

**CONVENING ORDER FOR A SERVICE INQUIRY**

**BY ORDER OF**

**MAJOR GENERAL D A H SHAW**

**GENERAL OFFICER COMMANDING 2<sup>ND</sup> DIVISION**

1. In accordance with section 343 of the Armed Forces Act 2006 (AFA 06), a Service Inquiry Panel, composed as under, is to assemble at Maindy Barracks Cardiff on 8 November 2011, to hear evidence and report upon the circumstances leading to and surrounding the death of 25204919 Private Gavin Williams 2<sup>nd</sup> Battalion the Royal Welsh, on 3 July 2006 and upon any other relevant matters which it thinks appropriate.

2. Composition:

- a. President: Brigadier GK Bibby CBE late COLDM GDS
- b. Member: [REDACTED]
- c. Member: [REDACTED]

3. The legal adviser to the inquiry is Brigadier N Jones ALS, Director Legal Advisory and legal counsel to the inquiry is [REDACTED]

4. The Panel is to investigate and make findings in fact relating to the matters specified in the Terms of Reference (TOR) at Annex A, recording all relevant evidence and expressing opinions as directed in the TOR. The findings, opinions and recommendations are to be cross-referenced to the evidence presented in the report.

5. The Officer convening the Service Inquiry directs that the evidence is to be taken on oath or by affirmation, as required, in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008. Any document or thing produced to the Panel by a witness, for use as evidence, shall be made an exhibit and treated in accordance with Regulation 11 of the Armed Forces (Service Inquiries) Regulations 2008. Documentary evidence is to be attached as an annex to the proceedings, having been signed by the President.

6. Any person to whom Section 343 (3) (c) of AFA 06 and Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008 applies and who, in the opinion of the President, may be affected by the finding of the Panel, is to be given notice of the proceedings and given an opportunity of being present and represented at the sittings of the Panel, or at such part as the President (after consulting with the Convening Authority) may specify, in accordance with Regulation 18 (above). *(The under-mentioned persons are to be afforded such an opportunity.)*

- a. [REDACTED]
- b. [REDACTED]
- c. [REDACTED]
- d. [REDACTED]
- e. [REDACTED]
- f. [REDACTED]
- g. [REDACTED]

- h. [REDACTED]
- i. [REDACTED]
- j. [REDACTED]

7. The President is to be alert to the possibility that as the Inquiry proceeds evidence may indicate the existence of other persons to whom Section 343(3)(c) of AFA 06 and Regulation 18 of the Armed Forces (Service Inquiries) Regulations 2008 applies. The President is to ensure that any such person is also to be given the opportunity of being present and represented before the Panel in accordance with Regulation 18. If in any doubt, the President should seek legal advice.

8. In accordance with Regulation 17 of the Armed Forces (Service Inquiries) Regulations 2008 (but subject to Regulation 18 of those Regulations), the President must obtain the consent, and the extent of any such consent, of the Convening Authority before permitting any persons to be present at the proceedings of the Panel other than as a witness.

9. If it appears to the Panel at any time during the Inquiry that any person may have committed an offence against Service Law, including a civil offence contrary to Section 42 of the Armed Forces Act 2006 the President is to immediately adjourn the Inquiry and seek legal advice. The President should also adjourn the Inquiry and seek legal advice should it appear at any stage that there are grounds to raise administrative action under AGAI Vol 2 Ch 67.

10. The Inquiry is to express its opinion in respect of any material conflict between oral and documentary evidence, which may arise, and give reasons for reaching that opinion. Any conflict in the evidence should be determined on the balance of probabilities, with reasons given in the report.

