public purse. The question, however, should not be whether these measures can be afforded but, rather, whether the Army can afford to do without them. In the opinion of the Review, they are part of the necessary price to pay to be permitted to recruit young people into military service.

RECOMMENDATION 2

The training environment for those under 18 should have the following features:

- (i) Those under 17 should be trained in establishments exclusive to this age group.**
- (ii) ATRA should aim to provide the facilities and the length of training presently provided by AFC Harrogate to all recruits under 17.**
- (iii) In the meantime, Phase 1 training at ATR Bassingbourn should be extended progressively to 26 weeks.**

⁴⁷ See paragraph 4.60.

⁴⁸ See paragraphs 4.8, 9.66 and 9.68.

⁴⁹ The Review understands this was the length of Junior Entry training, see paragraph 4.26.

RECOMMENDATION 3

Where young people over 17 but under 18 are trained together with adults in Phase 2 training, special provision should be made for their safety, welfare and development in the design of the training regime and the environment in which it is delivered. The Army should plan to eliminate the need for soldiers to join their units in the field army on completion of Phase 1 and 2 training until they reach the age of 18.

The screening of recruits

- 12.49 The Review accepts that it is difficult to predict, from a medical and social profile alone, who will have a successful and happy career in the Army. Everyone who has the necessary qualities to become a soldier should have an equal opportunity to do so, whatever their past experience.
- 12.50 However, the Army would benefit from greater and more accurate information about the medical and social background of its recruits than was available in 1995, as demonstrated by the cases of Sean Benton and Cheryl James. In both those cases, the Army was unaware of previous attempts at self-harm prior to enlistment which were known to medical professionals. The procedures for self-certification, or certification by parents, did not bring these facts to light.⁵⁰ These are considered to be relevant indicators of future propensity to self-harm.⁵¹
- 12.51 The Review would expect that the applicant's consent for disclosure of medical records and other confidential data should be part of recruitment practice. Such data should be obtained, not to screen classes of recruits out but, to enable the Army to be aware of all factors that may affect suitability for military life, or life in a particular cap-badge, and to make any necessary personal assessment.

RECOMMENDATION 4

The Army should routinely seek confirmation from others of self-declared medical and social histories, including access to medical or other confidential records. Such data is necessary to make a full assessment of the applicant's suitability and enable training centres to be aware of any particular vulnerability that may need addressing.

Parental involvement in the recruiting process

- 12.52 The Review would also endorse all efforts to encourage a parent of the applicant, or other responsible adult, to participate in the interview and selection process. This role should involve more than merely signing a consent form for the recruitment of those under 18. There should also be an invitation to attend the recruiting centre so that the overall process is understood. The parent, or other responsible adult, may be able to add information about factors in the social and medical history overlooked by the applicant. An information pack should be made available and provided before consent is given to recruitment of a minor.

⁵⁰ See paragraphs 5.3-4 and 5.15 and 6.1 and 6.99, respectively. See also paragraph 7.11.

⁵¹ See paragraphs 6.104, 9.15 and 9.28. See also the evidence of Professor Hawton to the House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev 73.

RECOMMENDATION 5

The Army should encourage maximum involvement in the selection process by the parent, or other responsible adult, of the applicant under 18.

RECOMMENDATION 6

A clear and concise information pack should be made available for the parent, or responsible adult, before consent is given to recruitment of a minor, explaining:

- (i) what the commitment to a military career involves;**
- (ii) where and when training will take place;**
- (iii) where and how further information can be obtained;**
- (iv) who to turn to if the young person encounters difficulties and problems;**
- (v) how long service will be for; and**
- (vi) when and how the options to leave the Army can be exercised.**

12.53 This communication in the selection process should only be the beginning of attempts by the Army to involve parents, or other responsible adults, in the progress of the recruit through the various stages of training, and to provide them with information.

12.54 In due course, both the parent, or responsible adult, and the recruit should be supplied with information about the code of conduct expected of recruits and instructors alike, with specific reference to the nature of permissible sanctions, behaviour that is not tolerated and how to complain about any violation of acceptable norms.

12.55 Where the recruit has encountered difficulties and unhappiness in the training process, procedures should encourage the sharing of information between the military authorities, the recruit and the parent or responsible adult. There should be consultation as to whether a trainee who has reached their 18th birthday will exercise their right to discharge if they are uncertain as to their future. Where the trainee is encouraged to 'soldier on' to the end of the training process this should be without prejudice to the right of discharge.

RECOMMENDATION 7

Recruits who joined the Army as minors and who have reached a settled decision that they are unhappy with pursuing a military career before they reach the end of their Phase 2 training, but after their 18th birthday, should be able to discharge as of right.

The practical content of the Military Covenant

- 12.56 It is clear that military life is very different from any other form of employment. The deprivations endured and the risks accepted are clearly set out in the Military Covenant.⁵² The ATRA Code also spells out what the Commanding Officer commits the Army to provide during training and the standard of behaviour that the recruit commits to.⁵³
- 12.57 The Army needs to ensure that it meets its side of the Military Covenant by looking after the soldier and providing acceptable accommodation. The training environment should both be free of harassment and afford the trainee privacy.
- 12.58 In the opinion of the Review, the spirit of self-sacrifice referred to in the Military Covenant should not mean that soldiers have to put up with sub-standard accommodation and sanitary and washing facilities because there are other pressing demands on the defence budget. As a people-based organisation, the Army must put the welfare of its people first. The discharge of the mutual commitments in the Military Covenant should not start with a 'credit note' to explain inadequate staffing ratios, recreational and welfare facilities.
- 12.59 The Commanding Officer of every training regiment needs to be provided with sufficient resources to deliver on all these obligations to an acceptable minimum standard. Where facilities are sub-standard, the Commanding Officer needs to be able to explain when and how they will be improved. The temptation to defer expenditure on training establishments until operational commitments and new military equipment is paid for should be resisted. The Army must be satisfied that it has provided decent, safe and otherwise appropriate facilities for its personnel, where the needs for private life and personal development are catered for as well as the military training. If these standards are not met, it must immediately plan to provide them.
- 12.60 What is appropriate for a 16 year old in Phase 1 training will differ from what is needed for someone over 18 in Phase 2 training, and thereafter. Recreational facilities, sporting facilities, opportunities for guests to visit and access to civilian facilities are all factors to consider. The quality of the environment affects the morale of the trainee and this affects whether or not he or she endures the rigours of the training process and makes a successful military career.

RECOMMENDATION 8

ATRA should maintain a regular audit of its training estate:

- (i) It must be satisfied that it has provided decent, safe, and appropriate facilities for its personnel where the needs for private life and personal development are catered for as well as their military training.**
- (ii) The physical and psychological environment should combine to inspire and motivate the trainee.**
- (iii) If it does not, ATRA must immediately plan to redress this.**

⁵² See paragraph 4.2.

⁵³ Annex A to G1 'Conduct and Behaviour' of the ATRA Handbook.

- 12.61 The problem of delays in trade training causing the phenomenon of SATT should be regularly monitored to ensure that the trainee does not regress or stagnate after Phase 1 training. Where delays remain inevitable, the trainee must be kept informed with a progress card, or something similar, explaining what has been achieved and what remains to be done before he or she is posted to a unit in the field army.

RECOMMENDATION 9

All reasonable measures should be taken to reduce or eliminate delays in Phase 2 training. Wherever there are delays, the trainee should be informed in a written record of the progress to date and the future timetable.

Supervisory ratios

- 12.62 The role of adequate supervisory ratios has been emphasised enough in the course of this Report to ensure that future defence planning must never forget the consequences of budgetary paring in a training establishment.⁵⁴ The Review considers that sufficient NCOs of the appropriate calibre for a training regiment, with the skills, commitment and the patience to turn young people into effective soldiers, is the essential pre-condition for anything else that the Army aspires to deliver. If ratios fall to unacceptable levels, pressure will build on staff, potentially resulting in oppressive behaviour.⁵⁵ There will be fewer NCOs to observe and deter such behaviour. With poor supervisory ratios, trainees may not have the confidence of solid relations with staff to be able to turn to the chain of command to report abuse within it.
- 12.63 The events at Deepcut have generated a profound crisis in the relationship between the public, the parents of future soldiers and the Army because of the perception, whether or not justified, that the Army neglected to deliver on its duty of care. There can be no Army without soldiers. There will be no soldiers without tomorrow's recruits. There is unlikely to be enthusiasm amongst tomorrow's parents to encourage and support a military career unless there is confidence that the Army can deliver on its promise of 'zero tolerance' of bullying and harassment and provide a career in which all can progress with equality and fairness.
- 12.64 To achieve this, the Army must invest in its instructors throughout ATRA in terms of both quantity and quality. Instructor to trainee ratios of over 1:40 are unlikely to be acceptable. Deepcut has had a high profile in the public mind for the past four years and has received corresponding attention by way of resources. It may not continue to do so indefinitely. Other training establishments may have similar problems now or in the future. They should not have to risk a repetition of the events that gave rise to this Review for adequate resources to be made available. A duty of care is not delivered by fire-fighting measures of throwing resources at the latest crisis only to divest them again when attention is diverted elsewhere.

⁵⁴ See paragraph 12.20 above. See also paragraphs 5.119, 6.168, 7.14, 8.25, 9.58-97 and 9.100-106. The conclusions of Chapter 9 (Suicide Prevention and Supervisory Ratios) are set out in paragraph 9.107 ff.

⁵⁵ See paragraphs 5.112, 5.156 and 9.63.

RECOMMENDATION 10

ATRA should require all its training regiments to identify the supervisory ratios it needs to train future generations of trainees in accordance with the effective duty of care principles outlined in this Report. Those ratios should be taken as the necessary minimum, in the absence of any subsequent comprehensive risk assessment to revise them.

The quality of instructors

- 12.65 The Review is aware that in 1995, and thereafter, a training posting was not seen as a particularly desirable one that would lead to the advancement of an instructor's career. Instructors who resent their posting could bring their resulting frustrations to bear on trainees and are unlikely to set the inspiring standards demanded.
- 12.66 The Army needs to ensure that changes in perception in this respect are permanent and that a successful tour of service in a training regiment is seen as a positive commendation to career progression. Training is a demanding function requiring patience, integrity, imagination and hard work. It requires instructors, themselves, to be trained in the requisite skills of handling the kind of young people they are likely to meet, so they can understand, inspire and motivate them.
- 12.67 The Adult Learning Inspectorate (ALI) have made this point in their report.⁵⁶ The Review is aware that this is the aim of the present Director General of Army Training and Recruiting. The budget to be allocated to the training organisation must ensure that this does not remain an aspiration.

RECOMMENDATION 11

Instructors must receive essential training in how they are to achieve the tasks they are to meet before they take up their post. A tour in a training regiment should be recognised as a difficult and demanding job, leading to enhanced career prospects.

- 12.68 In addition to the careful selection and training of instructors and supervisory staff, checks should be made to ensure that they are suitable people to work in close quarters day and night with young people.⁵⁷

RECOMMENDATION 12

Instructors should be vetted for their suitability to work with young people, applying standards that are no less rigorous than those applied to civilian establishments educating or training people under 18.

Information on standards of conduct

- 12.69 ATRA statements of policy as to the expected conduct of trainees and instructors alike should be revised and simplified. They should be issued to all recruits on enlistment and to all instructors, and members of staff, of training regiments before taking up their

⁵⁶ Adult Learning Inspectorate: 'Safer Training – Managing risks to the welfare of recruits in the British Armed Services', pp 25-26, March 2005.

⁵⁷ See paragraphs 4.37 and 4.45-47.

appointment. The Army style of inserting important statements of policy as Annexes to Appendices does not assist to ensure clarity and understanding. Important documents, such as the ATRA Handbook, should include a clear index of contents to assist those using it. Each statement of policy should be dated with a version number.

12.70 The Review understands that the documentation now in existence includes:

- (i) a booklet called 'Values and Standards of the British Army' that is issued to every recruit and trainee;
- (ii) the ATRA Code, a covenant with the Commanding Officer, that is issued to, explained to and signed by every recruit and trainee;⁵⁸
- (iii) a booklet called 'Basically Fair – Equality and Diversity in the British Army' that is issued to all recruits and trainees;
- (iv) the ATRA Code of Practice for Instructors that is issued only to instructors;⁵⁹ and
- (v) Guidance contained in the ATRA Handbook in relation to 'discipline', 'conduct and behaviour'⁶⁰ and 'relations between permanent staff and recruits under training'⁶¹ that sets out some useful examples of unacceptable conduct but is not issued to recruits and trainees.

12.71 Despite these various policy statements and guidance, it is apparent to the Review that many recruits remain unclear as to their content and the limits of what can be done to discipline them.⁶²

12.72 It should be clear what sanctions are available in respect of failures in the training context. It must be clear whether an instructor can order a trainee to do press-ups and, if so, how many can be required. It must be clear whether other sanctions, such as running around the square or pulling heavy weights and the like, can be awarded by a training instructor and, if so, what for. Trainees should be made aware of what behaviour the Army considers to be bullying or harassment and non-exhaustive examples should be given.

RECOMMENDATION 13

A single booklet should be issued to, and signed for by, recruits and trainees when introduced in the induction course. The contents of such a booklet should seek to explain concisely:

- (i) what is meant by bullying and harassment;**
- (ii) examples of the type of conduct that is considered inappropriate or unacceptable;**
- (iii) the nature and extent of acceptable sanctions that can be properly imposed and by whom;**
- (iv) that blanket punishments imposed on a group for the failings of an individual are unacceptable; and**
- (v) what a soldier should do if he or she witnesses a breach of these principles or has been a victim of bullying or harassment.**

⁵⁸ See paragraph 12.56 above.

⁵⁹ See paragraphs 4.83, 4.105 and 8.70 ff for references to the 1998 version of this Code of Practice.

⁶⁰ See paragraph 4.86.

⁶¹ See paragraphs 4.80-4.83.

⁶² For anecdotal evidence, see paragraph 4.110. See also paragraph 4.107.

- 12.73 Onerous duties that have to be undertaken by trainees should be fairly distributed to all eligible to undertake them.⁶³ If weekend leave previously awarded as a privilege is to be cancelled by way of penalty, this should only be as a result of a formal sanction of Restriction of Privileges awarded, following a fair hearing, by the Officer Commanding, or above, and formally recorded. The trainee should be made aware that NCOs have no authority to cancel such leave at the last minute as a penalty and that he or she can complain about any attempt to do so.⁶⁴ Equally, the assignment of guard duty should never be used as a punishment.
- 12.74 The grant of such leave may be subject to unforeseen emergency requirements, in which the urgent factor needs to be explained and the unit should endeavour to mitigate against the consequences, if at all possible.⁶⁵ The trainee must not be left with a sense of profound injustice with respect to a privilege that forms an important part of social life and a welcome relief from the rigours of the training regime.⁶⁶

RECOMMENDATION 14

Cancellation of weekend leave by an NCO is not a permissible informal punishment. This should be explained in the booklet issued to trainees.

Leave that has been granted should not be cancelled without good reason and the authority of the Officer Commanding. Good reason for cancellation should be explained to the trainee at the time.

The allocation of guard duty should never be used as a punishment.

- 12.75 Where these matters are spelt out in published codes and form the basis of mutual expectation between Commanding Officer, instructor, trainee and the family of a soldier, adherence to them should be reflected in unit standing orders or other procedures necessary to ensure that they are taken account of and consistently enforced.⁶⁷ The case of Sergeant BB discussed in Chapter 8 illustrates weaknesses in the application of the ATRA Code of Practice for Instructors in that case.⁶⁸

RECOMMENDATION 15

The standards set by the ATRA Code of Practice for Instructors should be enforced by formal disciplinary sanctions. Training regiments should adopt standing orders that require adherence to the Code of Practice to enable charges under the Army Act, or for breach of standing orders, to be brought. Breach of such standards should also be admissible evidence in a charge of 'ill-treatment' of subordinates.

⁶³ See paragraphs 6.122-123, footnote 41 in Chapter 6, footnote 86 in Chapter 10 and paragraph 10.32.

⁶⁴ See paragraph 12.25 above. Colonel Josling accepted in a meeting with Mr and Mrs James that trainees may have been unaware that NCOs had no right to cancel such leave unilaterally, see Appendix A4/8.020 F – 021 B.

⁶⁵ Leave should not be cancelled without compensation where the trainee has already incurred expense. The Regiment should be particularly concerned that trainees do not miss important one-off social functions such as weddings and funerals.

⁶⁶ See paragraph 5.153.

⁶⁷ See paragraphs 8.70 and 8.80-82.

⁶⁸ See paragraphs 8.70 to 8.74.

Collective responsibility

- 12.76 Soldiers should be instructed that any intimation of an intention to self-harm by a fellow soldier, however casual it may appear, should be taken seriously and reported to a responsible person immediately.⁶⁹

RECOMMENDATION 16

Every Officer, NCO, civilian instructor and trainee should be alert to both expressions of intention to self-harm, however trivial or jocular they may seem at the time, and to any breaches of standing orders designed to promote safety. Such matters must be reported through the chain of command, so prompt and effective action can be taken.

- 12.77 There should be a collective responsibility on the unit, at all levels, to deter unacceptable conduct and report it. It should not be left solely to the victim of bullying or harassment to make a complaint. Ill-treatment or harassment is unacceptable because it has occurred, not because the victim has the courage to complain about it.⁷⁰

RECOMMENDATION 17

Every Officer, NCO, civilian instructor and trainee should be alert to any sign of abuse and be required to report it through the chain of command, so prompt and effective action can be taken.

RECOMMENDATION 18

Failure to report any sign of abuse of power should itself be a matter for disciplinary sanction.

- 12.78 The Review encountered some difficulty, at both the local and national level, in identifying and recovering policy documents generated by the Army that were applicable to events in the past. In the inquest into the death of James Collinson, the Coroner noted that records of the assignment of weapons for guard duty had gone missing. There have been similar problems in the earlier cases. It is not merely documents of transient importance that do not appear to have been kept. In the course of this Report, there has been reference to policies relating to the age for guard duty, the retention of documents relating to discipline, the reporting of cases of self-harm to the RMP and such like. It appears to the Review that the Army may benefit from adopting orders to ensure that copies of former policy documents are retained and that, when policies are updated and revisions made, records are maintained so that the evolution of a policy, and the reasons for any change, can be ascertained. The development of a collective memory is an important aspect of collective accountability and ensuring that previous lessons learned are not readily forgotten. The question of the retention of documents in the context of disciplinary complaints is specifically addressed at Recommendation 25 below.

⁶⁹ See paragraphs 6.104, 9.27, 9.31-32 and 9.46. See also paragraphs 5.167, (including footnote 174), 6.98 ff and 10.129 ff in relation to such expressions of intention to self-harm prior to the deaths of Sean Benton, Cheryl James and Geoff Gray, respectively. In these cases, and in some of the evidence adduced at the inquest into James Collinson's death, such remarks were assumed to have been made in jest or jokingly and were, therefore, not taken seriously.

⁷⁰ See paragraphs 8.112 and 8.117.

RECOMMENDATION 19

There should be an instruction that:

- (i) policy documents be regularly reviewed in the light of experience;**
- (ii) previous versions of policies and instructions be kept centrally with a record of when and why changes were made; and**
- (iii) clear policies be established for the destruction or retention of classes of documents, the authority needed for destruction and the records needed to be kept of the fact of such destruction.**

Making and responding to complaints

- 12.79 The Review understands that the efficacy of a military unit depends on mutual trust between soldiers, including trust between Privates and their NCOs.⁷¹ Abuse of power destroys that trust. Detecting and deterring abuse of power by others enhances it. Thus, reporting such matters is an important aspect of the relationship between the trainee and the Army.
- 12.80 In a unit that is working well, the primary route for ventilation of grievances should, therefore, be the trainee's Corporal or other NCO with whom he or she has a close working relationship built on mutual confidence. This is one reason why appropriate supervisory ratios are so important in enabling strong bonds of awareness and understanding to be formed. But not all units will always work well. The chain of command should continue to be supplemented by trained Army Welfare Service and WRVS staff stationed at training regiments and elsewhere, who should raise questions of concern to the Commanding Officer of their own motion or encourage victims to do so.⁷² The principle of confidentiality does not prevent the staff of the Army Welfare Service or the WRVS from reporting concerns to the Commanding Officer, or providing information to an investigation, maintaining the anonymity of the victim if express consent is withheld.
- 12.81 As a matter of practicality, a trainee who is unable or unwilling to ventilate a grievance at such a level of provision, is unlikely to see an 'Empowered Officer' as more accessible and approachable.⁷³ In the opinion of the Review, this innovation is not, therefore, a sufficient response to the problem of the unwillingness to make complaints.
- 12.82 The Army should structure the complaints system on the premise that the events at Deepcut, and the matters noted in the 1995 and 2001/2 Duty of Care Schedules, show that significant numbers of trainees had apparently credible grievances they felt unable or unwilling to ventilate at the time.⁷⁴
- 12.83 The system of military complaints cannot depend on the efficiency of the individual Commanding Officer or the perception he or she creates that the chain of command is approachable and caring. The narrative of events connected with Sergeant BB outlined in Chapter 8 presents a substantial challenge to the present system, which has remained largely unchanged. First, there was the failure of other members of staff to bring unacceptable conduct witnessed by them to the attention of the Officer Commanding, or

⁷¹ See paragraph 9.32.

⁷² See paragraphs 8.46 and 8.105 ff.

⁷³ See House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol I, paragraphs 43 ff, 121, 149, 169 ff and 179 ff. See also Vol II, Ev 267. See also paragraphs 9.32 and 11.133.

⁷⁴ See paragraph 10.38.

the Commanding Officer.⁷⁵ Secondly, there was the issue of confidentiality where the alleged abuser was aware of visits to the Army Welfare Service, and to other members of staff.⁷⁶ Thirdly, there was the capacity of the person complained about to threaten, intimidate and deter complainants whilst still in post.⁷⁷ Fourthly, there was the risk that other trainees became complicit in the abusive conduct, tolerated it, denied its existence to investigators and retaliated against those who did report it.⁷⁸

RECOMMENDATION 20

The Army should convene a multi-disciplinary case conference of all the interested military agencies to examine the available papers relating to the case of Sergeant BB, with a view to developing a common approach to the detection and deterrence of abuse.

- 12.84 If such circumstances are tolerated or perceived to be the norm, it is unlikely that an internal regimental investigation, followed by an internal ventilation of complaints up the chain of command, will be seen as an attractive or practical instrument for dealing with complaints.
- 12.85 The effective resolution of credible complaints requires the system to: encourage early reporting; initiate thorough and prompt investigation, independent of the unit whose members are the subject of complaint; adopt interim measures to protect the complainant from retribution; and provide information to the complainant on the outcome of the investigation. If there are grounds for it, those in authority must take the necessary disciplinary (the equivalent of criminal sanctions in civilian life) and/or administrative (the equivalent of employment sanctions in civilian life) measures.⁷⁹ Commanding Officers must be trained as to when and how to remove from the unit, people who are the subject of investigation whose continued presence may impede the interests of justice.
- 12.86 Army instructions point out that administrative action should not be a substitute for disciplinary action where there is credible evidence of wrongdoing that breaches the Army Act.⁸⁰
- 12.87 However, the reverse is also true. A decision not to prosecute, an acquittal or, indeed, any outcome at a disciplinary hearing is not a substitute for separate consideration by the Commanding Officer of any necessary administrative action available to him. Criminal standards are not exhaustive of the duty of care owed in employment law and practice.