11. The Panel is to hear evidence from the witnesses outlined below:

- a. [REDACTED]
- b. [REDACTED]
- c. [REDACTED]
- d. [REDACTED]
- e. [REDACTED]
- f. [REDACTED]
- g. [REDACTED]
- h. [REDACTED]
- i. [REDACTED]
- j. [REDACTED]
- k. [REDACTED]
- l. [REDACTED]
- m. [REDACTED]

- n. [REDACTED]
- o. [REDACTED]
- p. [REDACTED]
- q. [REDACTED]
- r. [REDACTED]
- s. [REDACTED]
- t. [REDACTED]

12. The Panel may hear evidence from any such other witnesses as it deems appropriate and may dispense with the attendance of any witness if it concludes that the witness evidence will not assist the Inquiry, but its reasons for not calling any such witnesses should be explained in its findings. The President should note that witness statements taken by the RMP/SIB are not to be disclosed to the Inquiry or entered in as evidence unless the express consent of the witness providing the statement has been given. No statements or interviews conducted after caution may be disclosed to the Inquiry.

13. The President's attention is drawn to the following key documents

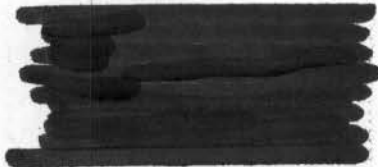
- a. Section 343 of the Armed Forces Act 2006.
- b. Armed Forces (Services Inquiries) Regulations 2008.
- c. LANDSO 3207 (Second Revise).
- d. JSP 832 Guide to Service Inquiries (issued 1 Oct 08).

14. The Service Inquiry Clerk is requested to provide:

- a. A suitable room for the Inquiry.
- b. Word processing and computer facilities, including stationery.
- c. A Bible.
- d. Copy of JSP 830 (Manual of Service Law).
- e. Food/accommodation/transport for all personnel attending the Inquiry.
- f. Act as Orderly to the Inquiry.
- g. A Verbatim Court Recorder.

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

16. The costs of the Inquiry are to be charged to **UIN: A3921A (or lie where they fall)**.



D A H SHAW  
Major General  
General Officer Commanding 2<sup>nd</sup> Division

24 October 2011

Annex:

A. Terms of Reference



### TERMS OF REFERENCE

The Inquiry is directed to hear evidence and report upon the circumstances leading to and surrounding the death of 25204919 Private Gavin Williams 2<sup>nd</sup> Battalion the Royal Welsh, on 3 July 2006 and upon any other relevant matters which it thinks appropriate.

1. In particular the Board is to report and comment on the following issues:
  - a. Establish the details of the incident (how, where what and when) which led to the death of Private Williams, and where possible utilise the evidence gathered by Wiltshire Constabulary and Royal Military Police (SIB) investigations.
  - b. Determine the medical cause of death by reference to all available evidence e.g. post mortem reports.
  - c. Ascertain whether service personnel were on duty at the time of their employment as it related to the death of Private Williams.
  - d. Establish the levels of training, relevant competences, qualifications and awareness of the individual(s) involved in the incident, including their knowledge of administrative action (e.g. AGAI 67), as well as formal disciplinary procedures at the time of the incident.
  - e. Whether there was any identifiable shortfall in training or standards with regard to any individual, system or process involved in the incident e.g. heat injuries awareness, methods of restraint etc.
  - f. Establish whether Army policy regarding unofficial punishments existed at the time of the incident, if so was it sufficient and widely promulgated throughout 2 Royal Welsh, and whether if such a policy exists now, it is sufficiently fit for purpose and widely promulgated throughout the Army.
  - g. Whether the death could reasonably have been prevented and if so, by what means it could have been prevented.
  - h. What lessons have been learnt as a result of this incident.
  - i. How and when are the AGAI 67 procedures taught and promulgated throughout the Army.
  - j. What actions have been taken or procedures implemented to prevent recurrence of this type of incident within the Army.
2. **Other Matters.** The Inquiry is to comment and express an opinion upon any other matters deemed by them to be relevant.

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PROTECT - STAFF

**SERVICE INQUIRY**

**NARRATIVE OF EVENTS**

**References:**

- A. GOC 2 Division Convening Order dated 24 Oct 10
- B. JSP 832 - Guide to Service Inquiries Issue 1.0 Oct 2008

**Introduction**

25204919 Pte Gavin Williams 2 R WELSH died on Mon 3 Jul 06 in Salisbury General Hospital. Immediately following his death a Wiltshire Police investigation commenced, which interviewed in excess of 1200 individuals and culminated in three serving soldiers from 2 R WELSH being charged with manslaughter. They were brought to trial at Winchester Crown Court and all three were found not guilty on 08. SIB RMP enquiries commenced on Fri 1 Aug 08.

On completion of the SIB investigation which culminated in AGAI 67 action being conducted by GOC 4 Div on 7 Jul 10, direction to convene a Service Inquiry was issued by PS2(A) to HQ 2 Div on 12 Nov 10. Following extensive consultation within DPS(A) at AD level and ALS where it was determined that a statutory Service Inquiry was necessary to ascertain what, if any lessons had been learnt as a result of the incident and to demonstrate to the family that the Army was being transparent in dealing with the facts of Pte Williams' death.

Following extensive discussion regarding the terms of reference for the SI, nomination of Legal Counsel and a trawl to identify the 1<sup>st</sup> President required due to the high profile nature of the incident and the rank and seniority of potential witnesses, the SI commenced formal proceedings at Maindy Barracks, Cardiff on 9 Nov 11 and concluded on 18 Nov 11. were present throughout.

**Summary of Proceedings**

In consultation with AD PS2(A) and ALS4 it was decided that the three individuals who had faced manslaughter charges would not be called as witnesses, due to the copious amounts of material already available as a result of the previous investigations. A total of 20 persons were called to give evidence, falling into three broad categories of; Chain of Command 2 R WELSH at time of incident, Chain of Command now and subject matter experts (SMEs) from PD Corps, APHC, INM (Heat Injury), Pathology, DTrg, DMS, PM(A) and DPS(A).

**Report Structure**

The following Annexes A to K are structured to reflect the individual Terms of Reference produced within Annex A to the Convening Order, and contain the Panel's findings and recommendations. Recommendations are also reproduced within Flag G of this report.

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**TERM OF REFERENCE 1(a)**

“Establish the details of the incident (how, where, what and when) which led to the death of Private 25204919 Gavin Williams”.

**FACTS ESTABLISHED**

**Background**

At the time of death, 25204919 Pte Gavin Williams (known as Williams 19, the last two digits of his service number, to differentiate him from the many other Williams in the Regiment which recruited mainly in South Wales), was 22 years old. He had enlisted as a Private soldier in May 2005, and after passing out at the Recruit Training Centre Catterick joined his unit in Nov 2005, the 2<sup>nd</sup> Battalion Royal Welsh Regiment in Tidworth, Wiltshire. The Battalion having recently returned from an operational Tour to Iraq in the same month.

At the time of the incident Pte Williams, was not a particularly fit individual, having failed his Basic Fitness Test three times (22 Feb 06, 03 Mar 06 and 29 Mar 06). He was placed on remedial PT on 29 Mar 06, but there is no record of his attendance for this training.

On 14 Jun 06, Pte Williams was officially posted as Absent Without Leave (AWOL). However, although posted AWOL, evidence shows he was on camp at Tidworth, but avoiding duty, for at least some of the time. It is entirely possible to avoid detection on camp as there is no method of checking when a soldier has returned to duty by way of swiping in or being checked in by the guard. There are at least three main entrances to Tidworth Garrison, and Pte Williams occupied individual accommodation. It is not uncommon for other soldiers to be unaware that a person is still posted AWOL.