RECOMMENDATION 21

All reasonable steps should be taken to encourage early reporting of complaints against staff by ensuring:

- (i) there is a prompt and thorough investigation, independent of the unit whose members are the subject of complaint;**
- (ii) all suitable interim measures are taken to protect the complainant from retribution, including removal from the unit of the alleged perpetrator of the conduct complained;**

⁷⁵ See paragraphs 8.30-33.

⁷⁶ See paragraphs 8.38, 8.44 and 8.54.

⁷⁷ See paragraphs 8.50, 8.55 and 8.68.

⁷⁸ See paragraphs 8.28, 8.74 and 8.75 ff. See also paragraph 8.116.

⁷⁹ See paragraph 8.96 ff.

⁸⁰ See paragraph 8.96 ff for the difference between disciplinary and administrative action and for an explanation as to why use of one does not exclude use of the other. See also paragraphs 7.44, 7.72 and 8.115.

- (iii) information is supplied to the complainant on the outcome of the investigation; and**
- (iv) appropriate disciplinary and/or administrative action is taken.**

Investigating complaints

- 12.88 The Review accepts that the practical welfare of trainees and soldiers cannot be secured by inventing new external agencies to investigate and intervene to the detriment of the social cohesion of the unit. It would be both impractical and undesirable for all complaints about harassment and bullying to be investigated by the civilian police: many of these incidents concern offences purely under military law; many complaints can be sufficiently resolved at the administrative level; and incidents of harassment and bullying may take place overseas and, thus, outside the territorial jurisdiction of the civilian police.
- 12.89 The Review does not doubt that effective redress of complaints is possible within present arrangements, depending on the experience of the supervisory staff, the welfare staff, the Officer Commanding and the Commanding Officer in these matters, as well as the efficiency of the RMP in gathering all available evidence in the course of the investigation. The statements taken by the RMP in the events described in Chapter 8 show trainees are prepared to make complaints to the RMP if they can trust the independence and integrity of the investigators.
- 12.90 The Review has seen no evidence that the RMP are unwilling to investigate allegations against NCOs or officers, or are incapable of doing so. However, as the incidents described in Chapters 7 and 8 illustrate, a delay or failure to call in the RMP can compromise effective investigation and frustrate disciplinary proceedings.⁸¹ In the field of sexual harassment and bullying, as seen in Chapter 7, particular expertise may be needed to encourage victims to make full and frank disclosure and to ensure the pursuit of all lines of enquiry to assess the full extent of the perpetrator's conduct.

RECOMMENDATION 22

Complaints of mistreatment, bullying and harassment should be promptly assigned to the RMP to investigate and report on, so that appropriate disciplinary and/or administrative action can be taken.

- 12.91 The Review has noted that in the case of Leslie Skinner, opportunities to investigate the full scale of offending were missed and the full picture was only captured some years later by Surrey Police. It is likely that the greater experience of the civilian police in investigating sexual crimes against young people contributed to this outcome.⁸² The lessons for Commanding Officers have been noted at paragraphs 12.85 and 12.87 above.

RECOMMENDATION 23

RMP training should be kept under review to ensure that investigators are skilled in best practice in interviewing complainants, recording their accounts, pursuing lines of enquiry in investigations and that they are aware of the particular problems that may arise where the alleged perpetrator retaliates, or others turn, against a complainant.

⁸¹ See paragraphs 6.142-144, 6.156, 7.24 ff, 7.67, 8.14 ff and 11.138.

⁸² See paragraphs 7.33 and 7.39. See also paragraph 5.95.

12.92 The Review discussed the issue of bringing the RMP within the remit of inspection conducted by Her Majesty's Inspector of Constabulary (HMIC) with the Deputy Provost Marshal in August 2005.⁸³ It was pointed out that the legislative regime for military and civilian police is not identical, the RMP has its unique issues and challenges and that an informal system of civilian peer review is used in major investigations. However, it seems much of the work of the SIB branch of the RMP applies civilian techniques of investigation and the Review sees no reason why this branch of the RMP, at least, should not be subject to regular independent inspections and public reporting on a similar basis as the civil constabulary. The HMIC would be able to examine the efficiency of the SIB to determine whether it is properly resourced and using available best practice, and whether improvements could be made. Such independent oversight could be beneficial to the reputation and efficacy of the RMP. Such an inspection regime could also ensure that the current Protocol regarding primacy for the investigation of deaths is working effectively and consistently. The Review has become aware that, since its meeting in August 2005, the Provost Marshal (Army) has had recent discussions with the HMIC to reach informal agreement on inspection.⁸⁴ The Review welcomes such developments and hopes that they will lead to a more formal arrangement.

RECOMMENDATION 24

The RMP should be brought within the regime of inspection of Her Majesty's Inspectorate of Constabulary (HMIC) so that the consistent application of best practice in the investigation of crimes and complaints can be monitored. HMIC can determine whether the RMP is sufficiently well-resourced and appropriately trained to perform the functions assigned to it.

Record-keeping

12.93 The general issue of keeping and maintaining records of policies has been noted at paragraph 12.78 and Recommendation 19 above. Given the importance of transparency in the field of complaints and the delivery of a duty of care, it is important that there should be Army-wide instructions as to record-keeping relating to self-harm, bullying, harassment and other serious complaints. The records should indicate the action taken and the outcome.⁸⁵ Such records should be stored for a minimum period, to at least ensure that they are available in the event of civil action before the expiry of a limitation period of six years (the current limitation period for complaints of deliberate harm).

RECOMMENDATION 25

There should be a minimum standard for the recording of information in respect of complaints. Such records should specifically explain what disciplinary and/or administrative action was taken, with justification, and note the outcome. A decision not to take any action should also be recorded in the same way. Documentation should be retained for at least six years.

An Ombudsman for the Armed Forces?

12.94 The Review is aware that, since 1983, there has been a Defence Force Ombudsman in Australia, whose functions are now performed by the defence section of the Commonwealth Ombudsman. According to its annual report for 2003-4, it has three

⁸³ See Appendix A4/15.063 E-F.

⁸⁴ See the uncorrected transcript of oral evidence to the Armed Forces Bill Select Committee for 1st March 2006, Questions 551 to 557. It is to be noted that, at the time of printing of this Report, a corrected version of the evidence was not available.

⁸⁵ See paragraphs 7.38 and 9.50.

investigative staff in Canberra handling the more complex complaints received. It regularly meets with the Resolution Complaints Agency of the Department of Defence and the Inspector General of the Australian Defence Force to consider the nature of the complaints and the most effective means of resolving them.

- 12.95 Since 1998, Canada has had an Ombudsman, reporting directly to the Minister of National Defence, who investigates complaints and serves as a neutral third party on matters related to the Department of National Defence and the Canadian Forces. The 2004 Annual Report noted that the Ombudsman's office:

"... has been working with great success to alter a tradition of closed ranks defensiveness within the military, and to help replace it with a culture of openness, equity and self-improvement ... The entire point in having an Ombudsman is to increase openness and transparency, and to identify and deal with problems that affect the welfare of CF [Canadian Forces] members."

The report noted that of the 1,265 complaints received, 1,117 were resolved by brokering settlements through diplomacy, consensus building and investigation and moral suasion.

- 12.96 In its report following a year-long inquiry into the duty of care in initial training in the British Armed Forces, the House of Commons Defence Select Committee (HCDC) recommended that there be a Military Ombudsman with full investigative powers with respect to complaints and authority to make binding adjudications on them.⁸⁶ It did not believe that a Military Ombudsman or an external complaints mechanism would constitute an obstacle to the chain of command.

- 12.97 The Ministry of Defence's (MOD) response to the HCDC report was published in July 2005. It did not accept the case for an Ombudsman, but acknowledged that resolution of complaints was *"slow and may not always be perceived as accessible and fair."*⁸⁷ In the Armed Forces Bill, published in November 2005, the proposal is to make military justice tri-service, enhance the role of the prosecutor and replace the Army Prosecuting Authority (APA) with the new 'Director of Service Prosecutions'. These measures are intended to speed up further consideration of a complaint after it has been considered by a Commanding Officer. The Review understands that it is intended to introduce an independent lay element into the body that considers complaints at the final stage. There will also be an annual report on how the complaints investigation system is performing. Further information as to the workings of the scheme had not been set out at the time that this Report was being printed for more detailed comment to be made. The Review is aware that in December 2005 the HCDC, with a new chairperson, reaffirmed its call for an Ombudsman. It said:

*"The establishment of the service complaint panel may introduce, in limited circumstances, an independent voice in the consideration of complaints but we do not believe that is sufficient. We urge the Government to table amendments to strengthen the degree of independence in its proposals and to meet the requirements of the previous Defence Committee's recommendations. If it does not, we urge the Armed Forces Bill select committee to express a clear view on the inadequacy of the Bill as introduced and to amend the Bill accordingly."*⁸⁸

⁸⁶ House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol I, paragraphs 122-114. See paragraph 1.18 ff above for further details on the HCDC's inquiry.

⁸⁷ 'The Government's response to the House of Commons Defence Committee's third report of session 2004-5, on Duty of Care', paragraph 118.

⁸⁸ House of Commons Defence Select Committee: Armed Forces Bill – First Report of Session 2005-06, paragraph 11.

- 12.98 The details of the scheme may remain hidden in the legislative details,⁸⁹ however, this Review believes that the present proposals in the Armed Forces Bill do not go far enough to ensure independent supervision and review of the discipline and complaints system. There is a danger that an historic opportunity will be lost for the Armed Forces to obtain independent assistance to achieve the goals they have set themselves to ensure the welfare of trainees and soldiers is effectively addressed. The public concerns that lead to the establishment of this Review underline the need for the Armed Forces to regain, secure and maintain the confidence of individual soldiers, their families and the public in the fair and effective working of the system.⁹⁰ According to military personnel quoted in the press, as well as in conversation with this Review, these concerns have had an adverse impact on the recruitment of young people into the Army, although clearly other factors are also in play.⁹¹ The Review is aware that the parents of the recruits of today, and those of tomorrow, have understandable concerns as to how the welfare of their children is and will be protected in practice. Surrey Police's Fifth Report articulates those concerns, irrespective of the accuracy of the individual grievances contained in the Duty of Care Schedules.
- 12.99 It will be difficult for the Armed Forces to satisfy the public that they have nothing to hide in the running of their discipline and complaints system if there is a perception of unwillingness to accept meaningful independent oversight, which is increasingly seen as a necessary counterweight to the powers and prerogatives of military life.
- 12.100 For the Review, the establishment of the office of a 'Commissioner of Military Complaints' (or Armed Forces Ombudsman) is now an essential step in improving confidence, transparency and justice. The full role of such a Commissioner may require further reflection but, for the Review, it is essential that soldiers and their families have access to an established authority who understands the military and its ways of working, but stands outside of the chain of command, and beyond its influence, in order to ensure that best practice is adhered to.
- 12.101 The Review considers that at least four functions need to be assigned to the Commissioner:
- (i) The ability to receive unresolved complaints from soldiers, or their families, about specific allegations of conduct prejudicial to their welfare. If these have not previously been the subject of complaint to the relevant authorities, the Commissioner will want to consider why this is and whether there are compelling reasons why such a complaint could not be made.
 - (ii) The second function is the supervision of the investigation of complaints that have been made to the authorities or to the Commissioner. As noted above, the Review accepts that the relevant military investigation force will normally be investigating these matters, subject to existing protocols with the civilian police. The Commissioner will need to be satisfied that investigations have been thorough, fair and effective and should have the power to recommend further steps be taken where necessary and practicable.

⁸⁹ *Ibid*, paragraph 12 where it recommended: "that MoD publish the secondary legislation relating to the Armed Forces Bill, in draft if necessary, to inform the select committee's scrutiny of the Bill."

⁹⁰ The Armed Forces Bill Select Committee took evidence from Lynn Farr and others connected with the Deepcut and Beyond Campaign on 2nd March 2006, when calls were repeated for an Ombudsman with a primary investigative jurisdiction both here and abroad.

⁹¹ For a recent example see the G2 section of the Guardian, 2nd February 2006.

- (iii) The third function is supervising how the authorities respond to the complaint. Where appropriate, the Commissioner should be consulted on decisions as to whether to bring disciplinary action and/or institute formal administrative action, including where it is intended that no such action is to be taken.⁹² The Commissioner should be given the opportunity to tender advice at this stage. Where the Commissioner is not satisfied with the outcome, despite the advice tendered, the Commissioner could intervene in the hearing of the complaint at the next level of redress. In an important case, the Commissioner should be able to institute legal proceedings to set aside legally flawed decisions not to prosecute.⁹³
- (iv) Finally, the Commissioner should report annually, in public, to the Minister of State for the Armed Forces on issues relating to the welfare of all soldiers, based on the evolving practical experience, complaint surveys, a programme of visits and such other means as deemed necessary or desirable to keep abreast of developments.

12.102 The tasks discussed above are designed to promote the effective operation of existing military proceedings rather than to replace them with alternative investigators or decision makers. The object is to provide independent assurance that the procedures are working as effectively as they can and that systemic issues of concern are addressed.

12.103 The Review has informally discussed the possible role of such a Commissioner with Commanding Officers and others and has understood that there is no objection in principle, or practice, to such independent oversight of the system, nor concern that it will undermine military discipline. If the system is already working well, there will be little need for concern in the military hierarchy and the Commissioner's principal role will be reporting to the Minister to provide an independent audit. If the Commissioner's existence stimulates better use of the system, it enhances the objective set out in Recommendation 21 above.

12.104 The Review notes that some of the issues that led to its establishment, including the Surrey Police Duty of Care Schedules, could have been satisfactorily addressed by an independent Commissioner of Military Complaints, in whom parents and others could have had confidence, even when distrustful of the Armed Forces themselves. Such an office must be viewed as an opportunity for balanced and objective handling of unresolved complaints, and not be seen as a threat to the chain of command.

12.105 The establishment now of such an office presents the Armed Forces with an opportunity for the effective ventilation and resolution of some of those concerns whose resolution have fallen outside the scope of this Review but, nevertheless, still trouble former soldiers or their families.⁹⁴ It would also go some way towards restoring public confidence in the handling of complaints by the Armed Forces, and avoid past mistakes being repeated. The Review concludes that establishing an Armed Forces Ombudsman is the only effective means by which confidence can now be fully restored and public trust maintained in the future.

RECOMMENDATION 26

There should be established a Commissioner of Military Complaints (the Armed Forces Ombudsman) who should be a person independent of the three Services with at least the functions set out in paragraph 12.101 above.

⁹² This should include scrutiny of advice from the Army Prosecuting Authority or its successor (currently intended to be the Director of Service Prosecutions, see paragraph 12.97 above).

⁹³ See for example the challenge in the case of *R v DPP ex parte Manning* [2001] QB 330, discussed in paragraph 8.92. It may be impracticable to expect a complainant to take such action themselves if a serving soldier.

⁹⁴ That is to say anyone who wants to make a complaint of conduct unconnected with the four deaths at Deepcut.

Guard duty

- 12.106 The Review has already discussed the Army's policy on armed guard duty for young people in Chapter 11. The opportunity for self-harm afforded by unsupervised armed guard duty was the one clear common factor behind all four deaths at Deepcut with which this Review is concerned.⁹⁵ The task of learning lessons and preventing repetition, not just at Deepcut but elsewhere throughout the Armed Forces, requires a broad statement of general policy.
- 12.107 For the reasons discussed in Chapter 11, in addition to measures designed to identify those who are at risk of self-harm, of whatever age, and the present policy ensuring direct supervision of trainees, there should be a minimum age to conduct unsupervised armed guard duties.⁹⁶

RECOMMENDATION 27

- (i) **The performance of armed guard duty by a trainee of any age should be directly supervised by an NCO, experienced adult soldier or MPGS guard.**
- (ii) **To ensure that there is no unsupervised access to weapons, trainees under 18 should only perform guard duty (whether armed or unarmed) as part of training and when directly supervised by an NCO, experienced adult soldier or MPGS guard.**
- (iii) **The minimum age for trained soldiers in the field army to conduct unsupervised armed guard duty should be 18.**

Sudden deaths

- 12.108 The case for revision of the Casualty Notification Orders has been addressed by Fiona Murphy in her opinion commissioned by the Review (see Annex C to this Report).

RECOMMENDATION 28

There should be full and prompt disclosure of information to the nominated next of kin of the fact of, and the circumstances then known about, the death of any soldier. Trainees should be encouraged to nominate both parents as their next of kin.

RECOMMENDATION 29

After the death of a soldier, there should be appointed a military liaison officer, as well as a civilian police liaison officer. The military liaison officer should be the single point of contact to explain procedures for the funeral, the return of property of the deceased soldier and, where the RMP have primacy, the progress of the investigations.

⁹⁵ See in particular paragraph 11.102.

⁹⁶ *Ibid.* See also paragraphs 11.56-67.

12.109 The law relating to access to an inquest or equivalent public inquiry into every sudden death of a soldier, wherever the location of the death or the place of residence of the soldier's family, has been addressed in Chapter 2.⁹⁷ The following recommendations are accordingly made.

RECOMMENDATION 30

There should always be an inquest, or, in Scotland, a Fatal Accidents Inquiry, into a sudden death of a soldier, wherever the death has occurred.

12.110 The inquest or Fatal Accidents Inquiry (FAI) is the primary means whereby the state discharges its duties under the Human Rights Act to effectively investigate deaths. The participation of the family of the deceased in such inquiries is of general benefit in the interests of a thorough investigation whose outcome can be accepted by all. Such participation is assisted by the ability of the family to have experienced legal professionals to advise them whether there are reasons for concern, and how they can be properly addressed. It seems unfortunate that a family who is suffering the trauma of having lost a child in military service should also have to spend significant sums of money on legal fees to understand whether and, if so, how they should participate in an inquest. Since death in service is an inherent risk of military service, and an inquest or FAI is an inevitable outcome of such deaths (given Recommendation 30 above), in the opinion of the Review there is a good case for the Military Covenant to be interpreted as requiring the provision of reasonable assistance to families with respect to legal costs arising in such proceedings. Reasonable funds should be provided for the purpose of obtaining legal advice so that a family is not required to deplete its own resources to participate in such an inquest, or FAI, or required to seek discretionary funding from the civil legal aid authorities. As already noted, there is a mutual benefit to the Armed Forces and the family in having a prompt, full and effective inquest, or FAI, into such deaths. The participation of lawyers experienced in this area can promote this objective. Where the circumstances are such that representation is necessary at the inquest or FAI, it is invidious for the Army to be legally represented at such an inquest at public expense whilst the family is not.

RECOMMENDATION 31

As part of the Military Covenant with the soldier, the MOD should ensure that the family of a deceased soldier have access to legal advice and, where appropriate, legal representation prior to, and during, the inquest or FAI.

12.111 There is now extensive case law, reviewed in Chapter 2, on how, in certain cases, a family should be able to participate in official inquiries into a death. As noted, the inquest is the statutory means of inquiry into a death. In a recent Court of Appeal case,⁹⁸ the Court was concerned with a case of attempted suicide in a prison where, although serious injury was sustained, there was no death and, consequently, no inquest. It was held that the matters of public concern related to the events required a form of inquiry where relevant evidence could be tested in public, although not all of the inquiry need be held in public, and that it was not always necessary for the families to be able to cross-examine witnesses for themselves. Similar situations might arise in the Armed Forces where service personnel are injured but not killed. The Review understands that the form of inquiry likely to be adopted

⁹⁷ See in particular paragraphs 2.11 ff and 2.23. The Review uses 'sudden' to mean the circumstances set out in s.8(1)(a) and (b) of the Coroners Act 1988, i.e. a sudden, violent or unnatural death, see paragraph 2.3 above.

⁹⁸ *R (on the application of D) (a patient by his litigation friend the Official Solicitor) v Secretary of State for the Home Department* [2006] EWCA Civ 143. See also paragraph 2.70 above.

would be the Board of Inquiry (BOI) procedure, although at present this sits in private and the attendance of family members, and their ability to raise concerns for examination, is limited. In the opinion of the Review, families should have an opportunity to attend a BOI established to examine the circumstances surrounding the death or injury of their child in order to learn lessons, and be able to examine the evidence, where compelling reasons of national security or the like do not preclude it.⁹⁹ In cases where there has been no other form of inquiry held in public, the BOI procedure should be permitted to evolve to encompass a form of family participation consistent with human rights principles.

RECOMMENDATION 32

Where there is a Board of Inquiry (BOI):

- (i) The family of a deceased or injured soldier should be permitted to attend and be offered the opportunity to add information that may be relevant and otherwise participate as circumstances require.**
- (ii) The family should receive all statements and reports into the death that they indicate they would like to see, and should receive a copy of the BOI's final report.**
- (iii) Such participation and disclosure of information should only be restricted by particularly compelling public interest considerations. The privacy concerns of witnesses to such a procedure would not generally suffice to justify restriction of access and disclosure.**

Disclosure and confidentiality

12.112 The question of the need for disclosure of material gathered in the course of Surrey Police's investigations has been considered in Chapter 2,¹⁰⁰ and is dealt with fully in the opinion of Fiona Murphy.¹⁰¹ That opinion points out that, under contemporary practice for custodial deaths and police complaints investigations, full disclosure can be afforded, including access to the report of the investigating officer, save where a compelling public interest precludes it, weighing up the relevant harm likely to be caused by disclosure with the consequence of non-disclosure.

12.113 In the opinion of this Review, where statements are taken for the purpose of investigation into a death or a complaint, the person providing the information will be aware that the statement may be provided to an interested party in due course and there is unlikely to be any issue of confidentiality arising that would interfere with the normal process of disclosure. Where disclosure is given for the purpose of an inquest, there may be an implied undertaking only to use the statement for the purposes of that inquest, potentially enforceable in proceedings for contempt of court, to ensure that premature publicity is not given to the material. Current practice also appears to be that formal undertakings are no longer generally needed so as to preserve the material from improper use. Material that is used at an inquest, or other public proceedings, will enter the public domain and cease to have any confidentiality attached to it.

⁹⁹ The Review notes that the issue of family presence at a BOI was raised in evidence before the Armed Forces Bill Select Committee on 16th February 2006 and 1st March 2006. The Review does not believe that presence of family members will deter frank disclosure by witnesses. Witnesses will be aware that transcripts of their evidence are likely to be disclosed in any event.

¹⁰⁰ See paragraphs 2.38 and 2.52.

¹⁰¹ See Annex C, Section 16.