**SOURCE**

Exhibit A1, 25204919 Pte G Williams conduct sheet extracted from JPA record, provided by [REDACTED] APC Glasgow

Exhibit B, AGAI report [REDACTED] Vol 1 (7 of 9), witness statement Wilts Police, [REDACTED]

Exhibit A1, 25204919 Pte G Williams conduct sheet extracted from JPA record, provided by [REDACTED] APC Glasgow;

Oral evidence from [REDACTED] at Service Inquiry Transcript and [REDACTED]

Transcript [REDACTED] Exhibit B, AGAI report [REDACTED] witness statement Wilts Police, [REDACTED]

Friday 30 June 2006

On the Friday (30 Jun 06) preceding his death, Pte Williams went into a public house known as the Ram, in Andover. He had previously borrowed [REDACTED] from [REDACTED] (who described him as his 'best friend'). As Williams was AWOL he would not have been paid.

[REDACTED] saw Pte Williams enter the Ram at around 1900-2000 hrs. He states Williams drank pints 'like they were going out of fashion' and that he knew Williams from his reputation having been 'arrested three times for fighting, down in Salisbury and in Andover', on one occasion he escorted the police to Williams' room for him to be arrested. [REDACTED] describes Williams as being rowdy.

[REDACTED] saw Williams talking to a bloke who 'looked a bit dodgy', and believed he was selling drugs. He saw Williams come out of the toilet and at one stage said "*I'm going to have a good time tonight*". [REDACTED] said he initially lent Williams [REDACTED] then another [REDACTED]. [REDACTED] concluded this was to buy drugs. [REDACTED] also said Williams was acting strangely after leaving the pub, "*tensing his body, grabbing his fists and sweating. He seemed paranoid and kept looking around* [REDACTED], a long term acquaintance also recalls giving Pte Williams a loan of [REDACTED] at around 5/6 pm that evening.

Once the group had returned to Lucknow Barracks at Tidworth, [REDACTED] heard loud music from Williams' room at around 5 or 6 in the morning. He found Williams covered in sweat, with three others in the room "acting very oddly", doing somersaults on the beds and kissing each other. He was under the impression they had been taking drugs. Williams appeared stressed, and tried to give [REDACTED] a tablet. Williams had between 15 and 20 tablets in his hand. Williams said he had taken 7 that morning and took another two washed down with beer in front of him.

Saturday 1 July 2006

The following day, Saturday 1 Jul 06, [REDACTED] saw Pte Williams again in the Ram public house that afternoon during the England v Portugal football game. Williams was described as drunk. [REDACTED] then went on to another pub in Amesbury, then to a nightclub (believed to be 'Sticky's'). He saw Williams who he describes as having had 'a lot to drink at that stage', and drinking shots which seemed to 'push him over the edge'. Williams attempted to fight [REDACTED] and [REDACTED] when he was taken outside by security staff. [REDACTED] left at around midnight.

Exhibit B, AGAI report  
[REDACTED]  
witness statement Wilts  
Police, [REDACTED]

Exhibit B AGAI report  
[REDACTED]  
witness statement Wilts  
Police, [REDACTED]

Exhibit AG, witness  
statement Wilts Police,  
[REDACTED]

Exhibit B AGAI report  
[REDACTED]  
witness statement Wilts  
Police, [REDACTED]

Exhibit AG, witness  
statement Wilts Police,  
[REDACTED]

Exhibit B, AGAI Report  
[REDACTED]  
witness statement Wilts  
Police, [REDACTED]



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On the evening of 1 Jul 06, the Officers Mess was holding its Summer Ball. [redacted] and [redacted]

[redacted] were some of the guests of [redacted] [redacted] was at the time [redacted].

They were all staying the night in empty soldier's accommodation on camp at Lucknow Barracks. After parting company with [redacted] at around 0300 hrs, [redacted] returned visibly upset, and informed him that a soldier had fired a fire extinguisher at his guests, and a young soldier had been aggressive towards them. The soldier had tried to gain forcible entry into the flat of six rooms. [redacted] then dressed and attended the scene where he saw a man who he did not know, drunk next to a dripping hydrant. He told him to get outside, which he did, but then ran away. [redacted] was able to establish that the man's name was 'Williams' and that he was in 'C Company' (from [redacted] who was present). Williams had apparently been abusive to [redacted] and [redacted]. Williams purported to apologise to [redacted], but when his back was turned Williams sprayed him with the fire extinguisher.

[redacted] then had the incident recorded in the daily occurrence book at around 0420 hrs, intending to deal with the matter on Monday. [redacted] did not know which Pte Williams it was as he had never seen him before. There are around 20 to 30 soldiers named Williams in the Regiment.

**Sunday 2 July 2006**

On Sunday 2 Jul 06, Pte Williams reported for the guard duty he had taken payment to perform (although still AWOL [redacted] [redacted] may have paid Pte Williams to carry out the duty for him).

Between 0900 hrs on Sat 1 Jul 06 and 0900 hrs Sun 2 Jul 06 [redacted], a [redacted] was on duty outside his normal role, as the [redacted]. At 0750 hrs on 2 Jul he attended the Guardroom and saw a man he now knows as Pte Williams enter the back door of the Guardroom, as if attending for duty. Williams was dressed in white trainers/flip-flops, C95 (camouflage) trousers, a tight civilian short sleeved 'muscle top', and a beaded 'surfer' necklace. [redacted] told Williams to go away and return correctly dressed. After failing to return 30 minutes later, [redacted] and [redacted] attended room 3, block 207, Lucknow Barracks. The door was locked so [redacted] used the BOS master key to gain entrance. Williams was sat facing away listening to loud music. He was asked if he was drunk, to which Williams replied "yes very drunk". He was unsteady on his feet but did not smell of alcohol, his eyes were not glazed nor did he slur his words. However his demeanour and behaviour led [redacted] to think he was drunk, though he did not consider the issue of drugs at the time. [redacted] ordered Williams to return to the Guardroom, and then left with [redacted] to

Exhibit A1, Vol 9, interview under caution, Wilts Police, [redacted]

Exhibit A1, Vol 10, sworn evidence of [redacted]

Exhibit A1, Vol 6, witness statement Wilts Police [redacted]

Exhibit B, AGAI Report [redacted] witness statement Wilts Police, [redacted]

make their way back to the Guardroom. Soon after it was established (via [REDACTED]), that Williams had been paid to cover the duty of another soldier. [REDACTED] then briefed the [REDACTED] of the incident, where he described Williams as indifferent and cocky. They then decided to see Williams. Williams was seen outside the accommodation still inappropriately dressed, when [REDACTED] asked him to remove the necklace which he did in a calm manner. Williams then became aggressive, adopting a violent posture, leaning forward with clenched fists, [REDACTED] thought he may attack. [REDACTED] remonstrated with Williams and informed him that he was to be reported for AGAI action, and to report to the Guardroom, at which time he left the accommodation block. Williams was seen again at the Guardroom smoking area at 0920 hrs. [REDACTED] considered him unfit for duty, and ordered him to get a meal and freshen up. However, by 0945hrs [REDACTED] informed [REDACTED] that Williams had run off. The BOO stated it would be dealt with later, and that when he was found he was to be told to report to either the Adjutant's office or the RSM's office so that 'discipline could be carried out'.

Pte Williams was seen by [REDACTED] later that day, 2 Jul 06, after 2100 hrs in his room looking hung-over, such that Pte Williams thought it was Monday (not Sunday).

### Monday 3 July 2006 – the day of the incident

All witnesses describe the day as being hot, bright and sunny. That morning the forecast for Larkhill area was at 1150 hrs - 24.1C, and 24.3C at 1250 hrs.

At around 0800 hrs [REDACTED] ordered [REDACTED] and [REDACTED] to find Pte Williams and bring him to the Guardroom. Williams told [REDACTED] to say he wasn't there.

[REDACTED] had commenced his duties that morning and had read the occurrence book which detailed the incident involving the fire extinguisher. [REDACTED] describes this as 'fairly routine occurrence' and that he was not mad about it.