- 12.114 As noted in Chapter 1,¹⁰² the Review understands that the families of Sean Benton, Cheryl James and Geoff Gray have been extensively briefed by Surrey Police as to the results of their investigations since 2002, but have not been provided with copies of the underlying witness statements, or the investigating officer's report to the Coroner. This appears to be the result of a combination of circumstances. In particular, a more restrictive approach was adopted because no inquest was outstanding into those deaths. If an inquest had yet to be held, disclosure would have been required for the purpose of participation in the inquest and, where necessary, limits on onward disclosure or use could be implied or requested. The outstanding inquest into the death of James Collinson may also have led to greater caution in disclosing documents to the families of Sean Benton, Cheryl James and Geoff Gray, for fear of prejudicing the inquest by incidental reporting. The experience of extensive media reporting of the allegations with respect to Deepcut, and a consequential anxiety by witnesses not to have their statements disclosed to some interested parties and the media, led to express limits on disclosure being placed by those who had given witness statements when consulted by Surrey Police.¹⁰³
- 12.115 In any event, the absence of disclosure has been a source of concern and potential conflict between some of the families and Surrey Police. The Review regards the continued absence of disclosure unfortunate and an unnecessary source of tension. In a normal case, the opinions of witnesses as to whom their statements may be copied to would not be sought, and would not confine the interests of fairness and the ability of the family to participate in the investigation into the death. It is difficult to see that fundamentally different principles are involved where the family need access to the statements in order to participate in the inquest and where they need access to the statements and supporting material in order to decide whether they should apply to the Attorney General for a *fiat* to bring proceedings for a fresh inquest.
- 12.116 It may be that the fact that there were no proceedings outstanding, to which implied limits on further disclosure attach, made some difference, but the current practice suggests that quite informal understandings can be reached in correspondence as to the purpose of disclosure. In most future cases, the Review would expect informal agreement to be reached in such cases, applying the spirit of the practices and protocols referred to in Fiona Murphy's opinion.
- 12.117 Where the nature of the material is particularly sensitive, or has been the subject of prior undertakings, and where onward disclosure would have a potentially damaging impact on outstanding proceedings, there may be a case for more formal agreements to be reached. The Review is in no doubt, that an enforceable agreement can be reached in sufficiently clear terms to prevent onward disclosure. Whether such a formal agreement is necessary in an individual case is another matter. It has been suggested that disputes about disclosure in such circumstances could be resolved by the aggrieved party seeking judicial review of refusals to disclose for the purpose of examining whether there is a case to re-open the inquest. In a strong case the police could themselves approach the Attorney General for a *fiat* to quash an inquisition where a fresh inquest is needed. Whatever the position, in the opinion of this Review, the question of disclosure should be resolved by sensible arrangements without the need for adversarial litigation. It is unfortunate that these questions have not been resolved to date in the present cases.
- 12.118 If the only way of resolving an impasse in a historically controversial case were a formal undertaking pursuant to an agreement, then an example of such an agreement is identified in Annex D. The Review does not commend such an agreement as a routine

¹⁰² See paragraph 1.9.

¹⁰³ See paragraphs 1.10, 1.68 and 1.70.

solution. Its terms may well be considered onerous and such a formula should not be used to restrict disclosure to which the families otherwise have a right of access on less restrictive terms. The agreement has been drafted merely to indicate that legal practice can draw up effective and enforceable arrangements to prevent unnecessary use of material that may be confidential in the narrow sense of the terms discussed above.

The need for a public inquiry?

(i) Introduction

- 12.119 The Review finally addresses the question of whether the issues identified in this Report require a public inquiry into the deaths at Deepcut, taking into account the legal background and suggested criteria for such an inquiry set out in Chapter 2.¹⁰⁴
- 12.120 The Review is conscious of the unprecedented public attention and concern that the four deaths at Deepcut have generated since 2002. From time to time there have been reports in the press quoting soldiers or former soldiers recounting lurid suggestions of sexual misconduct, harassment and oppressive behaviour by trainees and NCOs at Deepcut and, indeed, elsewhere in other military establishments. Finding credible, consistent and first hand evidence of such allegations has been another matter. The Review publicly invited anyone with relevant information about the background circumstances into the events at Deepcut to make contact with it, whether in confidence or otherwise. Save as indicated in Chapter 1,¹⁰⁵ there has been no new information adding to what is known from the guardroom daily occurrence logs, the RMP investigations and the investigations conducted by Surrey Police.
- 12.121 This Review is not a detective investigation. It was not set up to duplicate the considerable resources expended over the past four years by Surrey Police. Its brief was to examine all “*available material*” and it has looked hard to find where such material may be available. In Chapter 1 of this Report, the Review explained its functions and methods of proceeding.¹⁰⁶ The Review is conscious that it is not a public inquiry. It has not heard evidence in public and it has not reached any conclusions of fact on the allegations summarised in Surrey Police’s Duty of Care Schedules, and noted in Part 2 of this Report (Chapters 5 to 10).
- 12.122 Since the death of James Collinson, there have been a significant number of investigations, reports and internal reviews. There have been the four Surrey Police reports into each of the deaths, seen by HM Coroner for Surrey and this Review. There has been the Learning Account established in 2002 between the Adjutant General and Surrey Police, that has resulted in a mass of activity.¹⁰⁷ Much of the product of the Learning Account is summarised in the MOD’s evidence to the HCDC and is available for public inspection.¹⁰⁸ There has been the report of the Directorate of Operational Capability noted in Chapter 11.¹⁰⁹ There has been the Deputy Adjutant General’s final report into the deaths at Deepcut, a copy of which is reproduced as Appendix 15 to this Report.¹¹⁰ There has been the Fifth Report by Surrey Police that called for a broader inquiry into aspects of the duty of care for military trainees generally, and which appears to have directly resulted in the

¹⁰⁴ See paragraphs 2.72-79.

¹⁰⁵ See paragraph 1.41. See also paragraphs 4.95-96.

¹⁰⁶ See paragraphs 1.34, 1.41 ff, 1.49 ff and 1.63 and 1.73.

¹⁰⁷ See paragraph 1.13 ff.

¹⁰⁸ See the House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev 254-367.

¹⁰⁹ See paragraph 11.130 ff.

¹¹⁰ See also paragraph 11.95 ff.

decision of the HCDC to set up its year-long inquiry into the duty of care in the Armed Forces.¹¹¹ The families of the four soldiers who died at Deepcut were amongst those who contributed to that inquiry in the form of written and oral evidence. While it was acknowledged that the HCDC's inquiry was prompted by the deaths at Deepcut, it was not intended to be a fact-finding inquiry into those deaths.¹¹² The very large quantity of evidence gathered and reviewed by the HCDC is, itself, an impressive testimony to the scale of public concern the four deaths have generated. There has also been the report of the Adult Learning Inspectorate, published in March 2005, which provides some significant experienced civilian oversight of the training regime, its achievements and the areas where improvement is needed.¹¹³

12.123 The Review has benefited from early meetings with each of the four families and communications from their solicitors. It has been able to arrange for two of the families to meet the Commanding Officer of the Training Regiment at Deepcut at the time of their child's death, in order to belatedly address any questions they wanted to pose. The agreed transcripts of these exchanges, and other meetings that the Review arranged, are reproduced by mutual consent in the Appendices to this Report.¹¹⁴ It is apparent from these meetings, and the written representations made by two of the families to the Review,¹¹⁵ that concerns about the immediate circumstances of the death of their child, concerns as to whether bullying or harassment played any part in the death, some continued unease about the scale and quality of some of Surrey Police's investigations and outstanding disclosure issues with respect to the product of those investigations predominate.

12.124 The Review is aware of some unresolved issues concerning the methodology or mindset of Surrey Police's investigations. These have been identified and considered in a report, commissioned by Surrey Police, written by Devon and Cornwall Police (the Devon and Cornwall Review).¹¹⁶ The Review is aware that certain relevant matters are presently under consideration by the Independent Police Complaints Commission (IPCC).¹¹⁷ The Review has met the lead officer of the Devon and Cornwall Review, as well as responsible members of the IPCC to discuss these matters. The precise conduct of the investigations by the civilian police is not within the constitutional remit of the Minister of State for the Armed Forces, and cannot, therefore, be a matter of recommendation by this Review, although, as noted in Chapter 3, the question of who investigates deaths on military land plainly is and has been addressed. However, the Review has noted that Surrey Police's investigations from 2002 onward have been thorough and exhaustive. It concludes that no new reliable evidence as to how the four trainees met their death is likely to be available.

¹¹¹ See paragraphs 1.15 ff and 1.18 ff.

¹¹² See the House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol I, paragraphs 118 ff and 441 ff. See also paragraph 1.18 ff above.

¹¹³ 'Safer Training – Managing risks to the welfare of recruits in the British armed services'. See paragraphs 1.62 and 11.112 above.

¹¹⁴ See Appendix 4. For the meeting between Mr and Mrs James and Colonel Josling and the Meeting between Mr and Mrs Gray and Colonel Laden see Appendices A4/8 and A4/11, respectively.

¹¹⁵ The Review asked the MOD to make funding arrangements to enable the legal representatives of the families to make written representations and direct the Review's mind to issues of outstanding concern. Mr and Mrs Gray and Mr and Mrs Collinson made such representations. Mr and Mrs James and Mr and Mrs Benton did not.

¹¹⁶ See paragraph 1.53.

¹¹⁷ See paragraph 1.59.

(ii) An inquiry into how each of the four trainees died?

- 12.125 This Review was established to examine the circumstances surrounding the four deaths at Deepcut, rather than to reach an adjudication on the deaths themselves. It was never intended to operate as a parallel inquest and it has been anxious not to interfere with, or prejudice, the inquest into the death of James Collinson. Nevertheless, in light of the concerns of the general public and the families, the Review has spent much time scrutinising the available material as to how Sean Benton, Cheryl James and Geoff Gray died, and it has reached conclusions as to how those deaths probably occurred in order to be able to look at the broader questions as to what factors may have contributed to them.
- 12.126 The open verdicts of the inquests into the deaths of Cheryl and Geoff mean that there has been no certainty, to the standards required by the criminal law, as to whether their deaths were self-inflicted. Suicide was the only alternative to an open verdict left to the Coroner, sitting without a jury, in those inquests, given the evidence then available and once accident had been considered and excluded.¹¹⁸ The Review has anxiously considered whether a public inquiry into any one of these deaths is likely to result in more information relating to them becoming available or greater certainty being reached. Despite the concerns expressed by some as to the nature of Surrey Police's investigations, the Review has felt able to reach the conclusions it has on the basis of the available material it has seen. It has no reason to believe that avenues of investigation are outstanding, or new relevant information relating to the deaths could now come to light. In particular, it considers it highly unlikely that Mr Swann will be able to provide material about the deaths of Sean Benton, Cheryl James and Geoff Gray that contradicts the expert scientific conclusions noted earlier.¹¹⁹
- 12.127 This leaves the families of Sean, Cheryl and Geoff in the unhappy position of not having seen the available material, to which this Review has had access, relating to their child's death that has come to light since the original inquests. The families are, therefore, unable to form their own judgement, by reference to that material, as to whether the Review's conclusions are the appropriate ones. This is one important reason underlying their call for a public inquiry.
- 12.128 In the opinion of the Review, however, the answer to this dilemma is that the families and their legal advisers should have access, on the principles discussed in paragraphs 12.112-118 above, to the product of the Surrey Police investigations into the respective deaths and the reports summarising their conclusions. The presumption should be for disclosure of the whole product of the investigations. If necessary, disclosure could be subject to such undertakings as to confidentiality and non-disclosure to the press or unconnected third parties as may be necessary to prevent misuse of the evidence. Some editing of names or personal information may be legitimate in accordance with the principles of public interest immunity. The implication of confidentiality arising from the general context in which a statement is made to the police is not, however, sufficient to limit or prevent disclosure to a properly interested party for a proper purpose. The Review notes the opinion of Fiona Murphy and the supporting material to which she refers.¹²⁰

¹¹⁸ See paragraphs 2.27-30.

¹¹⁹ See paragraphs 5.53 ff, 6.87 ff and 10.119 ff, respectively. See also paragraph 1.48, and Appendix 3 for the Review's correspondence with Mr Swann.

¹²⁰ See Annex C to this Report.

RECOMMENDATION 33

The Review recommends to Surrey Police that the families of Sean Benton, Cheryl James and Geoff Gray be provided with copies of the respective Surrey Police report, and supporting witness statements, into their child's death, solely for the purpose of considering whether an application should be made to the High Court to set aside the previous inquest into their child's death. Such disclosure may need to be subject to an agreement or undertaking by the families, and their legal advisers, as to disclosure to third parties and/or subject to editing of any highly confidential information to which public interest immunity may apply.

- 12.129 The proper purpose of such disclosure is to see whether any, or all, of the families of Sean Benton, Cheryl James and Geoff Gray would wish to apply to re-open the inquisitions into their child's death pursuant to s.13 of the Coroners Act 1988. For reasons discussed in Chapter 2, the Review is satisfied that any applicant would not need to demonstrate that a different verdict is likely to be returned, whether or not the criteria for family participation set out in the human rights case law apply to the first two deaths.¹²¹
- 12.130 For the Review, the similarity in circumstances between these four deaths are such that it would be grossly unfair for different levels of participation by the families in the inquests into the deaths to be justified by the happenstance of the date of each tragic event. Mr and Mrs Collinson have been able to participate, with the assistance of a solicitor and counsel, in an inquest with a jury lasting some 13 days that was infinitely broader in scope and more detailed and transparent in its pre-inquest disclosure process than has hitherto been the case for the previous three deaths. As discussed in Chapter 2, as Geoff Gray died after 2nd October 2000, Mr and Mrs Gray are clearly entitled to participate into an inquest meeting similar standards under the terms of the Human Rights Act.¹²² A great deal more information has come to light about the circumstances surrounding the deaths of Sean Benton and Cheryl James than was available to anyone in 1995. The families have been unable to explore this material for themselves and, as similarly discussed in Chapter 2, it may be that an application by them under s.13 of the Coroners Act will result in the setting aside of the original inquest and the granting of a fresh inquest applying current human rights principles.¹²³
- 12.131 It is not for this Review to decide whether there should be a fresh inquest in any, or all, of the three deaths discussed above. The existing inquests can only be set aside by a Court that is satisfied that sufficient reason is shown under the law as it stands. However, if the families want the opportunity provided by a fresh inquest to examine for themselves the product of the Surrey Police investigations, the Review believes it would be appropriate that they have it. It may well be that, on receipt of the material, consultation between the families, the police and others may identify some commonality of approach. In the opinion of this Review, a fresh inquest offers the best opportunity for a focused examination and, to the extent possible, closure of issues that remain of concern for the families.
- 12.132 Shortly before this Chapter of the Report went to press, the Review had the benefit of the jury's verdict in the inquest into the death of James Collinson. It has been provided with a copy of the Coroner's remarks at the conclusion of the inquest, and is aware of the comments made by the families and others. Of itself, the open verdict does not strengthen the case for a public inquiry. As with the three previous deaths, the only alternative verdicts were accident or suicide. The Review is aware that there was no evidence to suggest that

¹²¹ See paragraphs 2.37 ff and 2.60 ff.

¹²² See paragraph 2.41 ff.

¹²³ See paragraphs 2.34 ff, 2.54 ff and 2.63 ff.

James had been killed by others, and the broader question of harassment or bullying at Deepcut was not an issue because there was no evidence at all to suggest that such conduct caused, or contributed to, James's death. If there had been, the Review is confident, on the principles discussed in Chapter 2, that the jury would have heard about it. The Review is aware that the broader scope of an inquest, required by Article 2 of the European Convention on Human Rights (ECHR) was accepted by the Coroner to be applicable. Whether James may have been bullied and, if so, whether bullying contributed to his death would have been a prime question for consideration at the inquest if there was credible evidence to support such a proposition. There was not. If fresh evidence comes to light, or had wrongly not been brought to the Coroner's attention, then a fresh inquest may be a possibility for his family, as it is for the other three families.

- 12.133 The Review expresses no conclusions on James Collinson's death in light of the very full and recent public inquest into his death, and the procedural history of this Review noted in Chapter 1. The Review is aware that the Coroner, in accordance with the law as it stands, directed the jury to the high criminal standard of proof of 'satisfied beyond reasonable doubt' necessary before it could return a verdict of suicide.¹²⁴ As explained previously, a lack of satisfaction as to this issue does not make any other hypothesis more probable.¹²⁵ The Review is also aware that there was no suicide note or other written material to suggest an intention by James to take his own life and that, from what was known about him, he did not fall into a high risk within his age group.¹²⁶ However, neither the fact that there was no note,¹²⁷ nor the fact that James died six months after Geoff,¹²⁸ is a factor pointing away from the hypothesis of self-harm. In the opinion of the Review, there comes a point when further clarity as to the precise circumstances of the deaths is unlikely to be achieved.

(iii) A case for a broader public inquiry?

- 12.134 The Review now considers the case for a wider public inquiry, prompted by and focused on the events at Princess Royal Barracks, Deepcut but beyond the circumstances of the four individual deaths that could be addressed in a fresh inquest. No one has identified draft terms of reference for a public inquiry that go beyond those deaths but are not as broad as an inquiry into all non-combat deaths in the Armed Forces. The Review has already concluded that there is no evidence of collusion, cover up, breach of legal duty of care or any other failure to foresee or prevent any individual death. There is no evidence that any of the trainees were bullied to death. Following the investigations of Surrey Police, the Review does not accept that the absence of evidence of complaints of bullying from trainees is, itself, suspicious. There is no reason to believe that following the events of alleged abuse described in Chapter 8, any of the instructors at Deepcut were behaving in a similar way.

¹²⁴ See also paragraph 6.69 for the Coroner's self-direction at the end of the inquest into the death of Cheryl James.

¹²⁵ See paragraphs 2.29 and 6.70.

¹²⁶ The Review notes its conclusion at paragraph 9.34 that: "*In the opinion of the Review, being young, under or about 18, and living 24/7 within the disciplined regime of an institution such as the Army is, itself, a significant factor indicative of risk.*" See also paragraph 12.19 above.

¹²⁷ The Review refers to Part 2 of Dr Walton's research ('Correlates of Suicide', April 1997, see paragraph 9.7 in Chapter 9 above) that revealed suicide notes were left by 52% of those whose deaths she studied and were considered self-inflicted, but were "*hardly ever left by those aged under 20*".

¹²⁸ See the oral evidence of Professor Hawton, to the House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev73, Question 404, where he stated: "*Another important factor of which we have become increasingly aware of is that exposure to suicidal behaviour in other people may be very important; so exposure to suicidal behaviour, such as through a family suicide but also amongst an individual's peers. This can lead to clusters of suicidal acts which it is well recognised can occur in young people. We also know that there is good evidence that exposure to suicidal behaviour in the media may in certain circumstances also be a vulnerability factor. Then, crucially, there is the availability of methods for suicidal behaviour and awareness and knowledge of them and how to use them.*"

- 12.135 The Deepcut and Beyond Group have continued to demand a broad inquiry into a large number of deaths and allegations of ill-treatment in a wide variety of different circumstances, with no apparent common denominator.¹²⁹ No evidence was received by this Review from members of that group as to any particular issues of common danger that needed addressing. The Review is, of course, aware of the general concern of an alleged link between bullying and deaths on Army premises and between bullying and self-harm. The Review is confident that if any evidence of bullying or harassment was available in the case of a military death, the Coroner, or anyone else conducting an inquiry into the death, would bring it to light. It is for this reason that the Review has concluded that there must always be an inquest in such cases (see Recommendation 19 above). In the few non-Deepcut deaths that the Review has noted, there has been no credible evidence that bullying made a contribution to the deaths.¹³⁰
- 12.136 As for the deaths at Princess Royal Barracks, Deepcut, as already noted, there is no credible evidence that any of the four deaths considered was prompted by bullying or harassment. If there is no evidence that bullying or harassment by anybody caused or contributed to these deaths, the Review cannot recommend a public inquiry just in case some unforeseen evidence might conceivably emerge, despite the previous investigations noted earlier.
- 12.137 Of course, this is not to say that the Review is satisfied that there has never been bullying, harassment or abuse of power at Princess Royal Barracks, Deepcut from 1995 to 2002. Far from it, as noted at paragraph 12.24 above, the Review has seen credible evidence to this effect, including allegations that NCOs did abuse their authority. However, the Review has received no representations from those who gave statements to Surrey Police that a public inquiry should be held into the bullying or harassment they allege occurred.¹³¹ It appears that many of those who could give direct evidence have been anxious to move on in their lives and are unwilling to return to these events. In the case of unsubstantiated allegations of harassment unconnected with any death, irrespective of when the conduct was alleged to have occurred, there is no legal duty on the state to hold a public inquiry, by contrast with the requirements of Articles 2 and 3 of the ECHR.
- 12.138 If bullying, harassment or abuse of power has occurred at Deepcut or elsewhere, the Review is satisfied that the Army does not tolerate it. It is not necessary to have a public inquiry to establish that bullying is abhorrent or should not be encouraged or condoned. Where there is reason to believe that someone, whether a Private, an NCO or a commissioned officer, has behaved in an unacceptable way, the Review is satisfied that the Army has the means and the will to investigate and discipline that person, where it can establish, to the requisite degree of probability, that such behaviour has occurred. The Army cannot act, or be expected to act, if there is no basis to believe that someone has acted in an unacceptable way. The issues for the Review have, therefore, been: how is unacceptable behaviour defined; how is such unacceptability communicated to all soldiers; what can be done to ensure that there is a collective responsibility to stamp it out; and how can confidence in the investigatory system be improved. Accordingly, the Review has made the recommendations it has in this Chapter. The Review has also made its recommendations arising out of the evidence it has seen about other matters that may have contributed to low morale and unhappiness in military training.
- 12.139 The families of the four soldiers who died at Deepcut have suggested that a public inquiry is necessary to restore public confidence in the Army. In making his comments at the end of the inquest into the death of James Collinson, HM Coroner for Surrey has expressed the

¹²⁹ See paragraph 1.35 ff.

¹³⁰ See paragraphs 3.36 ff, 9.24 ff, 9.26 ff and 10.23 ff.

¹³¹ See paragraph 6.128. See also, for example, paragraph 6.151.

personal view that if such an inquiry were necessary to restore public confidence, then the Army would have nothing to fear from it. His remarks to this effect are worth quoting in full (with original emphasis), to avoid any misrepresentation by selection:

"I am sure that many of us have considerable respect for our armed forces and the tasks required of them and they deserve that these matters be addressed thoroughly and independently so that rumour and speculation can be met head on. It follows that we should encourage them to recruit, support and train the very best candidates and provide for their various needs. Those of us who saw the barracks at Deepcut have a better understanding of what it is all about, including the size and diversity of the place as well as the apparent enthusiasm of many of the recruits. James was one such recruit and by all accounts he was a keen and good soldier.

"Yet many of the matters or problems of which we have heard obliquely do need further examination or at least balanced public exposure.¹³² Thus my own personal view – and I emphasise that it is a personal view – is that the MoD should take whatever steps are necessary to restore public confidence in the recruitment and training of young soldiers whether at Deepcut or elsewhere. I personally believe that they should have nothing to fear from an inquiry held in public (if that is what is necessary) where the various issues (outside the direct causation of the deaths of James and others) can be explored in greater depth and where the MoD can demonstrate, as the jury, counsel and I had demonstrated to us in a very limited way on the Friday of the first week of this inquest, that there really is a lot of good in the system – it is not all bad, by any means – and that there are some who are desperately trying to preserve the good and build on it. I will be writing to the SoS for Defence accordingly."

12.140 It will be for the Minister of State for the Armed Forces, as a matter of political judgement, to decide whether the restoration of public confidence does require such a public inquiry in light of the matters revealed in this Report or any material arising from the inquest into the death of James Collinson. Certainly, this Review has concluded that, as a matter of legal obligation or practical necessity, it is not required.¹³³ Unless there is reason to believe that some evidence or some issue of public concern has been ignored or not brought to light, it is not a realistic option to recommend a public inquiry to demonstrate that there is nothing to hide. As noted previously,¹³⁴ in the opinion of the Review, there has to be some evidence raising an issue that can be expressed with some precision, before the test of public concern in the Inquiries Act 2005 is engaged. The Review has concluded at paragraph 12.22 above that, although the Army did not cause any of the deaths, there were institutional failures before December 2002 that left, unaddressed, potential sources of risk that may have contributed to the deaths.¹³⁵ In the inquest into James Collinson's death, the Coroner found evidence of a breach of a number of local standing orders in the events surrounding the death. These relate to a period before the Army made a proper response to all four deaths. In the opinion of the Review, breaches of standing orders during guard duty can best be effectively addressed by direct supervision of those undertaking this task. Better supervision by experienced personnel and the elimination of

¹³² The Coroner has informed the Review that the issues to which he referred were, generally, record-keeping, the issuing of weapons to persons under age and breaches of standing orders (see paragraphs 12.18 above, in relation to the Coroner's summing up, and 12.140 below).

¹³³ For a discussion of the criteria for a public inquiry, see paragraph 2.69 ff.

¹³⁴ See paragraphs 2.76-79.

¹³⁵ See Section 2 (Conclusions as to the circumstances surrounding the deaths) of this Chapter.

unsupervised guard duty by trainees at Deepcut, as a result of the Deputy Adjutant General's findings in his final report, mean that this Review is satisfied that these matters have been addressed. It is not aware of any other issues arising from these events that have not been addressed. If there were evidence that, since the implementation of new measures in 2003, the lives and welfare of young trainees continued to be put in jeopardy by inadequate training, supervision, supervisory ratios, abuse of power, official indifference to abuse or other factors creating a risk of harm, the Review would recommend a public inquiry.

- 12.141 It appears to the Review that one constituency that might have an interest in a public inquiry would be the Army itself, or its senior officers connected with these events or the formation of policy in response to them. The Army has not been able to address in detail the allegations in the Duty of Care Schedules for the reasons set out in Chapter 1.¹³⁶ It has not been party to a public inquiry about the events described in Chapters 7 and 8 of the Report. If senior officers consider the factual foundation for some of this Review's broader conclusions in this Chapter unstable and, therefore, the case for the recommendations made in it unconvincing, there may still be good reason for the kind of inquiry envisaged in Surrey Police's Fifth Report.
- 12.142 The Review has, however, devoted much of its time and resources to meeting senior Army officers in command during the period under review and those with responsibility for Army policy today. It has been concerned to ventilate their views and publish their responses to questions in the Appendices to this Report, notwithstanding the informal nature of the meetings and the understanding that nothing would be published without their consent.
- 12.143 The Review has been careful to avoid adjudication on disputed fact where the nature of the material precludes any such assessment, as is the case with the evidence behind the Duty of Care Schedules. The material quoted in this Report has been carefully selected as illustrating concerns that are not restricted to one individual and are made by those with no evident reason to misrepresent or distort the facts. As previously noted, at the least it suggests that a substantial number of soldiers, even if only a small percentage of those who passed through Phase 2 training in the years covered by these events, were unhappy and did not ventilate their grievance at the time. If the Army accepts that this is, or may well have been, the case, the Review sees little benefit in re-ventilating these issues. If the Army does not, then there may well still be an absence of consensus as to what may have happened, and what needs to be addressed for the future, that will undermine aspirations of closure and moving on.
- 12.144 With this proviso, and excluding the possibility of fresh inquests, on the basis of all the material available to it, the Review does not recommend that any further public inquiry into the immediate or broader circumstances surrounding these deaths is now called for.

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In the opinion of this Review, for the reasons set out above, a public inquiry into the immediate or broader circumstances surrounding these deaths is not necessary.

¹³⁶ See paragraph 1.22 ff.

Epilogue

- 12.145 The Review returns to the four young people whose photographs appear at the front of this Report. Their deaths are tragic. The untimely loss of their young lives to their families and loved ones shattering and painful still.
- 12.146 Although the possibility of sacrifice and death in service must be ever present in the life of a soldier, as recognised in the Military Covenant, each of these deaths seems so unnecessary as to compound the grief of those they left behind.
- 12.147 This Review adds its profound condolences to each of the families concerned. It acknowledges their long and determined endeavours to obtain answers to questions that still trouble them.
- 12.148 The Review is, nevertheless, convinced that their loss has not been without consequence. The deaths of these four young people have had profound impact on the Army as an institution and the thinking of its Generals. The training agency that oversaw their progress, the Commanders of the place where they died and the staff of the Regiment they served in have all engaged in deep reflection and have responded with a commitment to improve what can be done to promote the welfare of young soldiers.
- 12.149 It is not just those who perform heroic deeds on the field of battle who deserve to be remembered:

"They also serve who only stand and wait."

By their deaths, each of these young people have served to help protect others from harm and abuse. Their deaths will not be forgotten. Their lives have not been in vain.

Annex A

Annex A: The Review Team

Nicholas Blake QC

Julie Albrektsen

Darren Beck

Kaspar Nazeri

Annex B

Annex B: List of Meetings and Key Visits

The Review has benefited from meetings with a number of individuals during the course of its work, as well as visits to a number of Defence establishments. The meetings and key visits are detailed below. The Review is grateful for the valuable contribution made to its work by all concerned.

Meeting or Visit	Date	Location
Meeting between Nicholas Blake QC, Surrey Police, and Michael Burgess, HM Coroner (Surrey)	19th January 2005	Guildford
Meeting between Nicholas Blake QC, Mr & Mrs Gray, Mr Thanki (solicitor) and Julie Albrektsen	4th February 2005	London
Meeting between Nicholas Blake QC and members of the House of Commons Defence Select Committee, by invitation of Bruce George MP (Chair)	10th February 2005	London
Meeting between Nicholas Blake QC, Mr & Mrs James, Mr Bache (solicitor), John Staples (Office of Lembit Öpik MP), Julie Albrektsen and Darren Beck	17th February 2005	London
Meeting between Nicholas Blake QC, Mr & Mrs Collinson, Mr Thanki (solicitor) and Julie Albrektsen	18th February 2005	Glasgow
Meeting between Nicholas Blake QC, Mr & Mrs Langford, Mr McGregor, Ms Jones, Mrs Higgins (members of the Deepcut & Beyond Group) and Julie Albrektsen	2nd March 2005	London
Meeting between Nicholas Blake QC, Lembit Öpik MP, John Staples and Julie Albrektsen	3rd March 2005	London
Meeting between Nicholas Blake QC, Lieutenant Colonel Laden and Darren Beck	3rd March 2005	London
Visit by Nicholas Blake QC to the Adjutant General's Headquarters, including meetings with the Adjutant General, Lieutenant General Irwin, the Deputy Adjutant General, Major General Tyler, and HQ staff. Darren Beck in attendance	7th March 2005	Upavon
Visit by Nicholas Blake QC to Princess Royal Barracks, Deepcut, including meetings with the Commandant of the Defence College of Logistics, Brigadier Wallace, the Commanding Officer of 25 Training Support Regiment, Lieutenant Colonel Griggs, the Padre, the Empowered Officer, a WRVS representative, NCOs (including former trainees at Deepcut), former Deepcut instructors, and trainees currently undergoing Phase 2 training. Julie Albrektsen and Darren Beck in attendance	15th March 2005	Deepcut

Meeting or Visit	Date	Location
Meeting between Nicholas Blake QC, Mr & Mrs Gray and Julie Albrektsen	22nd March 2005	London
Meeting between Nicholas Blake QC, Mr & Mrs Benton and Julie Albrektsen	30th March 2005	Hastings
Meeting between Nicholas Blake QC, Lieutenant Colonel Kerce and Darren Beck	25th April 2005	London
Meeting of the Deepcut & Beyond Group; Nicholas Blake QC made a statement to the Group	7th June 2005	London
Meeting between Nicholas Blake QC, Mr & Mrs James, Mr Bache (solicitor), John Staples (Office of Lembit Öpik MP), and Julie Albrektsen. Darren Beck present for part of the meeting	15th June 2005	London
Meeting between Nicholas Blake QC, Lieutenant Colonel (Retired) Harding, Julie Albrektsen and Darren Beck	21st June 2005	London
Meeting between Brigadier (Retired) Evans, Nicholas Blake QC, Julie Albrektsen and Darren Beck	22nd June 2005	London
Meeting between with Nicholas Blake QC and the Deputy Chief of the Defence Staff (Personnel), Lieutenant General Palmer. Darren Beck and Julie Albrektsen in attendance	22nd June 2005	London
Visit by Nicholas Blake QC to ATR Bassingbourn, including meetings with the Commanding Officer, Lieutenant Colonel Richardson, his staff and current recruits. Darren Beck, Julie Albrektsen and Kaspar Nazeri in attendance	19 October 2005	Royston
Meeting between Nicholas Blake QC, Mr & Mrs Gray, their solicitor, Mr Thanki, Lieutenant Colonel Laden, Julie Albrektsen and Darren Beck	14th July 2005	London
Meeting between Brigadier (Retired) Dalby-Welsh, Nicholas Blake QC, Julie Albrektsen and Darren Beck	20th July 2005	London
Meeting between Nicholas Blake QC, Brigadier (Retired) Brown and Darren Beck	22nd July 2005	London
Meeting between Nicholas Blake QC, Colonel Josling, Darren Beck, Julie Albrektsen	2nd August 2005	London
Meeting between Nicholas Blake QC and Deputy Chief Constable Moore (Surrey Police)	24th August 2005	Guildford

Meeting or Visit	Date	Location
Visit by Nicholas Blake QC to the Adjutant General's Headquarters, including meetings with the Adjutant General, Lieutenant General Viggers, and members of his staff. Darren Beck in attendance	25th August 2005	Upavon
Meeting between Nicholas Blake QC, Lieutenant Colonel Govan, and Kaspar Nazeri	7th September 2005	London
Meeting between Nicholas Blake QC and Michael Burgess, HM Coroner (Surrey)	13th September 2005	Woking
Meeting between Nicholas Blake QC, Brigadier Elderton, Darren Beck, Julie Albrektsen and Kaspar Nazeri	23rd September 2005	London
Meeting between Kaspar Nazeri, Julie Albrektsen and [Lance Corporal(f) E]	11th October 2005	
Meeting between Nicholas Blake QC and the Deputy Chief of the Defence Staff (Personnel), Air Marshal Pocock. Darren Beck in attendance	12th October 2005	London
Meeting between Nicholas Blake QC, Lieutenant Colonel Strutt and Kaspar Nazeri	13th October 2005	London
Meeting between Nicholas Blake QC, Lieutenant Colonel England and Darren Beck	13th October 2005	London
Meeting between Nicholas Blake QC, Mr Milne, Darren Beck and Kaspar Nazeri	14th October 2005	London
Meeting between Nicholas Blake QC, Mr & Mrs Collinson, Julie Albrektsen and Darren Beck	17th October 2005	Glasgow
Visit by Nicholas Blake QC to the Army Personnel Centre, including meetings with the Military Secretary, Major General Cottam, and his staff. Darren Beck and Julie Albrektsen in attendance	18th October 2005	Glasgow
Visit by Nicholas Blake QC to the Army Foundation Harrogate College (Harrogate), including meetings with the Director General Army Training and Recruiting, Major General Graham, the Commanding Officer, Lieutenant Colonel Drakeley, College staff and current recruits. Darren Beck and Julie Albrektsen in attendance	19th July 2005	
Meeting between Nicholas Blake QC and the Minister of State for the Armed Forces, Rt Hon Adam Ingram MP. Darren Beck in attendance	20th October 2005	London

Meeting or Visit	Date	Location
Meeting between Nicholas Blake QC, Meg Hillier MP and Julie Albrechtsen	31st October 2005	London
Meeting between Nicholas Blake QC, Devon & Cornwall Police and Kaspar Nazeri	9th November 2005	London
Meeting between Nicholas Blake QC, Lieutenant Colonel Laden, Darren Beck and Kaspar Nazeri	10th November 2005	London
Meeting between Nicholas Blake QC, Major (Retired) Whattoff, Darren Beck and Kaspar Nazeri	18th November 2005	London
Meeting between Kaspar Nazeri, Darren Beck and [Regimental Sergeant-Major Z]	29th November 2005	
Meeting between Nicholas Blake QC, Major Ambrose, Darren Beck and Kaspar Nazeri	30th November 2005	London
Meeting between Nicholas Blake QC, Major Gascoigne, Darren Beck and Kaspar Nazeri	2nd December 2005	London
Meeting between Nicholas Blake QC, Major Skinsley, Darren Beck and Kaspar Nazeri	12th December 2005	London
Meeting between Nicholas Blake QC, Wolverhampton Mr & Mrs James, Colonel Josling, Darren Beck and Julie Albrechtsen	6th January 2006	
Meeting between Nicholas Blake QC, Chief Constable Quick and Deputy Chief Constable Moore of Surrey Police, Michael Smyth and Kaspar Nazeri	10th January 2006	Surrey
Telephone conference between Nicholas Blake QC and Major General (Retired) Charlton-Weedy	16th January 2006	

Annex C

Annex C: Fiona Murphy Opinion

INTRODUCTION

I have been asked to provide an opinion to assist the Review: to consider by reference to my experience of controversial death inquiries in general and custodial death inquiries in particular, the experience of the Deepcut families, relevant procedures, best practice in other fields of investigation and to offer information to the Review with regard to modern inquest practice.

This opinion has the following structure:

- A. Family Liaison: A consideration of the families' experience from the first notification of their loved one's death to the conclusion of the first investigations. This section includes an analysis of the Army's current first reporting procedures and consideration of lessons from the procedures adopted by other state agencies in respect of family liaison.
 - B. Investigation: A consideration of the investigations that have been undertaken by the police, the Coroner and Army in relation to the deaths at Deepcut (save for the death of James Collinson which has not yet proceeded to an inquest). This section includes consideration of revised Army procedures issued in September 2005, whether it is appropriate to draw an analogy with the requirements of custodial death inquiries and an analysis of current practice and procedure in custodial deaths investigations.
 - C. Inquests: A consideration of modern inquest practice and in particular the impact of the House of Lords decision in *R (Middleton) v. West Somerset Coroner* [2004] UKHL 10 (hereafter referred to as *Middleton*).
- Appendices: There are two appendices, the first itemises the documents considered for the purposes of preparing this opinion and the second sets out the professional experience of the author.

A. FAMILY LIAISON

1. Pre-amble

- 1.1. This section of the opinion considers liaison with the families of the deceased in the context of the following key stages:
 - First notification and identification procedures;
 - The funeral arrangements;
 - Initial civilian police investigations;
 - Army investigations; and
 - Subsequent civilian police investigations.

- 1.2. Arrangements for the return of the deceased's property are also considered in this context.
- 1.3. The families' experience of these matters has been set out in recent years in their evidence to the Defence Select Committee, their interviews with Devon and Cornwall Constabulary in 2004, from statements provided by the families on various dates in 2002 and 2004 and with the benefit of a submission of Mr and Mrs Gray to the Deepcut Review dated 9th December 2005.
- 1.4. This opinion does not endeavour to identify or resolve factual disputes between the families' accounts of their experience and those deposed to by others concerned in those events. It is considered appropriate for the purpose of this opinion to solely consider issues of best practice on the basis of the families' subjective experience and the consequences that have flowed from that experience.
- 1.5. Following the review of the families' experience, there is consideration of the Army's current policies and procedures and a review of the corresponding procedures, particularly in relation to family liaison, as followed by the civilian police in relation to controversial deaths and by those agencies that are charged with responsibility for the investigation of custodial deaths.

2. The Families' Experience

Sean Benton

- 2.1. Sean Benton's parents first became aware of his death when a Captain of the local Territorial Army arrived at their place of work. The Captain told Mr Benton, "I've got some bad news." He then told Mr Benton that Sean was dead. It was Mrs Benton's recollection that the information provided was that "Sean was found shot". Mr and Mrs Benton were informed on Friday 9th June 1995 at about 12 noon. They were not offered any information concerning the circumstances.
- 2.2. Later that day they received a telephone call from the Coroner's officer asking them if they would identify Sean's body in St Peter's Hospital, Chertsey. The family arrived at 4.50 or 4.55 pm. The Coroner's officer informed them that Sean had shot himself, Mr and Mrs Benton were then asked various questions by the coroner's officer. Their responses were deposed in a statement that was subsequently relied upon at the inquest.
- 2.3. Certain of Sean's personal effects were returned on the occasion of the identification and by the Coroner's officer including some money, his birth certificate, a phone card and stamps.
- 2.4. The following Monday, 12th June 1995, an officer from the Training Regiment Deepcut visited Mr and Mrs Benton. Mr and Mrs Benton were anxious for information concerning the circumstances of Sean's death. Such information as was provided was confused and unclear. The information the Bentons have now been provided by Surrey police is not consistent with information they were provided with by the Army at this stage. The Bentons do not recall any further contact with the Army other than at the funeral.
- 2.5. The Bentons were not informed of the nature and extent of investigations at the time of Sean's death. There had not been any civilian police inquiry so far as they were aware.

- 2.6. At Sean's funeral, one of his colleagues appeared anxious to share information with his parents but he was not permitted to do so. It was not until 2003 that this young soldier shared Sean's last words with them.
- 2.7. The Bentons did not have any contact from the Army after the initial notification of Sean's death. No-one spoke with them in connection with the circumstances. Similarly, there was no liaison with them in connection with the Board of Inquiry (hereafter 'BOI') and significant sections of the Inquiry report were redacted from the copy initially supplied to them although they received an un-redacted copy in 2003.
- 2.8. They continued to ask questions and seek information from Surrey police and others but ceased their endeavours after some two and a half years as they felt they were getting nowhere. However, with regard to the re-investigation by Surrey police which commenced in July 2002, Mrs Benton remarked "I do feel they did their best ... it was a long time [after our son's death]".

Cheryl James

- 2.9. On Monday 27th November 1995, Mrs James was at home alone when an Army officer and a police officer came to the door and asked if her husband was home. Mrs James explained that he was at work. She was informed that they could not tell her anything until her husband was present. The Army officer went to Mr James's place of work and the police officer stayed with Mrs James. Mrs James elicited from the police officer that her daughter was dead but he would not give her any information whatsoever until her husband was present. Mr James explained,

"During the time [the army officer] was away, Doreen went through possible ways Cheryl may have died and the policeman shook his head at the wrong ones ... Doreen was very upset that they could not tell her straight ... she had to wait over an hour until I came home... I was not aware she did not know anything, so the whole episode became confused and unnecessarily distressing."

- 2.10. It was also the case that the Army officer to whom responsibility to inform Cheryl's parents of her death had been delegated, was from the local barracks and he did not have any information other than that Cheryl had taken her own life. Mr and Mrs James gained information concerning the circumstances from the media rather than the Army.

Although informed of their daughter's death on Monday 27th November, they were not permitted to view Cheryl's remains until Friday 1st December. They were informed initially that there had been an accident but within a matter of hours, that she had committed suicide.

- 2.11. Mr and Mrs James explained that they would have liked to have buried some of Cheryl's personal possessions with her but the Army was not willing to release them in time for the funeral. A box of Cheryl's possessions was sent with a courier who did not know what he was delivering. Other possessions were not returned. Some letters written by Cheryl were also kept back. Mr and Mrs James were told that normally the intended recipients of the letters would be contacted but there was a letter addressed to Cheryl's grandparents and they had not been contacted. Mr and Mrs James were also informed that certain letters had been kept back because they might be upsetting. When the letters were eventually provided and in Mr James's words, "The only upsetting thing about the letters really was the fact that she didn't like the Army, she didn't like Deepcut."

- 2.12. There was no contact from civilian police during the initial investigation of their daughter's death. They were not allocated a police Family Liaison Officer. So far as the Army's investigation in relation to Cheryl's death was concerned, the investigation was undertaken very quickly without any input from the family, "It was all done and dusted and nice and tidy and all filed away... the only task they took upon themselves was to make a phone call to an Army barracks in Wrexham." Mrs James continued, "I suppose this gentleman from Wrexham would be called a liaison officer ... he came backwards and forwards and if we had any questions ... he perhaps would find out for us ... it was never first-hand information. So, it got very, very muddled."
- 2.13. Mr James remarked, "Nobody visited; no contact; no letters; no apologies; no concerns; no support; no nothing."
- 2.14. After the inquest, Mr James contacted the Army and asked questions. He learned that the investigation had been completed on 14th December 1995, that is, a week before the inquest and two weeks after the funeral. The military police had not spoken with Cheryl's family or friends.
- 2.15. In Mr James's words, "Nobody came to us in the course of that investigation and said, 'What do you think?' ... The entire investigation was around a circle of people in the Deepcut camp who'd known her for less than five months. And yet they decided that she'd taken her own life."
- 2.16. The James family were not informed that the BOI was taking place. The inquest concluded in December 1995 with an open verdict whereas the BOI concluded in January 1996 that Cheryl had committed suicide. They had not been asked to contribute to the BOI and had not even been informed of the outcome until some nine months after it had had taken place.
- 2.17. Mr James sent letters after the BOI seeking further information. He had found it difficult to achieve answers. Mr James persisted in these endeavours until about September 1997 when he concluded that he was achieving nothing.
- 2.18. Mr and Mrs James regretted that the Commanding Officer at the time of Cheryl's death had not contacted them personally.¹
- 2.19. At the end of July 2002 and after the police re-investigation had commenced, Mr and Mrs James unexpectedly received a briefing note from the Army which was defensive and asserted that there had not been a cover-up. Mr and Mrs James felt the timing was inappropriate, as the police re-investigation had barely started.
- 2.20. Mr and Mrs James were informed of the identity of the senior investigating officer and an individual who would act as a go-between between the investigation and the Army so that there would not be contact with Army officers seeking to persuade the re-investigation of their own version of events.
- 2.21. Mr and Mrs James appreciated the acknowledgement by the re-investigation that insufficient investigation had been undertaken at the time of Cheryl's death.

¹I am advised that through the auspices of the Deepcut Review, Colonel Josling has now met with Mr and Mrs James.