Between 1030 and 1100 hrs [REDACTED], [REDACTED] and [REDACTED], with [REDACTED] were told to get Pte Williams by [REDACTED]. They attended his room which was locked. [REDACTED] opened the door with the duty keys to find Williams hiding in the shower. He was 'shaking like a leaf'. The room stank of beer, [REDACTED] didn't know whether Williams was shaking due to a hangover, or he was frightened. He was told to dress and escorted to the Sp Coy lines.

[REDACTED]

Exhibit C (7 of 14), sworn evidence of [REDACTED]

Exhibit B, AGAI report [REDACTED] witness statement Wilts Police, [REDACTED]

Exhibit C (13 of 14), Crown Court Trial summing up HHJ Royce, dated 29 Jul 08, p.33. Exhibit B, AGAI report [REDACTED] witness statement Wilts Police, [REDACTED]

Exhibit B, AGAI report [REDACTED] sworn evidence of [REDACTED]

Exhibit B, AGAI report [REDACTED] witness statement Wilts Police, [REDACTED]

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[REDACTED] had begun his duty at 0800 hrs that day and had been made aware of the guard duty incident on Sunday regarding Williams; by [REDACTED] (including the fact Williams had been aggressive). [REDACTED] then drafted some charges at 1024 hrs and sent the same by e-mail to the [REDACTED], [REDACTED] (a witness), [REDACTED] (who he thought was [REDACTED]), and the [REDACTED]. The purpose of the e-mail was to collect evidence and charge Williams for Absence Without Leave (AWOL), threatening [REDACTED] on the Sunday, drunkenness on the Sunday and for the threatening behaviour against his guests in the early hours of Sunday morning. It called for relevant persons to collect evidence which would be sent for legal advice in support of post charge Custody before being dealt with by the [REDACTED] (under extended powers if possible).

In his phone call to the Guardroom (described earlier in this report), [REDACTED] spoke to [REDACTED], when the remark "bring him to me hot and sweaty" or "panting like a dog" was used. [REDACTED] explained that although he did not know Williams he knew of him (he had been briefed by [REDACTED] about his aggressive behaviour towards him, Williams had been aggressive to [REDACTED] guests and he believed Williams was facing civilian charges of GBH), and so therefore wanted him brought to him compliant, and "on the back foot". [REDACTED] admits that he envisaged that the RP staff could order Williams to undertake drill movements such as mark time and about turns on his way to his office. [REDACTED] believed this to mean 'a beating'. In [REDACTED] view, he thought [REDACTED] had taken events over the weekend personally. When Williams arrived (following the drill session instigated by [REDACTED]), Williams and he were left alone in [REDACTED] office. Williams was not aggressive and [REDACTED] was surprised how compliant he was. [REDACTED] told Williams he had disgraced himself and the Regiment; he was a troubled lad who needs to 'get a grip'. Williams was 'clearly sorry for what he had done'. Williams did not show any signs of ill health to him or smell of alcohol. [REDACTED] was clearly angry about the incident over the weekend but Williams' attitude had surprised him. Williams was informed there would be charges, but was also told to write three letters of apology to [REDACTED]. He had Williams remove his cap badge which would be returned once the letters had been written. [REDACTED] states that in retrospect this was regretted. [REDACTED] was told about the letters and the cap badge. He did not give any specific order as to what was to happen next, other than mentioning the letters to [REDACTED]. [REDACTED] stated he heard Williams being marched away and also thought Williams could probably face AGAI action for failing to attend a duty (outwith the charges he had laid), instigated by Williams' Company under AGAI action. He also stated that he wouldn't be surprised if there was an administrative physical training session conducted by a fully qualified PTI. He did not however brief anyone in the RP staff what charges Pte Williams was likely to face so no double jeopardy could arise.

Exhibit A1, Vol 9,  
Interview under caution  
Wilts Police, [REDACTED]  
[REDACTED] Exhibit A1 Vol  
11, SIB interview under  
caution [REDACTED]  
[REDACTED] Oral evidence from  
[REDACTED] at Service  
Inquiry [REDACTED]  
[REDACTED]

Exhibit A1, Vol 10, sworn  
evidence of [REDACTED]  
[REDACTED]; Exhibit A1, Vol 11,  
SIB interview under  
caution [REDACTED]  
[REDACTED] and  
Exhibit B, AGAI report  
[REDACTED]  
sworn evidence of [REDACTED]  
[REDACTED]

Exhibit A1, Vol 10, sworn  
evidence of [REDACTED]  
[REDACTED]

Exhibit A1, Vol 9, sworn  
evidence of [REDACTED]  
[REDACTED]



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The drill was witnessed by several individuals who describe the weather as hot and Williams becoming distressed. [redacted] describes [redacted] as shouting "shut the fuck up", "get your knees up". [redacted] thought the drill lasted from approximately 1015 hrs to 1115 hrs (but this would not have included the time Williams spent at [redacted] office). Other witnesses say it didn't seem anything out of the ordinary and that Williams seemed to be coping. [redacted] saw the drill and heard Williams complain of a stitch, but also stated [redacted] had probably heard all these excuses before'. [redacted] described Williams as being in a "bad way and wasn't coping with it". [redacted] in fact says the drill was if anything lighter than usual because of the weather and that Williams was complaining of a stitch and retching.

[redacted] believed Williams was to be marched back to the Guardroom and write the letters. He believed 'that would be it'. Pte Williams was marched back to the Guardroom, and stood on the white line. At this point [redacted] was spoken to as Williams was stood to attention. [redacted] says he briefed [redacted] regarding the letters and the removal of the cap badge, although [redacted] denies any knowledge of the letter writing. [redacted] and [redacted] shouted at Williams regarding his disgracing the Battalion – particularly with regard to the cap badge. [redacted] says that [redacted] shouted back "I don't care, I hate the Army, I hate you, I don't want to be here".

[redacted] was instructed by [redacted] to "phone [redacted] up" (the [redacted]). Although [redacted] questioned this, he did so, telling [redacted] that they had "a naughty boy here and could they bring him over". [redacted] agreed. Williams then went to the toilet, and complained he "had the shits". [redacted] was then told by [redacted] that he would take him to the Gym. [redacted] then left to attend a mess meeting.

It was at this mess meeting that [redacted] said [redacted] told him he had given someone "the beating of his life" or "the beating of my life". [redacted] says he would have spoken about it but that it was not the harshest beating he had delivered as his duties as an RP required him to do.

[redacted] saw [redacted] march Williams past BHQ on the way to the gym, and heard [redacted] shouting at him. This was described as 'a good bollocking' and [redacted] stated "I don't recall his drill being particularly bad – it seemed fine and he didn't appear to be flagging at this stage". [redacted] goes on to

Exhibit B, AGAI report  
[redacted]  
witness statement Wilts  
Police, [redacted]

Exhibit A1, Vol 2,  
sworn evidence of [redacted]

Exhibit B, AGAI report  
[redacted]  
sworn evidence of [redacted]

Exhibit B, AGAI report  
[redacted]  
sworn evidence of [redacted]

Exhibit B, AGAI report  
[redacted]  
sworn evidence of [redacted]

Exhibit B, AGAI report  
[redacted]  
witness statement Wilts  
Police, [redacted]

Exhibit B, AGAI report  
[redacted]  
sworn evidence of [redacted]

Exhibit B, AGAI report  
[redacted]  
witness statement Wilts  
Police, [redacted]

Exhibit B, AGAI report  
[redacted]  
witness statement Wilts  
Police, [redacted]

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say "I've never really seen drill being used as a punishment, it is something that is used in day to day life. If you were in trouble you would be marched to locations on the camp".

By his own admission in interview [REDACTED] admits to saying or believing the situation to be that Williams was "not fucking working with him", and he was "working against" him, Williams "made me look a twat in front of everyone". [REDACTED] confirms he took it upon himself to take Williams to the gym with no AGAI action instigated.