- 2.22. They subsequently had concerns as to the reinvestigation.²
- 2.23. In the family's view the investigation was now demonstrating a lack of impartiality, for example, only half a dozen statements (selected by the police) were given to the psychologist asked to prepare a profile of Cheryl.
- 2.24. Mr and Mrs James were minded to make a formal complaint concerning the meetings between Surrey Police and the Army. They were advised that if they were to do so the investigation would be closed down, handed to another force and started all over again.
- 2.25. In the event, the re-investigation appeared to conclude hastily in September 2002. At the time of writing, the family have not been provided with a copy of the Surrey police re-investigation report.

Geoff Gray

- 2.26. On Monday 17th September 2001 at 9.30 am, a female Captain and a chaplain from Deepcut came to Mr and Mrs Gray's home. Mrs Gray answered the door and she was asked to arrange for her husband to come home. Mrs Gray was alarmed and explained that she was Geoff's mother but they would not explain why they were there.
- 2.27. After Mr Gray had returned home, the chaplain explained that three shots had been heard at 1.15 am and Geoff had been found dead. The Captain stated, "It looks like he's took his own life".
- 2.28. Shortly thereafter, the Grays received a telephone call from the Adjutant at Deepcut who also stated that Geoff had committed suicide. Also, that day there was contact from the Coroner's officer who advised them that, "it looks like the lad turned the gun on himself." She did not advise the family of their entitlement to have an independent pathologist present at the post mortem which was to take place that day.
- 2.29. The following day the Army sent a car for the Grays to assist with the identification procedures.
- 2.30. The Gray family's experience in respect of initial civilian police investigations was similar to that of the Benton and James families. They had little contact with the civilian police prior to 2002.
- 2.31. There has not yet been a BOI in relation to the death of Geoff Gray.³
- 2.32. In common with the family of Cheryl James and Geoff Collinson, the Gray family received assurances from Surrey Police that neither the Army nor the MOD would be involved in the re-investigation commenced in 2002. However, they subsequently discovered that this was not the case.

² Mr and Mrs James recorded a complaint to Surrey police that they had been misled about the involvement of the MoD by the police officers concerned in the re-investigations of the deaths. Thames Valley Police investigated that complaint at the request of Surrey police. An Assistant Chief Constable of Surrey Police accepted that he had unintentionally misled Mr and Mrs James in this regard.

³ I am advised that Surrey police informed the Army in April 2002 that it would be inappropriate to proceed until Surrey police investigations were complete.

- 2.33. Family liaison officers were appointed to the 2002 investigation but they did not have available up to date and/or high quality information concerning the investigation.

James Collinson

- 2.34. On the morning of Sunday 23rd March 2002 a Major attended Mr Collinsons' home. He told Mr Collinson that James had died, "in a tragic accident." Mr Collinson asked how and the Major replied, "I don't know." The Major then informed him that James had been shot. There was a delay of some 11 hours between James's death and the notification. The Coroner's officer called Mr Collinson and took a statement over the phone. Mr Collinson found this strange and difficult.

The padre and a Captain from Deepcut arrived at Mrs Collinson's home shortly afterwards.

- 2.35. There was a delay before Mrs Collinson was permitted to view James's remains. Mrs Collinson was required to provide a statement to the Coroner's officer before identifying her son.

- 2.36. The condolence letter was inaccurate as to the time of James's death.

- 2.37. Mrs Collinson explained that James's belongings were returned by the Major who pushed two boxes into her hallway, shook her hand and left. In the words of Mrs Collinson, "It is very, very traumatic to have that dumped on your doorstep." The belongings were dirty and in disarray. There were a number of items missing and there has never been an explanation.

Mrs Collinson initiated contact with the civilian police which prompted a police officer to visit her almost three weeks after James had died.

- 2.38. A few days after the funeral Mr Collinson sought information from a Captain concerning the investigation. He stated, "What investigation? One body, one gun. Draw your own conclusions."

3. Themes

- 3.1. The themes that emerge from the families' experience may be summarised as follows:
- Mechanistic compliance with procedure in relation to informing the nominated next-of-kin;
 - Insensitivity;
 - Lack of early and good quality information concerning the circumstances of death;
 - Delay;
 - An appearance of secrecy and a concern to conceal information;
 - A lack of co-ordination between investigating and family liaison officers;
 - Lack of independence between those conducting investigations and those whose conduct may fall to be criticised; and
 - An absence of record keeping in respect of the management of information and property.

4. The Services Procedures

- 4.1. The "Joint Casualty & Compassionate Policy & Procedures" issued by the Ministry of Defence (hereafter 'MOD') and dated 11th July 2005 have been considered. The procedures that were operative at the relevant times have not been considered. The focus of comment will therefore not be upon any failure to comply with the current operational standards but rather upon any deficiency in the current policy and observations with regard to improvement.
- 4.2. The first point to note is that the document is extremely substantial. The list of contents alone runs to some 30 pages; however, there is no index. This document is unlikely to prove of use and value in the immediate exigencies of a fatality. The document has a series of appendices which offer advice of a more practical nature and in a more digestible form and no doubt difficulties associated with negotiating the document might be ameliorated by training and/or experience. The procedures identify speed and accuracy of reporting as of critical importance. However, there is a complexity of agencies and individuals involved in the initial reporting procedures, which in my opinion may not serve those critical objectives. There appears to be a vast array of agencies and individuals who may or will be concerned in the process. In my view, procedures appropriate for major wartime casualties (which may well necessitate the involvement of a large number of agencies) will not be appropriate for other types of casualty notification. Consideration should be given to separating the procedures and thereby simplifying them as appropriate. It is unclear why it is considered necessary for the entirety of this document to be marked "restricted."
- 4.3. Chapter 1 of the procedures require Service personnel to nominate an individual whom they wish to be notified if they are killed, missing, wounded, injured or ill. This individual is designated as the "Emergency Contact." Service personnel are also required to nominate someone as their "next-of-kin." The procedures appear to envisage that the next-of-kin will be a single individual although I am advised that the nomination forms themselves do contemplate more than one individual. At any rate, the drawing of a distinction between the Emergency Contact and the nominated next-of-kin adds an unnecessary level of complexity through out the procedures.
- 4.4. Under the current procedures, the Service takes responsibility for informing both the Emergency Contact and the nominated next-of-kin where different. The procedure states that the "next-of-kin" has "certain rights regarding funeral arrangements and inheritance (unless specifically excluded by a will). Consequently the MOD is obliged to inform the next-of-kin ... In the event of death it is generally the next-of-kin who will be the focus of the support and assistance provided by the MOD." In chapter 4 of these very lengthy procedures it is stated that, "the wishes of the casualty will be respected and the persons to be notified are those nominated by the casualty." At paragraph 0415, the Casualty Notification Officer (hereafter the 'CNO') is advised to establish with the Emergency Contact/next-of-kin whether there is anyone else who should be informed. Paragraph 0423 is also relevant and requires that the parents or legal guardians of casualties under 18 years of age should also be informed even where they are neither the Emergency Contact nor the next-of-kin.
- 4.5. In some respects the procedures appear to be based upon a misunderstanding of the relevant law and although revised in July 2005 are likely to lead to a replication of the distress that was occasioned to Mrs James and Mrs Gray as described at paragraphs 2.10 and 2.31 above respectively.

- 4.6. Pursuant to section 9 of the Administration of Estates Act 1925 and section 14 of the Law of Property (Miscellaneous Provisions) Act 1994 rights and entitlements with regard to inheritance and funeral arrangements vest with the executors appointed by the deceased's will or those entitled to the grant of letters of administration (where there is no will). The vesting of rights under intestacy are not complex (and are summarised in the Casualty Notification Form) but it is only necessary for current purposes to note that the parents of each of the young recruits who died at Deepcut appear to have been equally entitled under their child's intestacy and thus equally entitled with regard to, for example, the funeral arrangements. Rights and entitlements will often vest in more than one person. It is also important to emphasise that the nomination record initially made by the Service personnel will not necessarily inform the Services of the next-of-kin at the time of death.
- 4.7. In any event and in my view, deciding whom to inform about a death can not sensibly be approached by reference to the technicalities of inheritance law nor can the nominations by Services personnel be the sole determiner of who should be informed of a fatality.
- 4.8. In the policing context, officers have responsibilities to communicate with the 'family' of the deceased. The Association of Chief Police Officers (ACPO) Family Liaison Strategy makes clear that 'family' is a broad concept and includes partners, parents, siblings, children, guardians and others who have had a direct and close relationship with the deceased.
- 4.9. Police officers are relied upon to make sensible decisions about who to notify themselves and when to rely upon other family members. They are however trained to take account of cultural and/or lifestyle diversity. Where the family is large, officers encourage the nomination of an individual as a point of ongoing contact but the identity of this person "is a matter for the family to decide" with the officer's assistance.
- 4.10. In reality, this appears to be a sensible and practical approach which in my view should now be considered for adoption by the Services after appropriate liaison with the police to ensure that best policing practice is taken on board.
- 4.11. In order to address the imperatives of expeditious notification, it is sensible for Service personnel to be asked to nominate one or more individuals as 'emergency first point(s) of contact'. Having informed that individual or individuals as a matter of first priority, the CNO should, subject to the family's wishes, have responsibility for identifying others to be informed including, but not exclusively, those entitled under the deceased's will or intestacy.
- 4.12. Letters of condolence are acknowledged to be an important source of comfort in respect of Service deaths and are provided by a Minister of State (if the Service member has died in Service) or the Prime Minister (if the Service member has been killed in Service), a senior Service Representative, the Commanding Officer and the Joint Casualty and Compassionate Centre (JCCC). The letter from the JCCC also provides practical information.
- 4.13. It is noted in the context of the remarks above that letters of condolence appear to be addressed to the deceased's sole nominated next-of-kin. For the reasons stated above, this is not considered a sensible or practical approach. It is considered that the family might be invited to nominate a member or members to whom the letters should be addressed or alternatively the letters might be addressed simply to the family or loved ones of the deceased.

- 4.14. The procedures require the Casualty Notifying Officer (CNO) to complete a report following his initial visit and this is a sensible precaution. It is admirable that the procedures do emphasise throughout the importance of accuracy in the provision of information. However, the pro forma documents do not prompt the CNO to record the information that has been provided to the deceased's family in respect of the circumstances of the death. It is considered that accurate records of the information provided are essential so that any error in the information provided at that early stage will be readily apparent and can be corrected as further and better information emerges (see paragraph 5.12 below). It is recommended, therefore, that bereaved families should receive a copy of the CNO's report (which should contain a summary of the information provided) so that they might have an opportunity, after the immediate trauma of the notification, to consider and absorb the information provided.
- 4.15. The Protocol of September 2005 (see paragraph 11 below) envisages the provision of a 'short factual explanation ... of the known circumstances' at the time of first notification and cautions that 'extreme care must be taken not to offer any information beyond confirmed facts'. It is of course important to strive for accuracy but this imperative should not detract from the need to provide all available information to the bereaved as soon as practicable. The risks arising from the provision of information, which on subsequent investigation proves to be incomplete, or misleading, can be minimised by appropriate caveats, to the effect that the information is the best that is available at that time, and the provision of a formal record of the information provided.
- 4.16. In summary, the revised procedures fail to address the concerns that emerge from the families' experience in these cases with regard to first, the unnecessary presumption that a sole nominated next-of-kin should be informed of the death and secondly, the imperative of providing early information confirmed in writing.
- 4.17. Chapter 12 of the Services Procedures of 11 July 2005 concerns the disposal of effects. Annex B to Chapter 12 provides detailed guidance in respect of the disposal of effects in Army units.
- 4.18. In summary the relevant procedures contemplate:
- Arrangements to be co-ordinated by a Committee;
 - Care being taken in the collation of personal effects and the preparation of an inventory. The procedures state clearly that the inventory should not be provided to the next-of-kin;
 - Laundering as necessary; and
 - Despatch to the next-of-kin by road freight or post.
- 4.19. In light of the families' experiences and in my view, consideration should be given to amending the procedures to provide for the deceased's family's views to be sought as to whether they would wish to have sight of the prepared inventory. In contrast to the procedures relied upon in respect of custodial death there is no provision for records to be maintained in respect of the handing over of belongings and such a procedure would likely be of benefit in introducing clarity and ensuring that errors are identified and rectified. It is recommended that a procedure in this respect should be considered.
- 4.20. Given the continuing liaison between Army personnel and family members as contemplated elsewhere in the procedures, consideration should also be given to charging the Visiting Officer with responsibility for delivering the deceased's belongings in person, following a discussion with the bereaved family as to the most appropriate arrangements. Finally, on this topic, it is not clear whether the initial convening of a Committee to address

property matters contributed to delay in these cases, however, the necessity for this rather technical approach is queried.

- 4.21. Chapter 11 of the Services Procedures of 11 July 2005 which concerns funeral arrangements is silent on the topic of arrangements for the attendance of the deceased's colleagues at the funeral and no criticism is made. This is undoubtedly an appropriate area for the exercise of discretion. However, as is noted below (see for example, paragraph 5.7 below) the importance of an open and transparent approach in all dealings with bereaved families following a controversial death can not be overemphasised. Opportunities for the bereaved to speak with those who were in close contact with their loved ones can only serve to dispel concerns and/or inform the family's contribution to the investigative processes. Prison custodial death procedures (see for example paragraph 5.19 below) do emphasise the importance of the bereaved being afforded an opportunity to speak with individuals with knowledge of their loved one, independent of the state agency whose conduct may be called into question in the course of subsequent investigations.

5. Lessons from other agencies

- 5.1. The importance of effective family liaison throughout investigative death procedures has been recognised in a series of governmental and non governmental reports including, in particular, the Macpherson Report. Accordingly, effective procedures are now enshrined in the policies and guidance issued by agencies concerned with the bereaved and, in particular, those agencies that hold responsibility for liaison with the bereaved in the context of an investigation touching upon the circumstances of their loved one's death.
- 5.2. In Death Certification and Investigation in England, Wales and Northern Ireland, The Report of a Fundamental Review 2003 (Cm 5831) (Chairman: Tom Luce), these imperatives were emphasised in the context of sudden death of all types and explained,

"Once the family is told of the death they are likely to be deeply shocked and disorientated particularly if the death has been traumatic. They may not be receptive to or able to retain information. There may be communication difficulties between surviving family members." (Chapter 12, paragraph 16).

- 5.3. Given the particular difficulties experienced by families in the immediate aftermath of bereavement, the importance of written information that can be absorbed more fully in the days and weeks following the death should be addressed,

"Leaflets can help, though many of the families we have seen say that anything longer than a page or two may not have much impact. There are nevertheless good and relatively simple guides. The Department for Work and Pensions has a clear and comprehensive guide to the various administrative processes that bereaved families need to go through – registering the death, and dealing with pensions and estate matters for example. There is, too, a good short leaflet from the Home Office. Another valuable source of information and advice is "Sudden Death and the Coroner: Coroner's Post Mortem and Inquests" published by Victim's Voice." (Ibid, Chapter 12 paragraph 20)

- 5.4. It is for these reasons that it is recommended that the CNO's report, including a summary record of the events as they are known at that time, should be provided to bereaved families (see paragraph 4.14 above)

- 5.5. Beyond the initial notification procedures, family liaison is of importance not only in assisting the deceased's family with the trauma of bereavement but also in ensuring the investigation has the benefit of the family's perspective.
- 5.6. The Association of Chief Police Officers (ACPO) has developed a Family Liaison Strategy. This document was finalised in 2000 and offers a blueprint for effective, professional liaison with bereaved families in the context of a homicide investigation. The guidance makes plain that the model is intended to apply to cases where homicide is suspected rather than confirmed.
- 5.7. The ACPO guidance takes care to emphasise the central importance of high quality liaison:

"It is of paramount importance that families are treated appropriately, professionally, with respect and consideration given to their needs. This absolute principle must be reflected at all levels within police structures."

"One of the primary concerns of family members will be the need for information. The trauma of bereavement can be compounded by the frustration of not knowing the surrounding facts. The victim's family must be provided with the timely sharing of all possible information so far as the integrity of the investigation permits."

"The conduct of the first contact with the family is vital in laying the foundations for a successful partnership. At no time must a family be deliberately misled; contact must be honest and as far as possible open."

"Immediate appropriate information to the family concerning the death of the victim and explaining to the family what happens now in respect of the body e.g. the post mortem(s) and coroners' processes. The family should be informed of their right to have a representative present at the post mortem"; and

"Establishing from family members any immediate evidence, information or rumours, which they may be aware of, so that it can be passed directly to the Major Incident Room and SIO [Senior Investigating Officer] for urgent attention."

- 5.8. The Strategy acknowledges that professional family liaison is not only intended to assist the development of a relationship of trust and confidence between bereaved and investigator but to optimise the family's contribution to the investigation itself. Accordingly, ACPO has set the following four main objectives for family liaison:
- To provide care, support and information in a sensitive and compassionate manner to the family who are themselves victims of crime;
 - To ensure that family members are given information about support agencies and that referrals are made to Victim Support and other agencies in accordance with the family's wishes;
 - To gather evidence and information from the family in a manner which contributes to the investigation and preserves its integrity; and
 - To secure the confidence and trust of the family thereby enhancing their contribution to the investigation.
- 5.9. The strategy envisages that those sensibly defined objectives apply equally to circumstances where there is controversy as to whether the deceased met his/her death as a consequence of homicide or not. Further, the strategy acknowledges the importance of a dynamic and planned approach to family liaison which should be responsive to changes in the needs of the family, the lines of enquiry and the available intelligence.

- 5.10. With regard to the initial meeting with the family, ACPO emphasises the importance of a planned and professional approach. Action to be taken by family liaison officers in advance of the initial meeting include:
- Familiarising themselves with the enquiry;
 - Familiarising themselves with what information has been established concerning the family, including any known family composition or group dynamics, cultural or lifestyle considerations, religious beliefs or possible communication requirements in terms of language or disability;
 - Familiarising themselves with any available information and intelligence which could impact on the liaison role e.g. impact assessment document, community tension indicators, previous police involvement with the victim and/or family members;
 - Establishing the extent and nature of contact with the police since the time of the incident/death;
 - Establishing what information has been passed to the family, to whom and by whom; and
 - Establishing what information concerning the incident is already in the public domain.
- 5.11. Specific guidance with regard to the handling of this first meeting includes the handing of a letter to the family (“as far as possible personalised”) which should provide information including:
- Names and contact details of the senior investigating officer (SIO) and the family liaison officer (FLO);
 - A brief explanation of the roles of the SIO and FLO;
 - What the family can expect from the police, that is, honesty and integrity, support and a commitment to fully investigate and apprehend any perpetrators; and
 - An indication of willingness to learn from the family through the openness of feedback.
- 5.12. The ACPO approach envisages that this planned and strategic approach should continue throughout the investigative process. For example, the officer with investigative responsibility should record the family liaison strategy in his/her decision file including, “decisions and reasons affecting the level of release of information to the family; any requests made by the family that have not been acceded to and the reason for this action; any complaints made by the family and the SIOs action to progress and resolve the matters raised.” The merit of those requirements is that the decision making is therefore amenable to audit, supervision and thereby a level of appropriate accountability. The ACPO guidance reflects an appreciation of the importance of understanding the distinct roles of the officer(s) charged with investigative responsibility and the officer(s) charged with liaison responsibility, and emphasises that the investigating officer should also meet the bereaved family as soon as practicable.
- 5.13. Thus, the ACPO approach makes plain that family liaison initiatives can be no substitute for direct and regular contact from the investigating officer. The reasons for this are explained to include affording the investigating officers an opportunity, “to determine for themselves the relationship with the family and address any concerns or needs they may have, by actively encouraging them to comment on any family liaison or investigative issues,” and secondly because investigating officers, “will have the opportunity, at the appropriate time, to receive feedback from families to allow for strategic dissemination of lessons learnt in terms of both good and bad practice”.

- 5.14. The guidance emphasises the risks associated with indirect communication and the responsibility that rests with the investigators to ensure that communication barriers are overcome. In the event of communication, breakdown strategies to address those difficulties including lay involvement and working with intermediaries are proposed.
- 5.15. The guidance appreciates that effective family liaison cannot be achieved through good will alone. Thus, the necessity of systems and procedures to facilitate family liaison officers is identified and in this context, the importance of supervision and scrutiny is acknowledged.
- 5.16. The responsibilities that now rest with the Independent Police Complaints Commission (hereafter the 'IPCC') with regard to the investigation of deaths in police custody are discussed below at paragraph 14. Those who have lost a loved one in police custody now have a legitimate expectation that they will be consulted and kept informed at each stage of the investigation and receive prompt and comprehensive disclosure of documentation.
- 5.17. The role of the Prisons and Probations Ombudsman (PPO) in investigating deaths in prison is discussed at paragraph 15 below. Effective family liaison is at the very centre of those investigative procedures and there is particular acknowledgement of the benefits that will be derived to the investigation from effective communication with the deceased's family.
- 5.18. Additionally and notwithstanding the investigative role now discharged by the PPO, the Prison Service retains a role in family liaison that is discharged in co-operation with the PPO. This twin approach mirrors the current Protocol for investigation of deaths on MoD premises (see paragraph 11 below). In the prison context, however, detailed and public guidance is available in the form of Prison Service Order (PSO 2710) as to how that responsibility will be discharged. PSO 2710 sets out mandatory requirements, practical advice and guidance based on good practice in family liaison. The key elements are that:
- Governors must have in place a local protocol explaining the support to be offered to a family bereaved by a death in custody;
 - Arrangements must be in place to ensure prompt notification to the next-of-kin (and any other person reasonably nominated by the prisoner) in a suitable manner giving an accurate factual account of what has happened. Governors are encouraged to appoint a dedicated family liaison officer, who can be trained and prepared for deployment when required;
 - A senior member of staff or a dedicated family liaison officer (and a deputy to cover absences) should become the named point of contact for the family, to make and maintain contact with the family, beyond the inquest if necessary, and to provide information and practical support;
 - A letter of condolence will be sent to the family who will be invited to visit the establishment; and
 - When the police so authorise, personal possessions and monies will be handed over promptly in accordance with detailed guidance, a list of items handed over is maintained, and a receipt obtained.
- 5.19. Prison Service procedures expressly envisage the family being afforded an early opportunity to visit the location of their loved one's death (similar arrangements are made in police custodial death inquiries) and an opportunity provided to meet with staff and prisoners. In practice, such visits frequently occur at an early stage and afford an opportunity for families to obtain timely information from those with direct knowledge of the events.

- 5.20. The NHS complaint procedures provide for those aggrieved by NHS treatment to have access to independent advocacy and assistance to facilitate liaison between the NHS and the complainant. The Independent Complaints Advocacy Service (ICAS) set up by the Department of Health, “will offer one-to-one contact with an advocate/caseworker within three weeks of a client’s request and within that timeframe will prioritise clients who have an urgent deadline they need to meet as part of the NHS complaints procedure.”⁴
- 5.21. ICAS lists its core principles in its annual report 2003/4. The first is cited as “*empowerment* – ICAS empowers people by providing them with information and guidance, enabling clients to decide whether they wish to pursue a complaint about the NHS and, where needed, for an advocate to support them in doing so.”
- 5.22. In the context of work related deaths, the Health and Safety Executive has also developed policy in relation to the disclosure of information to the relatives of people killed through work activities.

“[HSE Inspectors called upon to investigate a fatality are required] to ensure that early contact with the bereaved family is made in every case; to meet the bereaved as soon as they wish; to explain our role and responsibilities; and to issue the bereaved families leaflet pack to them. Inspectors should also keep relatives informed of the progress and outcome of the investigation.”⁵

“There may also be a need for further contacts to keep the family informed of developments. The structure of the initial visit could be used as appropriate for this and any other meeting. The family should be advised that they could expect to be contacted by HSE about the progress of the investigation no later than 2 months from commencement of the investigation. They should be told that they will always be informed of the outcome of the investigation.”⁶

- 5.23. It has long been recognised that individuals who assume responsibility for liaison with the bereaved cannot simply rely on innate ability to approach the task sensitively. The consequences of poor liaison can be catastrophic not only for the relationship between the state agency and the bereaved but for the efficacy and quality of the investigation itself. Thus, training to a high standard is of central importance to an effective family liaison strategy.

6. Conclusions

- 6.1 The deaths at Deepcut took place within the confined circumstances of an Army barracks. There appears to have been a significant lack of information sharing at the crucial early stages of the investigations concerning these deaths. The manner in which these families were informed of the deaths and the treatment they received from officialdom at that stage, established an atmosphere of mistrust which has thwarted the families’ ability to interact with the process throughout.
- 6.2. A rigorous approach to family liaison, consistent with best practice in the examples provided above, could have achieved a great deal in developing the trust and confidence of the families.
- 6.3. The September 2005 Protocol for the investigation of deaths on MoD premises (see

⁴The First Year of ICAS, 1 September 2003 -31 August 2004, page 5.

⁵Operational Minute 2002/05, paragraph 3.

⁶*Ibid*, Paragraph 18.

paragraph 11 below) places with the civilian police the primary responsibility for family liaison, among other matters. Those responsibilities should now be discharged by the civilian police to the high standards of the ACPO guidelines. However, an important role will remain with the Services who will have particular responsibility in the early stages of the investigation in sharing prompt and high quality information with the bereaved. In the development of Standard Operating Procedures further to the Protocol, it will be of importance to ensure that standards are maintained in liaison through training and transparent record keeping.

B. INVESTIGATION

7. Pre-amble

- 7.1. This section of the opinion considers the investigations undertaken in relation to the deaths at Deepcut in the context of:
- Police investigations;
 - The inquests; and
 - Boards of Inquiry.
- 7.2. The families' experience is summarised as before from their evidence to the Defence Select Committee, their interviews with Devon and Cornwall Constabulary in 2004, from statements provided by the families on various dates in 2002 and 2004 and with the benefit of a submission of Mr and Mrs Gray to the Deepcut Review dated 9 December 2005.
- 7.3. The particular procedures with regard to Boards of Inquiry are considered. Thereafter there is a consideration as to the suitability of drawing an analogy with custodial death investigations and an explanation of the modern practice and procedure in custodial deaths investigations by reference to the standards of investigation and bereaved families' entitlement to disclosure.

8. The Families' Experience

- 8.1. Prior to their inquests, there had not been any investigation by civilian police in relation to the deaths of Sean Benton, Cheryl James or Geoff Gray. The inquests therefore relied upon investigations conducted by the Royal Military Police (hereafter the 'RMP'). Following the inquests concerning Sean Benton and Cheryl James, Boards of Inquiry took place. The BOI in respect of Geoff Gray has yet to take place. The inquest touching upon the death of James Collinson has not yet taken place. Alone of the deaths, the civilian police took primacy in relation to the investigation of James Collinson's death.
- 8.2. The question of primacy in the investigations and the narrow scope of the inquests in each of three deaths are the subject of comment by Mr. Blake.
- 8.3. It is the case that the Army BOI did not involve the families and they only received copies of the conclusions, some time after the BOIs had happened, and then only in an edited state.

9. Themes

- 9.1. The themes that emerge from the families' experience may be summarised as follows:
- No or insufficient information was provided to the families with regard to the role of legal representation before an inquest;
 - The inquests proceeded on the basis of information collated solely by the state agency whose responsibility for the death fell to be examined;
 - The families felt excluded from the investigative process. Their participation was not sought. In relation to the Boards of Inquiry they were directly and intentionally excluded;

- There was a lack of full, timely and complete disclosure. The families were not provided with contemporaneous records that may have been of assistance in resolving factual conflicts. It is unclear whether the Coroner had access to all such contemporaneous records;
 - The inquests proceeded with such speed after the first two deaths that a question mark must arise as to whether there was sufficient opportunity to collate and reflect upon the available evidence;
 - The evidence of family members was shaped by statements that they were required to give at an exceptionally early stage in the process and in ignorance of the purpose for which their account was sought;
 - The inquests proceeded in ignorance of information that subsequently came to light;
 - The inquests did not have the benefit of expert ballistic evidence;
 - The inquests left a number of questions unresolved;
 - The investigations did not permit an open and accountable process by which systemic failings which may have contributed to the deaths might be identified;
 - The inquests did not explore issues of procedure and policy;
 - The deaths were considered in isolation from one another without an overview of the systemic factors that may have contributed to the pattern of deaths;
 - The inquests did not consider the findings of previous inquests, the recommendations of previous Boards of Inquiry or the review conducted by Brigadier Evans of Phase 2 training; and
 - The families of Sean Benton and Cheryl James did not participate in such exploration of systemic issues as was undertaken by the Army independently of the coronial process.
- 9.2. Apologies have been extended to the families in respect of the shortcomings of the original investigations and it is accepted that civilian police should have retained primacy.

10. The Services Procedures

- 10.1. The BOI process is enshrined in the Army Act 1955. It is a wholly internal, domestic investigation. Annexe A to Chapter 5 of the Queens Regulation (hereafter “the Annexe”) sets out the administrative instructions in respect of BOIs. The remit of a BOI in such circumstances is:

“To address itself in particular to the following and, if possible, to adduce and record evidence thereon:

- Whether any lack of training or supervision, which should be rectified, was a contributory factor;
- Whether the deceased was on authorised leave of absence at the time death occurred;
- The medical cause of death as shown in the death certificate or as given in evidence;
- The circumstance which was instrumental in bringing about the death, e.g. a traffic accident, drowning or a fire; and
- Whether the death was linked to any procedural or equipment faults or any other military failings that may require rectification to avoid a recurrence.”

- 10.2. With regard to the report but not the record of proceedings, it is envisaged that disclosure to the bereaved will be forthcoming, "The board of inquiry report must be made available to the next-of-kin on request, subject to the minimum security and/or disclosure requirements." (Paragraph 15(a)(6))
- 10.3. However, the procedures prevent effective participation by the deceased's family. Neither the public nor family members are permitted to be present at the Inquiry proceedings. There is no provision for consultation with regard to the terms of reference and the record of the proceedings remains confidential.
- 10.4. In relation to composition, "A board of inquiry is, where practicable, to be composed of Service personnel or a majority of Service personnel particularly where the report or opinions on questions of fact may lead to disciplinary action against, or financial consequences for, persons subject to military law." (Paragraphs 35-36).
- 10.5. The conclusions of the board are narrowly circumscribed, "Boards of inquiry reports (and any subsequent reports), and any subsequent comments by the Authority or his superior commander are not explicitly to attribute blame or negligence." (Paragraph 15 (a) (5)).
- 10.6. Similarly with regard to recommendations, "If so required by the authority an inquiry is to record the steps which have been taken or should be undertaken to prevent a recurrence of the matter and to make any recommendations it thinks fit to this end, but is to refrain absolutely from making recommendations regarding disciplinary action." (Paragraph 64 of the Annexe)
- 10.7. It is clear that the systemic issues to be addressed by BOIs are of concern to bereaved families and there seems little value or purpose in excluding the bereaved from the process. Indeed, in my opinion, the quality and value of those inquiries would have been significantly enhanced by the effective participation of the families. The inquests in relation to the first three deaths proceeded prior to the House of Lords clarification in *Middleton* that one of the primary purposes of an inquest should be the identification of systemic failings that may have contributed to the death. As such, the BOIs and not the inquests were the only process by which the identification of systemic issues was capable of being achieved. However, without the effective participation of the families the Boards were an inadequate vehicle for the identification of those lessons. Moreover, the BOIs investigation of systemic issues proceeded after the corresponding inquest with the consequence that the inquests were not informed by that investigation.
- 10.8. The inter-relationship between investigative processes capable of establishing the immediate facts surrounding a death and learning the lessons arising from any systemic default is considered below at paragraph 11.5 and for example, at paragraph 14.3. It is noted here, however, that there appears to be a total absence of independent oversight to the Army's processes in this regard.
- 10.9. The Coroner's investigation of the narrow question of how the deceased recruits came by their deaths has to date been examined in isolation from the Army's examination of the systemic issues that may have contributed to those deaths. The latter investigation has proceeded without any direct involvement of the family and without any element of independent oversight or public scrutiny. In the custodial death context, those investigations are now considered together and in the context of a post-Middleton type inquest.

11. Revised MOD Procedures

- 11.1. In September 2005 the MOD published an agreed protocol for the investigation of deaths on land or premises owned, occupied or under the control of the MOD.
- 11.2. The key features of the Protocol are:
- Primacy for conducting the investigation of all deaths will now rest with the Chief Officer of Police under whose jurisdiction the death occurs;
 - Primacy in this context includes responsibility for the preparation of case papers for the coroner and the Crown Prosecution Service;
 - The police will liaise, in appropriate circumstances, with the Health and Safety Executive;
 - Arrangements for liaison between Army and police personnel;
 - Arrangements for investigating police officers to have unfettered access to all information and material subject to legal advice in respect of disclosure which has the potential to undermine security or prejudice national interests;
 - Police investigating officers will be able to utilise MOD expertise to assist the investigation;
 - The MOD will retain responsibility for the 'pastoral' aspect of family liaison and the police will have responsibility for engaging the family in the investigative process. Consideration will be given to the joint deployment of a military 'visiting officer' and a police 'family liaison officer';
 - The MOD will take responsibility for initial scene preservation pending arrival of the civilian police;
 - The MOD will also retain responsibility for the implementation of first reporting procedures;
 - Boards of Inquiry (BOI) (to establish the facts, to make recommendations on actions to prevent a recurrence and to inform any decision about whether other action, such as administrative or disciplinary action, should be initiated in respect of any individual) should be convened within 48 hours of the incident and concurrently a Learning Account (to identify immediate lessons to prevent a recurrence) will report within 24 hours; and
 - The civilian police will have primacy in deciding whether a BOI can continue and whether it should be adjourned to avoid impeding or tainting the police investigation.
- 11.3. The Protocol envisages that Standard Operating Procedures will be devised by the participants.
- 11.4. Clearly, the clarification of police primacy in relation to the investigation of the factual circumstances surrounding all deaths on military premises is a welcome development.
- 11.5. However on the face of the Protocol it appears to be the case that the civilian police will have responsibility not only in respect of establishing the immediate facts and circumstances of the death but also in identifying issues of systemic failings which may have contributed to the death.⁷ The obvious risk is that civilian police officers, without knowledge of the establishment under investigation, may experience difficulty in discharging this role notwithstanding the arrangements that are in place to ensure assistance is provided by the MOD. It is a related concern that such a role is outside the

⁷This is implicit in paragraph 4.2 of the Protocol which states that the police will retain primacy throughout including in respect of the presentation of case papers to the Coroner.

traditional policing responsibility and police procedures, including for example, those identified in the MIM, do not direct officers to consider systemic issues of the type necessary to assist a coroner conducting a post-Middleton inquest (see below at paragraph 13). Such a role has hitherto been discharged by Chief Officers only in respect of systemic failings within their own or other police forces.

- 11.6. Improved independence will increase public confidence in the investigation but clear procedures will need to be developed to ensure that systemic issues are given appropriate weight. Models established in the context of independent investigation of custodial deaths are relevant in this context (see paragraph 14 and 15 below).
- 11.7. The Protocol does not state whether and at what stage information gathered for the BOI and Learning Account will be shared with the civilian police, the bereaved family, the prosecutorial authorities and the coroner. It is considered that by analogy with custodial death investigations there should be a presumption in favour of full disclosure and efforts made to ensure that there is effective family participation in this aspect of the inquiries including, for example, in the agreement of terms of reference for BOIs and Learning Accounts. In like manner to the custodial death investigations, provision should be made to ensure that BOIs and Learning Accounts are revisited after the corresponding inquest.

12. Analogy with custodial deaths

- 12.1. In *R (Plymouth City Council) v HM Coroner for Devon* [2005] 2 FCR 428, Wilson J. (as he then was) helpfully summarised the three distinct duties on the state arising from Article 2 of the ECHR⁸ as follows:
- *“A negative duty, namely a duty not by its agents intentionally to take a person’s life save in the circumstances specified in the Article. The facts in McCann v UK (1995) 21 EHRR 97, namely the fatal shooting by soldiers of suspected terrorists in Gibraltar, therefore gave rise to a breach of this duty in that none of the specified circumstances existed.*
 - *A positive duty, namely to take all reasonable steps to protect a person’s right to life under the Article. In some situations, this duty (“the protective duty”) requires the state to do more than effectively to operate a criminal justice system designed to deter the taking of life. One example is that the state is required to take all reasonable care to protect the life of a person involuntarily in its custody: per Lord Bingham of Cornhill in *R (Amin) Secretary of State for the Home Department* [2004] 1 AC 653 at 30. Another example is that the state is required to seek to protect a person from death as a result of incompetent medical treatment or care by its effective operation of a system of professional and other regulation: *Calvelli v Italy*, ECHR, 17 January 2002, 32967/96 at 49; and*
 - *A second positive duty, collateral to the first, namely the investigative duty. Article 2 requires the state to furnish an appropriate investigation into the cause of a death which has been, or may have been, caused or contributed to whether by a violation of such domestic laws, criminal and civil, as protect the right to life or by a breach of the state’s protective duty under Article 2: see *Edwards v UK* (2002) 35 EHRR 487 at 69. In *R (Khan) v Secretary of State for Health* [2004] 1 WLR 971 at 67(3) the Court of Appeal observed, “The procedural obligation introduced by Article 2 has three interlocking aims: to minimise the risk of future like deaths; to give the beginnings of justice to the bereaved; and to assuage the anxieties of the public.”*

⁸For a discussion as to the applicability of Article 2 duties to these deaths, please see the Review at paragraphs 2.42 - 2.53.

12.2. In the same judgment Wilson J also helpfully summarised the requirements that must be met if an investigation is to be adequate to comply with the obligations imposed by Article 2 of the ECHR:

- *“The Convention is not prescriptive about the manner in which an investigative duty under Article 2 should be discharged; but, the more serious the events which call for enquiry, the more intensive should be the process of public scrutiny: see R (Khan) v. Secretary of State for Health [2004] 1 WLR 971 at 62(2);*
- *For example, a death in custody is at the serious end of the spectrum: see Amin at 31;*
- *Whatever its form, the investigation must meet minimum standards: see Amin at 32 and 25. Thus the investigation must be:*
 - (i) Independent;*
 - (ii) Effective;*
 - (iii) Reasonably prompt;*
 - (iv) Open to a sufficient element of public scrutiny; and*
 - (v) Open to appropriate participation by the next-of-kin;*
- *In the absence of criminal proceedings or a public enquiry, a coroner’s inquest is the means by which the state ordinarily discharges the duty: see Middleton at 20;*
- Different enquiries can be taken in combination as being the means of discharge: see Amin at 46.

12.3. The application of the above principles to the investigation of custodial deaths is now well established.

In the Deepcut cases the state had assumed responsibility for the welfare of young Army recruits and in addition to the duty of care to them that arose in life;⁹ in my opinion, there was an obligation under Article 2 to conduct an effective official investigation into the circumstances of their deaths including in relation to any systemic failures that may have contributed to the death.

12.4. In my opinion and in light of the following factors, it is appropriate to draw a close analogy with custodial deaths:

- The events in issue lie wholly, or in large part, within the knowledge of the state and its employees;
- The deaths occurred with the closed environment of an Army barracks;
- The particular relationship between serving soldiers and the state in that soldiers live and work at the same place and are to that extent effectively ‘on duty’ so long as they are on MOD property;
- The pattern of deaths and the identification of a series of systemic issues that may have contributed to them;
- The level of public disquiet occasioned by the deaths;
- The public interest in dispelling rumour and ensuring that so far as possible that the full facts are brought to light;
- The public interest in ensuring that suspicion of deliberate wrongdoing (if unjustified) is allayed;

⁹ The Review has noted that the Army owes a duty to its soldiers to take reasonable care (see paragraph 4.39 of the Report).

- The public interest in ensuring that culpable and discreditable conduct is exposed and brought to public notice particularly in circumstances where those responsible for the alleged culpable and/or discreditable behaviour continue to bear responsibility for potentially vulnerable young recruits;
- The public interest in ensuring that dangerous practices and procedures are rectified; and
- Significantly, that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his/her death may save the lives of others.

13. Police Investigative Practices

- 13.1. Initiatives undertaken in the wake of the Macpherson Inquiry have led to the development of extensive national and local policy in respect of the investigation of suspected homicides and other critical incidents. The primary document setting out the revised policy and procedure is the MIM.
- 13.2. Reliance on these modern policing methods has become the norm in police custodial death investigations including in circumstances where the possibility that the criminal acts of police officers and/or third parties have contributed to the death is remote. The methodology has the capacity to achieve a rigorous investigation that is amenable to public scrutiny and the capacity to engender the confidence of bereaved families and their representatives.
- 13.3. Central to those initiatives is an understanding of the importance of early evidence collation, professionalism with regard to record keeping and the importance of effective family liaison. The latter concern is dealt with at paragraphs 6.1 – 6.5 of this opinion.
- 13.4. In relation to crime scenes, the precious nature of the scene is emphasised in police procedures and its preservation identified as one of the primary responsibilities for the police at any scene. The first officer on scene must do all that is possible to prevent:
 - Movement of exhibits;
 - Evidence being obliterated;
 - Additional material being added; and
 - Loss of evidence.
- 13.5. The scene should only be entered to preserve life, arrest an offender, or search for other victims. The scene should be cordoned off as soon as practicable. If entry is essential, then care must be taken to avoid using the route that may have been used by any suspect. The body should not be disturbed save for the purpose of saving life. Any interference with the crime scene should be fully recorded in an Incident Report Book and the duty officer informed. A Crime Scene Log should be brought into existence as early as possible and deployed to record all relevant movements of people and exhibits. Detailed guidance with regard to the management of such logs has been promulgated nationally.
- 13.6. Thereafter an Incident Management Log (IML) is commenced with the intention of ensuring that all actions and decisions taken at an early stage are recorded and recallable. The IML is the primary recording vehicle for the supervisory officer at the scene, irrespective of rank. All other officers in attendance must record all relevant actions in their notebooks.
- 13.7. Strategic and important tactical decisions are recorded separately in a Decision Log which will amount to a systematic recording of Senior Investigating Officer (hereafter the 'SIO')

decision making. This log is the definitive record upon which the SIO will rely in the event of being required to account for decisions reached. Supervision of the SIO is achieved through review of the Decision Log as the primary reference point for examining the strategic direction of the investigation.

- 13.8. Policy has also been developed to ensure that proper regard is given to community concerns and an impact assessment in this regard should be conducted at an early stage. The assessment should be evidence/intelligence based, objective and capable of withstanding scrutiny.
- 13.9. Policy developed since 1999 has placed family liaison at the very centre of effective investigation. It is important to note that police policy envisages careful record keeping in the form of a Family Liaison Log so that the process of liaison is accountable, auditable and amenable to supervision.
- 13.10. The essence of modern policing methodology is intelligence based. Matters with which intelligence officers should be tasked include:
- Researching the victim's history including his associations and lifestyle;
 - Researching the history and associations of all suspects; and
 - Preparing material for submission to and searches of police information sources including the plethora of available computer based resources.
- 13.11. Detailed guidance is offered with regard to responding to information as it becomes available to the investigation and the implications for assessing information, structuring information and identifying new lines of enquiry.
- 13.12. Detailed guidance is also offered with regard to arrest, search and interview strategies to maximise the efficacy of those lines of enquiry.
- 13.13. A professional and structured approach to forensic evidence is also identified in policy. For example with regard to pathology, checklists are provided to ensure that best evidence is secured including the identification of further expert evidential needs.
- 13.14. Current policy envisages regular review, assessment and supervision aided by the recording tools described above.

14. Deaths in Police Custody

- 14.1. Separate but related policy has been developed in relation to the investigation of deaths in police custody. The standard of investigation is intended to achieve the same level of quality, openness and transparency outlined at paragraph 13 above but in order to achieve an appropriate level of independence, the investigation will be conducted, managed or supervised by the IPCC.
- 14.2. The IPCC published its statutory guidance in August 2005. The document provides a template intended to engender confidence in the investigation of complaints against the police. The guidance is not limited to controversial death investigations. The importance of openness and transparency, the provision of early information to the bereaved including with regard to the terms of reference and investigation plan and the importance of regular reviews are emphasised.

- 14.3. Whether or not there are critical findings, the IPCC will consider whether any action should be taken, whether in relation to force practice or in management discussion with the police officer(s) or staff member(s) concerned. Bereaved families will receive information concerning any such action. Disclosure in this context is considered under paragraph 16 below.
- 14.4. The IPCC has responsibility not only in relation to the investigation of the factual circumstances of the death but also the learning of lessons arising from the broader circumstances of the death.

15. Deaths in Prisons

- 15.1. Since 1 April 2004, all deaths in prisons and deaths of residents of Approved Accommodation (probation hostels) and immigration detention accommodation have been investigated by the Prisons and Probation Ombudsman (PPO) so as to introduce an element of independence to those investigations. Additionally the PPO has the discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by a prison.
- 15.2. The PPO has yet to publish its detailed guidance with regard to the method of investigation. However, PPO investigations have different aims to the old Prison Service investigations and are generally much broader and extend backwards in time to consider events before the deceased's prison term, including action by the courts and the police prior to the individual's prison incarceration. In like manner to the IPCC improved family liaison (as discussed above at paragraph 6 above) is central to the new procedures, the intention being to put the family at the centre of the investigative process.
- 15.3. The aims of PPO investigations include:
- Establishing the circumstances and events surrounding the death, especially as regards management of the individual by the relevant Service or Services, but including relevant outside factors;
 - Examining whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence;
 - In conjunction with the NHS where appropriate, examining relevant health issues and assessing clinical care;
 - Providing explanations and insight for the bereaved relatives; and
 - Assisting the Coroner's inquest in achieving fulfilment of the investigative obligation arising under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.
- 15.4. Within that framework, the PPO sets terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths where a common factor is suggested.
- 15.5. Police investigation has primacy over investigations by the PPO. Disciplinary issues emerging revert to the relevant Service and the PPO will take responsibility for alerting the relevant Service.

- 15.6. The PPO reports are published (to the website) so as to facilitate the drawing together of lessons across separate investigations by bereaved families and non-governmental organisations.

16. Disclosure

- 16.1. Comprehensive disclosure in advance of inquests is now the norm in custodial death inquiries. Disclosure encompasses contemporaneous documents, the statements of witnesses, interviews under caution of those under investigation and the reports of investigating officers.

Home Office Circular 31/2002, promulgated on 5 June 2002, sets out the relevant policy in this regard. This circular superseded a previous circular (20/1999) which was intended to achieve similar purposes and which was implemented on 28 April 1999. The circular which although directed to Chief Officers of Police, was adopted in principle by other agencies concerned in custodial death inquiries, including the Prison Service, the PPO and the IPCC. So far as the PPO is concerned, the objectives of the circular are now achieved through their own detailed procedures which since January 2006 benefit from a memorandum of understanding achieved with ACPO. IPCC procedures are, I understand, in the course of development.

- 16.2. At any rate, the relevant aspect of the circular are as follows:

3. Inquests are non-adversarial. There are in law no parties to the matter, and no issues to be litigated between them. However, where a death occurs in controversial circumstances, it can be difficult to avoid an adversarial approach arising, particularly where the deceased was in legal custody.

4. In such circumstances, disclosure of information held by the authorities in advance of the hearing should help to provide reassurance to the family of the deceased and other interested persons that a full and open police investigation has been conducted, and that they and their legal representatives will not be disadvantaged at the inquest. Advance disclosure may also remove a source of friction between interested persons and facilitate concentration on the facts surrounding the death. Experience has shown that pre-hearing disclosure in cases relating to deaths in police custody has been useful in allaying suspicions that matters are being deliberately concealed by the police which might otherwise have distracted attention from the real issues and made it more difficult for inquests to achieve the purpose required in law.

5. Chief Officers are advised, therefore, that there should continue to be as great a degree of openness as possible, and that disclosure of documentary material to interested persons before the inquest hearing should be normal practice in the cases described in paragraph 7 below. In all cases Chief Officers will want to consider whether there are compelling reasons why certain documents, or parts of documents, may not be disclosed. But there should always be a strong presumption in favour of openness.

6. It is common practice in most forces to keep bereaved families fully informed during the course of the investigation. We consider that this is essential good practice which should be followed in all cases. It is important to establish contact with the bereaved family as early as possible and keeping them fully informed will help to allay any fears that matters are being concealed by the police, particularly in the more controversial cases.

8. The courts have established that statements taken by the police and other documentary material produced by the police during the investigation of a death in police custody are

the property of the force commissioning the investigation. The Coroner has no power to order the pre-inquest disclosure of such material, and limited powers to prevent such disclosure. Disclosure will therefore be on a voluntary basis.

9. All the material which is supplied to the Coroner should normally be made available to all those whom the Coroner considers to be interested persons.

10. There are some kinds of material which require particular consideration when pre-inquest disclosure is being arranged:

(i) There may in some cases be a question of whether disclosure of certain material might have an impact on possible subsequent proceedings, whether criminal, civil or disciplinary. This is likely to arise, however, only in exceptional cases. Where the material might have an impact on subsequent criminal proceedings, the matter should be discussed with the Crown Prosecution Service. These reasons would only justify withholding of documents, or parts of documents, where there was a genuine risk, not simply a remote possibility, that disclosure would have a prejudicial effect.

(ii) There may be material which contains sensitive or personal information about the deceased, or unsubstantiated allegations about the deceased, or other material which may cause concern or distress to the family of the deceased. Such material should be handled with appropriate care and sensitivity, particularly over the way in which such material is disclosed to the family of the deceased. The handling of such material should be discussed with the family or the family's legal representatives.

(iii) Personal information about third parties which is not material to the inquest – for example, the addresses of witnesses – should be deleted from documents to be disclosed. The names of witnesses should not be disclosed where an application to the Coroner for anonymity is being considered.

(iv) Where disclosure of material which is not likely to be called in evidence is contemplated, it may be preferable to arrange for interested persons to view the material in advance, rather than the material being copied and provided directly to them, on the grounds that such material is generally not likely to be relevant.

(v) Any person who is asked to give a statement during the course of the police investigation of a death in custody should be made aware that his/her statement may be used in the context of an inquest and may therefore be disclosed in accordance with this guidance. That can readily be done by a declaration to that effect at the beginning of the statement.

11. Where any of paragraphs 10(i) – (iv) above apply, Chief Officers should seek the views of the Coroner concerned about how pre-inquest disclosure should best be handled. This would be consistent with the Coroner's role in controlling the conduct of the inquest. It would also enable account to be taken of any concerns that the Coroner might have regarding possible prejudice to the inquest hearing. However, consulting the Coroner on specific issues should not be used as an opportunity to delay the whole disclosure process. In cases where the Coroner decides to hold a pre-inquest hearing, that may provide an opportunity for the handling of disclosure to be discussed. It should be emphasised, however, that the Coroner has no power to order or prohibit disclosure of material which is in the possession of the police.

12. Disclosure of the investigating officer's report will not normally be expected to form part of the pre-inquest disclosure. That does not mean, however, that it is impossible for such a report to be disclosed where a Chief Officer considers that it would be right to do so. Where contemplating such disclosure, the Chief Officer should consider carefully, with the benefit of legal advice, whether it is in the public interest for the report to be disclosed to interested persons in whole or in part. The Chief Officer should also seek the views of

others with an interest in the report, including the Police Complaints Authority in supervised investigations and the Crown Prosecution Service. Where a Chief Officer decides to disclose the investigating officer's report, expressions of opinion by the investigating officer and his or her recommendations and conclusions should be redacted.

13. Pre-inquest disclosure to interested persons should be on a confidential basis, solely for the purpose of enabling interested persons to prepare for the inquest. That should be explained to and should be clearly understood by all interested persons when disclosure takes place.

14. Interested persons other than the police, including the family of the deceased, who have in their possession material about the death not otherwise disclosed to the police or the Coroner, should at the same time bring it to the attention of the Coroner and offer to provide similar pre-inquest disclosure to other interested persons.

15. The precise timing of pre-inquest disclosure in a particular case will depend on the particular circumstances. It should be noted that in most cases the custody record and pathologist's report are disclosed prior to full pre-inquest disclosure. There will be cases on which CPS advice is sought on whether criminal proceedings are appropriate. In such cases, in order to avoid prejudice to a criminal trial, disclosure should not take place until either the CPS have advised against a prosecution or any criminal proceedings have finished. Subject to that proviso it is recommended that arrangements should normally be made for pre-inquest disclosure to take place as soon as the Chief Officer is satisfied that the material may be disclosed and in any case not less than 28 days before the date of the inquest proceedings. However, where possible, pre-inquest disclosure should be made as far in advance as possible. It is not good practice to delay disclosure to the 28 day point where there is no good reason to do so.

16. It is not anticipated that pre-inquest disclosure of documentary material will involve substantial additional costs. Indeed pre-inquest disclosure, through saving unnecessary adjournments and avoiding unnecessary suspicion, should actually save time and associated costs in many cases. The police should normally meet the costs of any reproduction of documents which is necessary for disclosure to interested persons.

- 16.3. Thus, the circular provides a comprehensive solution to areas of difficulty that had hitherto beset the disclosure process in custodial death inquiries, including confidentiality, sensitivities with regard to certain categories of information and the interrelationship with other legal processes.

In the context of custodial death inquiries, Para 12 of this circular is now out of date in consequence of statutory and procedural developments. Claims to class based public interest immunity in respect of investigating officers' reports (as reflected in the statutory framework of the IPCC and procedures of the Prison and Probation Ombudsman) are no longer sustainable.

- 16.4. The PPO promulgated Disclosure Guidance for Fatal Incident Investigations in March 2005. In essence, the Guidance is intended to achieve the objectives defined in Home Office Circular 31/2002.

- 16.5. The PPO's Disclosure Guidance states that there is a presumption that disclosure should occur as fully and as early as his powers and the law permit. The Guidance continues, "It will be particularly important in the pre-inquest phase to disclose information to the family of the deceased, their personal representatives, and anyone else who will be involved in the inquest, so that they can properly prepare for it."

- 16.6. The Guidance acknowledges that, “Documents may be disclosed during the course of the investigation, but before the report has been drafted ... for example, it may be that early disclosure of documents to the family allows them to raise relevant issues during the course of the investigation, or provides them with a full opportunity to prepare for the inquest.”
- 16.7. The Guidance continues, “There may be requests for additional disclosure after the inquest is over. The investigator should consider each request in the light of the guidance set out above ... Bereaved relatives should be told that, pre-inquest, the documents can only be used for the purpose of preparing for the inquest. However, once the inquest is over, it is up to bereaved relatives how they use the documents.” The Guidance provides, “A record must be kept of all the documents that have been disclosed, to whom and when.”
- 16.8. The PPO’s practice is to send a draft of the report in advance to the relevant Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies, omissions, or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman also has discretion, generally exercised in favour of bereaved families, to send a draft of the report, in whole or part, in advance to the interested parties including the family.
- 16.9. The Police Reform Act 2002 placed on statutory footing the entitlement of complainants against the police to information concerning their complaint, including the investigation of their loved one’s death and disclosure of documents including the report of the investigation.
- 16.10. Section 20 (4) of the Act gives the complainant a statutory entitlement to information as to:
- *The progress of the investigation;*
 - *Any provisional findings of the person carrying out the investigation;*
 - *Whether any report has been submitted upon the conclusion of the investigation;*
 - *The action (if any) that is taken in respect of the matters dealt with in any such report; and*
 - *The outcome of any such action.*
- 16.11. Section 20(7) of the Act provides that information may be withheld from the complainant, “on proportionality grounds if its disclosure would cause, directly or indirectly, an adverse effect which would be disproportionate to the benefits arising from its disclosure.”
- 16.12. Paragraphs 23(12) and 24(10) of Schedule 3 to the Act provide specifically for disclosure of relevant information to the complainant in the form of an investigation report “notwithstanding any obligation of secrecy imposed by any rule of law or otherwise.”
- 16.13. Paragraph 12 of the Police (Complaints and Misconduct) Regulations 2004 provides that:
- “(1) [Disclosure may be withheld where] the non-disclosure of information is necessary for the purpose of:
Preventing the premature or inappropriate disclosure of information that is relevant to, or may be used in, any actual or prospective criminal proceedings;

Preventing the disclosure of information in any circumstances in which its non-disclosure:

Is in the interests of national security;

Is for the purposes of the prevention or detection of crime, or the apprehension or prosecution of offenders;

Is required on proportionality grounds; or

Is otherwise necessary in the public interest.

“(2) [Information may not be withheld from the complainant under paragraph (1) unless]:

There is a real risk of the disclosure of that information causing an adverse effect;
and

That adverse effect would be significant.”

- 16.14. The IPCC Statutory Guidance clarifies that the ‘harm test’ amounts to a judgement as to whether releasing the information may cause more harm than good. In relation to inquests, the Guidance provides that decisions about disclosure in advance of inquests should take into account the views of the coroner who should be consulted in advance although the final decision is a matter for the IPCC in managed and independent investigations and for the police in local and supervised investigations. The coroner has no power to prohibit or order disclosure of any particular document. The Guidance refers to the Home Office circular (see paragraph 16.3) and notes that, “It may be that disclosure can be made more quickly than set out in that circular and if so that should happen.” Further, the Guidance provides that, “A decision by the police, or the IPCC, not to disclose some part or all of an investigation report to a complainant should be properly recorded along with the reasons for the decision which should be given to the complainant, unless this information itself may lead to harm. The record should set out the factual basis for the decision rather than merely repeating the provisions of the law.” Appeal procedures to afford a mechanism to challenge decisions against disclosure have been established.
- 16.15. The Police Reform Act 2002 and the PPO’s procedures now expressly envisage disclosure to bereaved families of the investigation report(s) subject solely to a ‘harm’ test. Thus, in practice investigation reports are provided as a matter of routine. In the custodial death context, the only remaining controversy relates to the reports of investigations completed under the Police Act 1996 (that is, the transitional cases). In practice, even those reports are now being disclosed to bereaved families (on occasion following threatened or commenced judicial review proceedings).
- 16.16. Under the Home Office Circular 20/1999 promulgated on 28 April 1999 bereaved families were required to sign an undertaking to retain confidentiality in the documents disclosed. This procedure was not replicated in the 2002 Circular and does not feature in either the IPCC or PPO’s current practice. It is understood that the requirement to sign a confidentiality clause gave rise to difficulties of practical application and was considered unnecessary.
- 16.17. Protection against onward disclosure of documents with the potential to prejudice ongoing coronial or other proceedings is afforded by the availability of contempt proceedings. Moreover, in consequence of the application of the harm test, disclosure with the potential to cause significant harm to third parties will not occur in any event. The harm test falls to be considered by those responsible for exercising discretion as to whether or not to provide disclosure and in the course of balancing on the one hand the public interest in disclosure to bereaved families in furtherance of Article 2 imperatives with the public interest in maintaining confidentiality.

16.18. In January 2006, ACPO and the Prison and Probation Ombudsman published a 'Memorandum of Understanding' which addresses some of the complexities that arise in balancing those potentially competing imperatives. It is clear that disclosure will not be provided if it has the potential to compromise criminal investigations and/or prosecutions. Absent those concerns and at paragraph 5.2 of the memorandum it is stated that,

"The police will normally tell witnesses that their statements or documents may be shared with the PPO's investigating team. But it is not essential that such consent is obtained before sharing information with the PPO. Although the information may have been given to the police in confidence, it can still be shared with the PPO. The only requirement is that the police first consider:

- *Whether the public interest to assist the PPO's investigation outweighs the public interest in keeping the information confidential. As the PPO's investigation is considered to partially satisfy the State's obligations under Article 2 of the European Convention on Human Rights to conduct an independent investigation into a death in custody (the inquest is the other part of meeting this obligation), it will nearly always be in the public interest to assist the PPO's investigation.*
- *Whether the statement or document contains information that might cause particular prejudice to the person who made it (for example, serious harm to their business interests). In the rare case that there might be such prejudice, the police can still disclose the information, but should give the person prior written notice that this will be done.*

16.19 The PPO Disclosure Guidance (see above at paragraphs 16.6 - 16.9) states a clear presumption in favour of disclosure to bereaved families and disclosure will only be withheld on a content specific basis and where it is expressly envisaged that serious harm will result. Where there is a real risk of serious harm to the interests of a third party through disclosure, consideration is given to the means by which such harm might be minimised or extinguished and disclosure achieved. It is expressly envisaged within IPCC procedures that any decision against disclosure should be explained in writing and reasons provided. The provision of reasons is an important protection and affords bereaved families an opportunity to understand and accept the reasons relied upon or to challenge the decision reached (whether under appeal procedures which, for example, the IPCC have established or by way of judicial review).

16.20 In summary, therefore it is increasingly recognised that the requirements of Article 2 may well outweigh considerations of confidentiality but that where there is an objection to disclosure on the grounds that it will 'do more harm than good,' reasons should be provided to ensure that the decision against disclosure is open, transparent and amenable to legitimate challenge.

17. Lesson from the custodial death model

- 17.1. In consequence of the procedures described above, bereaved families now have a number of legitimate expectations with regard to the conduct of custodial death investigations by the police (whether under IPCC supervision/management or not), the IPCC and the PPO.
- 17.2. Their views concerning the terms of reference for the investigation will be sought at an early stage. The learning of lessons will be a key term of reference in any such investigation.

- 17.3. Disclosure of documents relevant to how their loved one came by their death is now the norm. As the investigation progresses information is shared with bereaved families and their comments sought. The investigation plan and investigative tools such as time lines and logistical reconstructions are shared. In appropriate cases key contemporaneous documents including for example, custody records, occurrence logs, medical records and related are provided at an early stage in the investigation and so as to facilitate the effective participation of the family. Following completion of the investigation, the investigation report is disclosed together with the documents that have been relied upon in the formation of the report including statements of witnesses, interviews of those whose conduct has been called into question and further contemporaneous documents that have been collated. Prior to a decision as to whether criminal proceedings will be instituted care is necessary to ensure that the accounts of witnesses will not be contaminated by disclosure.
- 17.4. Documents disclosing policy and procedure and guidelines relevant to the circumstances of death will be disclosed so that bereaved families may have an early opportunity to consider the extent to which non-compliance with policy or procedure may have contributed to their loved one's death. Bereaved families are thereby given an opportunity to participate in identifying the lessons to be learned and the methodology by which any such lessons might be implemented in practice. Families' experience in this regard can be one of great meaning and value.
- 17.5. Whereas the Home Office Circular envisages disclosure no later than 28 days before the inquest, in practice disclosure is usually achieved at a much earlier stage.
- 17.6. These improved procedures have brought tangible benefits for the quality of the investigations themselves and ensured that the corresponding inquests have improved prospects of clearly identifying the factual circumstances of the death and systemic issues.
- 17.7. There does not appear to be any valid explanation as to why families, who suffer the loss of loved ones in Army barracks under controversial circumstances, should have a lesser expectation to openness and transparency than that which arises in the custodial death context.

C. INQUESTS

18. Pre-amble

- 18.1. In this section of the opinion, there is consideration of modern inquest practice including the impact of the *Middleton* case, post mortem procedures, the role of pre-inquest meetings and the availability of public funding.
- 18.2. Finally, there is consideration as to whether concerns identified above might be capable of being addressed in the context of a modern post-Middleton type inquest.

19. Post Mortem Procedures

- 19.1. Rule 7(1) (a) of the Coroners Rules 1984 affords to “any relative who has notified the coroner of his desire to attend, or be represented at the post-mortem examination” an entitlement to be informed of the date, hour and place at which the examination will take place. This duty is binding unless it is not practicable to notify the family or to do so would cause the examination to be unduly delayed. The duty only arises following notification by the family of their wish to attend and creates an obvious difficulty if, as will usually be the case, the family are unaware of the entitlement. However, under rule 7(4) there is a general discretion to notify any person of the arrangements and to permit attendance. The model charter for coroners (Home Office Circular 46/1999) encourages coroners to notify the next-of-kin of the arrangements so that they may be represented.¹⁰ Families are also entitled to arrange a second post-mortem but an opportunity to arrange for an independent pathologist to be present at the first post-mortem is the preferred option in terms of avoiding delay and ensuring that the independent pathologist is on an equal footing to the pathologist instructed by the coroner. It is my opinion, therefore, that the Coroners Rules should require Coroners to inform families of their right to attend the post mortem with their own pathologist. In the interim, CNOs (see paragraph 4 above) should be charged with the responsibility of informing the family of their entitlements in this regard or in the alternative, the coroner’s officer who will be attending to arrangements for the identification of the deceased should assume responsibility.
- 19.2. Currently coroners have a broad discretion as to whether or not to instruct a forensic pathologist in respect of any particular death. If a coroner is informed by police that a person may be charged with homicide in relation to the death, the views of the police should be sought and in such circumstances the pathologist will usually be on the ‘Home Office List’ of accredited forensic pathologists. However, the decision is for the coroner and not the police (see *Jervis* at paragraph 6-31). Accredited forensic pathologists have specialist expertise in the conduct of post mortems to the high evidential standard that is required for legal proceedings. They operate to formal performance standards (see for example, Code of Practice and Performance Standards for Forensic Pathologists, November 2004). It is the practice of many coroners (although there is no consistency in this respect) to require the services of an accredited forensic pathologist in respect of every death in custody. For the reasons identified at paragraph 12 it is my view, that an accredited forensic pathologist should be relied upon in respect of deaths on MOD premises.

¹⁰ Public funding is available to meet the corresponding expense, see paragraph 22 of this opinion.

20. Post Middleton Inquests

- 20.1. In this section of this opinion, I will endeavour to explain the practical consequences of the House of Lords' decision in *Middleton* for modern inquest practice and thus the likely form of inquiry that would follow in the event that there were to be fresh inquests in respect of the first three deaths. In summarising the position, I rely upon my own extensive experience (of some 13 years) representing bereaved families in connection with custodial death inquests and the collective experience of the many solicitors in Bhatt Murphy who undertake such work.
- 20.2. Over many years, including both prior to and subsequent to the coming into force of the Human Rights Act 1998, extensive argument concerning the meaning of the word, "how" in s. 11 of the Coroner's Act and had become the norm.
- 20.3. Those arguments had a bearing on a number of aspects of inquest practice including the nature and extent of pre-inquest disclosure, the extent of expert evidence, the introduction of evidence concerning training and other procedures, the jury's findings, and the Coroner's powers to report action that should be taken to prevent the recurrence of similar fatalities under rule 43 of the Coroners Rules 1984. Following the House of Lords' decision in *Middleton*, custodial and other controversial inquests now proceed without the necessity for extensive legal argument of this type and the focus of the preparations and evidence is now more consistently upon learning the lessons, if any, of the death under investigation. Thus, the experience of involvement in an inquest is more consistently meaningful for bereaved families. In appropriate cases there has been an expansion of evidence concerning policy and procedure albeit inquests of similar breadth had occurred in individual coronial jurisdictions before the clarification of the law in this regard.
- 20.4. Allied to those developments has been a new approach to recording the conclusions of the inquest. Whereas there was no statutory or common law provision that a verdict had to be returned in a particular form,¹¹ the practice had developed of relying upon the short form verdicts set out in Form 22. The consequence was that even where the inquest adopted an expansive role including full consideration of systemic failings, the Coroner or jury was inhibited from reflecting in the verdict anything more than that the death was contributed to by neglect. Since the decisions of the House of Lords in *Middleton*, the practice has been adopted of providing to the jury a questionnaire from which they might structure a narrative verdict. This new approach has proven more meaningful for those state agencies responsible for learning any lessons from a tragedy and bereaved families alike. In my opinion, such questionnaires prove most useful when they are both succinct and carefully focused. The form of questionnaire is usually agreed between the interested parties.
- 20.5. The resulting narrative verdicts afford the Coroner or jury an opportunity to offer conclusions going beyond the strictures of a short form verdict. Narrative verdicts are thus capable of reflecting a range of conclusions including, for example, that the deceased died at his own hand without a settled intention to take his/her own life (the latter conclusion being a necessary finding pre-requisite to a suicide verdict). Moreover, juries and Coroners have provided narrative verdicts of real meaning and value in identifying systemic contributors to the cause of the death and the identification of lessons to be learned, in a range of factual scenarios. Those public verdicts are considered likely to make a significant contribution to the prevention of future similar fatalities.

¹¹ See for example, *R v HM Coroner for South Glamorgan ex parte BP Chemicals Ltd* (1987) 151 JP 799

- 20.6. Such advances in inquest practice would not be possible without corresponding changes relating to pre-inquest disclosure (see paragraph 16 above); pre-inquest meetings (see paragraph 21 below), the nature of the evidence to be heard (including the expanding role of expert evidence) and public funding (see paragraph 22 below). It is also relevant to mention that current jurisprudence is advancing in relation to the consequences of this expanded role for Coroner's resources¹² and the expanding role of judges in coronial inquiries.¹³

21. Pre-Inquest Meetings

- 21.1. The current Practice Notes for Coroners (revised 20 November 2002) do not mention the role of pre-inquest meetings but these have become the norm in custodial and other controversial inquests. It is the practice of many Coroners to convene a pre-inquest meeting as soon as practicable after the conclusion of the initial investigation whether by the police, IPCC, PPO or otherwise and following disclosure of the fruits of that investigation to the interested parties. In advance of the pre-inquest meeting, the Coroner will usually provide a list of witnesses whom he intends to call to give oral evidence and a list of statements that he considers appropriate to read into evidence.¹⁴ A primary objective of the pre-inquest meetings is to achieve, so far as it is possible, the agreement of the interested parties as to the oral and documentary evidence that will be adduced. The meeting also affords an opportunity for the interested parties to make submissions with regard to the admission of further evidence, including the need to ensure evidence is available from individuals of sufficient seniority within institutions to assist the tribunal with regard to issues such as training, policy and procedure. The pre-inquest meeting also affords an early opportunity for the Coroner and interested parties to agree in principle the likely issues and themes that will fall to be explored at the inquest. Pre-inquest meetings also provide an opportunity to resolve any difficulties that there have been to date with regard to the provision of disclosure. Other functions include discussion and agreement of suitable expert witnesses and the form and method of their instructions. In complex and difficult cases, another topic that can fruitfully be resolved is the preparation of bundles for the use of the court, witnesses and interested parties. It is not uncommon for more than one pre-inquest meeting to prove necessary in complex cases.

22. Public Funding

- 22.1. Public funding (formerly 'legal aid') for representation before an inquest is specifically excluded from the public funding regime by Schedule 2 of the Access to Justice Act 1999. However, funding may be provided by way of a grant of exceptional funding under section 6(8) (b) of the Act. In respect of custodial death inquests, the Lord Chancellor has devolved responsibility for decision making to the Legal Services Commission (LSC) and in reality, most custodial death inquests do now have the benefit of public funding. In all other

¹² The Coroner's concerns about the resource implications of a new inquest were acknowledged in *R (on the application of the Commissioner of Police for the Metropolis) v. Her Majesty's Coroner for South London* [2002] ETHIC 2392 Admin (the New Cross Fire inquest) and the Divisional Court clarified that section 7 of the Coroner's Act 1988 permitted coroners to appoint deputies if the burdens of a particular inquest would prevent him/her carrying out his/her other duties. In the event the Coroner concerned appointed a judge to act as her deputy.

¹³ In *Death Certification and Investigation in England, Wales and Northern Ireland, The Report of a Fundamental Review 2003* (Cm 5831) (Chairman: Tom Luce), at Chapter 9, paragraph 8 (c) it was recommended that a "small number of exceptionally complex or contentious inquests should be taken by suitably trained Circuit Judges, and a yet smaller number of still more complex inquests should be heard by suitably prepared High Court Judges, each sitting as coroner. This provision, too, should be sparingly used." In *R (on the application of Neil Sharman) v. Her Majesty's Coroner for Inner North London* [2005] EWHC 857 (Admin) the Division Court endorsed the recommendation of the Luce Report commenting that this, "extremely difficult case would have benefited from judicial oversight at a higher level."

¹⁴ By virtue of r.37 of the Coroners Rules 1994, the coroner may only admit documentary evidence if there is no objection from any of the interested parties.

cases, the LSC offers recommendations to the Lord Chancellor with whom the decision with regard to a grant of exceptional funding rests. The Lord Chancellor has issued guidance to indicate the types of case he is likely to consider favourably under this power. The relevant guidance was issued on 1 November 2001. Before approving an application the Lord Chancellor would expect the LSC to be satisfied that either there is a significant wider public interest¹⁵ in the applicant being legally represented at the inquest¹⁶ or funded representation for the family of the deceased is likely to be necessary to enable the coroner to carry out an effective investigation into the death, as required by Article 2 of the ECHR.

22.2. The Lord Chancellor and the LSC's guidance in this regard have been amended to take account of the decision of the Court of Appeal in *R (Khan) v Secretary of State for Health* [2003] EWCA Civ 1129 which considered the particular circumstances in which the Article 2 investigative obligation requires funding to be provided for the deceased's family to be legally represented at the inquest or at an equivalent investigation. Accordingly, in determining whether there should be a grant of exceptional funding, consideration will be given to the following:

- The nature and seriousness of any allegations which are likely to be raised at the inquest, in particular any allegations against public authorities or other agencies of the state. Particular regard will be given to any of the following circumstances: closely related multiple and avoidable deaths from the same cause within the same institution; criminal conduct; attempts to conceal information or otherwise interfere with an investigation into the circumstances surrounding the death;
- Whether other forms of investigation have taken place, or are likely to take place, and whether the family have or will be involved in such investigations;
- Whether the family may be able to participate effectively in the inquest without funded legal representation. This generally depends on the nature of the issues raised and the particular circumstances of the family; and
- Any views concerning the necessity of representation expressed by the coroner, although these are not determinative.

22.3. In general, applicants must also satisfy the financial eligibility limits for Legal Representation as set out in regulations and which in effect mean that the applicant must have very modest means. However, with effect from 1st December 2003 the Lord Chancellor acquired discretion to waive financial eligibility limits relating to representation at an inquest where the LSC requests him to do so (Regulation 5C of the CLS (Financial) Regulations 2000 as amended). The Lord Chancellor will consider such a waiver in relation to inquests that satisfy the guidance set out above if, in all the circumstances, it would not be reasonable to expect the family to bear the full costs of representation at the inquest. Whether this is reasonable will depend in particular on the history of the case and the nature of the allegations to be raised, the applicant's assessed disposable income and capital, other financial resources of the family, and the estimated costs of providing representation. Where funding is granted to provide advocacy at an inquest into the death of a member of the applicant's family, the Commission may waive contributions in whole or in part (Regulation 38(8A) and (9) of the CLS (Financial) Regulations 2000 as amended on 1st December 2003). Where it is appropriate for a contribution to be payable this will be based upon the applicant's disposable income and disposable capital in the usual way ignoring upper eligibility limits. As funding will cover only one off advocacy services at the inquest, an appropriate total contribution will normally consist of one month's assessed

¹⁵ "Wider public interest" means the potential of the proceedings to produce real benefits for individuals other than the client (other than benefits to the public at large which normally flow from proceedings of the type in question).

¹⁶ This means that an applicant must be able to demonstrate that representation is necessary to obtain any benefits that may arise, not just, that the inquest itself may provide benefits.

income contribution, and a proportion of the assessed capital contribution. Contributions should always be based on what can reasonably be afforded by the applicant and his or her family in all the circumstances of the case.

- 22.4. The Lord Chancellor also has discretion to waive the upper financial eligibility limits with regard to provision of legal advice and assistance towards the preparations for an inquest including disbursements such as experts' fees (Regulation 38(8A) and (9) of the CLS (Financial) Regulations 2000 as further amended on 25 July 2005).
- 22.5. Accordingly exceptional funding is available to cover preparation for the inquest (whether under Legal Help or Legal Representation if the applicant is financially eligible or exceptional funding if the applicant's means place him/her outside the upper eligibility limits for Legal Help/Representation) and advocacy at the hearing itself. Public funding is thus available in respect of:
- Preparation, advice and assistance;
 - Disbursements, for example, obtaining a second post mortem;
 - Counsel or solicitor's fees for acting as advocate at the hearing;
 - The costs of any other legal representative attending the hearing;
 - The cost of instructing counsel for the hearing;
 - The cost of any conference at or immediately before the hearing; and
 - Costs in relation to any preliminary hearing at which advocacy is required.
- 22.6. The circumstances of the Deepcut cases would appear to have the type of exceptional characteristics that would justify the grant of exceptional funding and waiver of the financial eligibility limits.¹⁷

23. Jury Inquests

- 23.1. In the inquests that have taken place to date, the Coroner has sat without a jury. Section 8(3) (a) - (d) of the Coroners Act 1988 specifies the circumstances in which a coroner is required to sit with a jury.

"If it appears to a coroner ... that there is reason to suspect –

(a) ...

(b) ...

(c) ...

(d) *That the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public".*

The circumstances specified in s. 8(3) (d) need not have caused the death.¹⁸

¹⁷ The Review's remarks that such discretions should be exercised wherever possible to give effect to Convention rights (see Paragraph 2.52) are noted in this context.

¹⁸ R v. Inner London Coroner, ex parte Linnane [1989] 1 WLR 395

- 23.2. Moreover, and in addition to the mandatory requirements of s.8(3), s.8(4) provides a wide discretion:

“If it appears to a coroner ... that there is any reason for summoning a jury, he may proceed to summon a jury.”

- 23.3. Juries are mandatory (by reason of s.8 (3) (a) and (b)) in respect of custodial death inquests. It is not known whether the Coroner concerned with these cases has been invited to sit with a jury. It is considered that the arguments advanced at paragraph 12 are relevant in this context and given the need to resolve factual issues in particular, in my opinion, it would be appropriate for the Coroner to sit with a jury in cases raising the kind of questions these deaths do.

24. The relevance of post-Middleton inquests to these cases

- 24.1. It is beyond the remit of this opinion to offer a view as to whether the additional material collected by Surrey Police that has not previously been examined by the inquest might be capable of leading to different verdicts to those that were returned at the original inquests. However, if it is the case that this additional material is capable of achieving a more complete picture of how and in what circumstances these young people came by their death, a public inquest conducted in accordance with modern inquest practice and procedure and benefiting from the fruits of the additional investigations and effective family participation might well have the capacity to address many of the families' outstanding concerns.¹⁹
- 24.2. For the reasons set out above (paragraph 20), an inquest conducted in accordance with current standards would not be constrained by the narrow remit that necessarily circumscribed the original inquests.²⁰ Re-opened inquests would consider not only how but also in what circumstances the deceased came by his/her death. A central imperative would be the consideration of any systemic failings that may have contributed to the deaths.
- 24.3. Moreover, such an inquiry has the possibility to allay legitimate public concern through the public identification of any systemic failings. In the words of Mr and Mrs Gray,

“The care and safety of this country's young soldiers whilst under the control of the armed forces is not only of paramount importance to soldiers themselves and their families, but to the public at large. Clearly, the public must have confidence in their Armed Services in order to trust that their loved ones are able to work well in good conditions and are valued for their contribution. The manner of Private Gray's death together with the manner in which it was investigated is of vital importance to the issue of trust in and the morale of our Armed Services.”

Fiona Murphy
Bhatt Murphy
6 February 2006

¹⁹ See Chapter 2, paragraph 2.34 – 2.40 of the Review for a discussion of the circumstances in which a fresh inquest may be required.

²⁰ See Chapter 2, paragraphs 2.24 and 2.54 – 2.68 of the Review.

APPENDIX 1

Deepcut

Duty of Care : Third Report of Session 2004 - 2005 :
Volume 1 and 2 Defence Committee 3 March 2005

Government's Response to the House of Commons
Defence Committee's Third Report of Session 2004 - 2005
on Duty of Care

Deepcut Investigation: Final Report Surrey Police

Services Materials

Queen's Regulations Chapter 5 Annex A on Boards of
Inquiry and Regimental Inquiries Joint Casualty &
Compassionate Policy & Procedures Ministry of Defence July 2005
Protocol for the Investigation of Deaths on MOD Land etc Ministry of Defence September

2005

Police Materials

Family Liaison Strategy (Policy Ref D:2:12:26) ACPO
Making the New Police Complaints System work better IPCC
Statutory Guidance

Prison Materials

Prison Service Order 1301, Investigating Deaths in Custody
Terms Of Reference For Investigation Of Deaths Prison Service
Prisons and Probations Ombudsman
Guidance on Disclosure Prisons and Probations Ombudsman

Materials Concerning Inquest Practice and Procedure

Circular 31/2002 Pre-inquest disclosure Home Office 5 June 2002
Circular 46/1999 Model Coroner's Charter Home Office
Coroners' Society of England and Wales:
Practice Notes for Coroners The Coroners' Society of England and Wales November 2002
Code of Practice and performance standards for
forensic pathologists Home Office and the Royal College of Pathologists November 2002

Public Funding

The CLS Code, Procedures and Guidance Amended 27
The Community Legal Service (Financial) Regulations 2000 July 2005

The Luce Report

Death Certification and Investigation in England, Wales
and Northern Ireland: The Report of a Fundamental
Review 2003 ("The Luce Report") (Cm5854) June 2003
Reforming the Coroner and Death Certification Service:
A Position Paper (Cm6159) Secretary of State for the Home Department March 2004
How the Inquest System Fails Bereaved Families:
INQUEST's Response to the Fundamental Review
of the Coroner Service INQUEST December 2002
Position Paper on the Review of Death Certification
and Coroner Services Action for Victims of Medical Accidents November 2002

The Shipman Inquiry

The Shipman Inquiry: Third Report

Health and Safety Executive Materials

Operational Contact with, and Disclosure of Information to, the Relatives of Persons Killed through Work Activities (OM2002/105)	Health and Safety Executive	Minute 21 August 2003
Operational Contact with, and Disclosure of Information to, the Relatives of People Killed through Work Activities (3rd draft)	Health and Safety Executive	Circular 1 November 2001

INQUEST materials

Response to consultation for change to the role of the Prisons and Probation Ombudsman		
Response to Prison Ombudsman Disclosure Guidance Submission to the Joint Committee on Human Rights Inquiry into Deaths in Custody		February 2005 December 2003
Further submission to the Joint Committee on Human Rights Inquiry into Deaths in Custody		September 2004

Centre for Corporate Accountability

Response to HSE on Consultation on Family Leaflet and Operational Circular	Centre for corporate Accountability
Response to Draft Minute on Contact with and Disclosure of Information to Relatives of Persons Killed Through Work Activities	Centre for corporate Accountability

NHS

Complaint Procedure The First Year of ICAS, 1 September 2003 - 31 August 2004:	NHS NHS Independent Complaints Advocacy Service
ICAS Annual Report	ICAS

APPENDIX 2

Fiona Murphy is a solicitor and a founding partner of Bhatt Murphy solicitors, a leading human rights firm. The entire compliment of Bhatt Murphy's fee earning staff including partners, solicitors and trainees are engaged in inquest practice and corresponding public and private law litigation. The firm has developed particular expertise in this field of law and is associated with many of the leading cases.

Fiona is an experienced public and inquest lawyer and has represented bereaved families in a number of controversial cases. She has successfully challenged coroners who have failed to carry out their responsibilities in respect of controversial (mostly custodial) deaths, the Director of Public Prosecutions for failing to prosecute police officers and Chief Officers of Police for failing to respond lawfully to complaints against their officers.

Her notable controversial death cases include *R (Hurst) v Her Majesty's Coroner, Northern District of London, CA 2005* - which declared that relevant sections of the Human Rights Act applied to pre-Act deaths and *O'Brien v. The Director of Public Prosecutions* which led to the prosecution of police officers in relation to the restraint related death in custody of Richard O'Brien and contributed to the establishment of the Butler Inquiry. She has represented a number of bereaved families in achieving post-Middleton system neglect verdicts.

Fiona has given evidence to and/or been consulted by the European Committee on the Prevention of Torture, the United Nations, the Butler Inquiry (which concerned the independence of prosecutorial decision making in the context of custodial deaths), the Home Affairs Select Committee concerning Police Complaints & Discipline and the Middleton Report Reviewing Civil Justice and Legal Aid.

Fiona has lectured on a broad range of issues relevant to controversial death investigations and has extensive experience of supervising other lawyers in relation to controversial death investigations.

Fiona is a senior member of the Police Action Lawyers Group and Inquest Lawyers Group. She is also a founding director of British Irish Rights Watch, a non governmental organisation which has a particular interest in controversial death investigations.

She studied for her undergraduate law degree at the London School of Economics and obtained her post graduate legal qualification from the College of Law, Lancaster Gate. She qualified as a solicitor in April 1992 and had gained 9 years experience in leading human rights practices in London and Boston, USA before establishing Bhatt Murphy in October 1998.

Annex D

ANNEX D: Draft Disclosure Agreement

1. This agreement is made between the following parties:
 - (a) the Chief Constable of Surrey Police (“the Chief Constable”);
 - (b) [S], the solicitor representing Mr and Mrs [P]; and
 - (c) Mr and Mrs [P], the parents of the deceased [D].

The parties agree as follows:

2. The Chief Constable agrees to provide to [S] with copies of the documents set out in the schedule to this agreement (“the documents”), solely for the purpose of [S] advising Mr and Mrs [P] whether an application should be made to the High Court of Justice for the inquest into the death of [D] to be set aside and a fresh inquest ordered (“the application”), and, if so advised, to enable [S] to make the application.
3. [S] and Mr and Mrs [P] acknowledge that the documents are the product of a confidential police investigation and undertake to hold the documents on the terms of this agreement.
4. This agreement is intended to have legal effect and, in the event of a breach or anticipated breach of the terms of this agreement, it is agreed that:
 - (a) If the Chief Constable gives notice in writing, the documents and any copies taken thereof shall be returned forthwith to the Chief Constable;
 - (b) Damages are not an adequate remedy and the Chief Constable is entitled, in the event of a threatened or actual breach, to the remedies of injunction, specific performance and other equitable relief; and
 - (c) Damages may also be payable and shall include the costs of any proceedings taken by the Chief Constable against a third party to whom disclosure of the documents or their contents has been made in breach of this agreement and shall be payable to the Chief Constable by [S] and/or Mr and Mrs [P].
5. [S] and Mr and Mrs [P] will keep the documents, their existence and their contents strictly confidential, and, save as provided for in paragraphs 6, 7 and 8 below, will not reveal them to any third party without the written consent of the Chief Constable unless disclosure is required by law or by a court of competent jurisdiction.
6. Disclosure of the documents to counsel instructed to advise and to any expert witness instructed upon terms that the documents are confidential and shall not be disclosed to a third party, shall not be regarded as disclosure to a third party.
7. Disclosure of the documents to the Attorney General for the purpose of considering his consent to proceedings under s.13 of the Coroners Act 1988 shall not be regarded as disclosure to a third party.
8. Where Mr and Mrs [P] decide to make the application, [S] shall give the Chief Constable advance notice of the intention to use the documents in the application and, if not agreed, [S] and Mr and Mrs [P] shall ensure that the documents remain confidential to the court unless and until the court otherwise directs.

9. [S] will keep the documents, and other material containing, reflecting or which are generated from their content, separate from all other documents and materials and at [S]'s usual place of business in the United Kingdom.
10. Save for the purposes provided for in paragraphs 6, 7 and 8 above, [S] may not make further copies of the documents in any format, including but not limited to photocopies, faxes or electronic scans, whether for the purpose of sending to Mr and Mrs [P] or otherwise, without the written consent of the Chief Constable.
11. These undertakings will not apply to the documents and their content to the extent that the documents or their content becomes publicly known, other than by breach of the terms of this agreement by [S] or Mr and Mrs [P], provided, however, that [S] or Mr and Mrs [P] gives reasonable notice to the Chief Constable of the fact that the documents or their content has entered the public domain before taking any step which would otherwise be in breach of the terms of this agreement.
12. This agreement is governed by English law and is subject to the exclusive jurisdiction of the English courts.

Signed by
Chief Constable of Surrey
Date

Signed by
[S]
Date

Signed by
Mr [P]
Date

Signed by
Mrs [P]
Date

Annex E

ANNEX E: Glossary

ACC	Army Catering Corps
ACPO	Association of Chief Police Officers
Adjt.	Adjutant
AFC	Army Foundation College
AG	Adjutant General
AGAI	Army General Administrative Instruction
AITO	Army Individual Training Organisation
ALI	Adult Learning Inspectorate
APC	Army Personnel Centre
ASMT	Army School of Mechanical Transport
ASPWG	Army Suicide Prevention Working Group
ATR	Army Training Regiment
ATRA	Army Training & Recruiting Agency
ATSM	Anti-Terrorist Security Measures
AWOL	Absent Without Leave
AWS	Army Welfare Service
BKA	Bundeskriminalamt
BOI	Board of Inquiry
Brig.	Brigadier
Capt.	Captain
CID	Criminal Investigation Department
CMS(R)	Common Military Syllabus (Recruit)
CO	Commanding Officer
CODC	Commanding Officers Designate Course
Col.	Colonel

COS	Chief of Staff
Cpl.	Corporal
CPS	Crown Prosecution Service
CR	Confidential Report
DAG	Deputy Adjutant General
DAOR	Discharge As Of Right
DASA	Defence Analytical Services Agency
DCDS(Pers)	Deputy Chief of the Defence Staff (Personnel)
DCOS	Deputy Chief of Staff
DG ATR	Director General Army Training and Recruiting
DOC	Directorate of Operational Capability
DST	Defence School of Transport
EIOT	Equal Opportunities Investigation Team
FSS	Forensic Science Service
Gen.	General
GOC	General Officer Commanding
HCDC	House of Commons Defence Select Committee
HGV	Heavy Goods Vehicle
HMIC	Her Majesty's Inspectorate of Constabulary
ISID	Intentionally Self-Inflicted Death
ITG	Initial Training Group
ITO	Individual Training Organisation
JE	Junior Entry
LANDSO	Land Standing Order
LCpl.	Lance Corporal
Lt.	Lieutenant
Lt. Col.	Lieutenant Colonel

Maj.	Major
MCM	Manning & Career Management
MGS	MOD Guard Service
MOD	Ministry of Defence
MPGS	Military Provost Guard Service
MRO	Manning & Records Office
MTI	Military Training Instructor
NAAFI	Navy, Army and Air Force Institutes
NCO	Non-Commissioned Officer
NVQ	National Vocational Qualification
OC	Officer Commanding
P File	Personnel File
PNC	Police National Computer
Pte.	Private
PTI	Physical Training Instructor
PVR	Premature Voluntary Release
RAAT	Regular Army Assistance to Training
RAF	Royal Air Force
RAOC	Royal Army Ordnance Corps
RCT	Royal Corps of Transport
RE	Royal Engineers
Regt.	Regiment
RLC	Royal Logistic Corps
RMAS	Royal Military Academy Sandhurst
RMO	Regimental Medical Officer
RMP	Royal Military Police
RN	Royal Navy

ROP	Restriction of Privilege
RP	Regimental Provost
RSM	Regimental Sergeant-Major
RTU	Return to Unit
RUC	Royal Ulster Constabulary
SATT	Soldiers Awaiting Trade Training
SE	Single Entry
Sgt.	Sergeant
SIB	Special Investigations Branch (of the RMP)
SOCO	Scene of Crime Officer
Spr.	Sapper (Royal Engineers)
Sqn.	Squadron
SSL	Secondary School Leavers
SSM	Squadron Sergeant-Major
TA	Territorial Army
TNA	Training Needs Analysis
Tp.	Troop
UKLF	United Kingdom Land Forces
W/Pte	Woman Private (this designation is no longer in use)
WO (1 or 2)	Warrant Officer, Class 1 or 2
WRVS	Women's Royal Voluntary Service

Annex F

Note

Appendices are provided on the enclosed CD.

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