[REDACTED], the [REDACTED] began work at the gym at 0845 hrs on the day of the incident. [REDACTED] stated in evidence that Wet Bulb Globe Test readings were obtained from [REDACTED] also a [REDACTED], that day at around 1000 hrs. There is little or no evidence to support this, but in any event such readings are there to assist in any risk assessment regarding exercise for the day. [REDACTED] believed that the readings were 24 (degrees) for the morning and 26 for the afternoon. According to the guidance, the reading of 24 (presuming this was the WBGT reading and not the ambient temperature reading) would have advised a person could carry 20kg and march at 4mph, e.g. a Basic Combat Fitness Test.

In fact, the guidance states an un-acclimatised person could have a work rate of 'High, e.g. marching at 3.5mph, with a 20Kg load patrolling, digging and field assaults'.

[REDACTED] stated that on the morning of 3 Jul 06, Support Company (to which Pte Williams belonged) and elements of the Recce Coy were taken by his staff for their Personal Fitness Test (PFT) consisting of press-ups, sit ups and a 1.5 mile run, all to be done in certain times according to age and gender. No issues had arisen to his knowledge.

[REDACTED] confirms he received the call from the Guardroom, and was then visited by [REDACTED] with Williams. [REDACTED] told him that "in 21 years he had never come across anyone having his cap badge taken off him". No instructions regarding any AGAI action or otherwise were received. No history of any drill was passed to [REDACTED] had received soldiers for Corrective Military Training several times in his 13 year career and saw nothing unusual about it.

Whilst passing the doorway to the Gym, [REDACTED] heard Williams shout to [REDACTED] "I've been feeling ill, I'm not doing any more". [REDACTED] described Williams as looking pissed off, but not in any pain of any sort, with a note of defiance, with no recognition of any rank. [REDACTED] was heard to reply dismissively "Shut up". Williams did not look excessively hot to him given the conditions of the day, or ill.

[REDACTED]  
Exhibit B, AGAI report [REDACTED], interview under caution Wilts Police, [REDACTED] and [REDACTED] sworn evidence of [REDACTED]

Exhibit B, AGAI report [REDACTED] sworn evidence of [REDACTED]

Exhibit A1, Vol 20, Exhibit DCS/2, JSP 539 Climatic Injuries in the Armed Forces: Prevention and treatment.

Exhibit B, AGAI report [REDACTED] sworn evidence of [REDACTED]

[REDACTED]  
Exhibit B, AGAI report [REDACTED] witness statement Wilts Police, [REDACTED]

Williams entered the gym, and [REDACTED] carried out a dynamic risk assessment on Williams; he spoke to him, asking what he had done to be brought to him. Williams was slightly red in the face, with beads of sweat in his hair. [REDACTED] told Williams to get a cup of water, but told not to gulp. Williams was shaking, and told to relax. Williams confirmed he had no injuries. Williams said he had returned from AWOL, and had been very drunk on Saturday night but could not remember what he had done. Williams then had another cup of water. The gym had fans inside and was described as cooler than outside. [REDACTED] concluded he was fit for exercise. [REDACTED] told Williams to put on gloves and punch the punch bag 10 times, and then 10 squat thrusts. He did these, and no concerns were raised. Williams had another drink of water. He was told to repeat the last exercise, he punched the bag 10 more times but after two or three squat thrusts complained that his stomach was hurting and that he had been 'shitting and pissing blood since Friday'. [REDACTED] stated that "one half of him believed him, the other didn't". After another drink of water, Williams said he felt better, and [REDACTED] decided to take him back to the Guardroom so Williams could be taken to the Medical Centre. A slightly longer route was taken 'to avoid the Cpls Mess meeting and embarrassment it would cause [REDACTED] and Williams'. [REDACTED] made Williams carry a 5Kg 'power bag' (a blue cylindrical padded weight with handles). [REDACTED] says he learned this technique from [REDACTED] when a prisoner complained of stomach cramps but then "did a runner". It was "psychological, another thing to think about other than run away". [REDACTED] says Williams did not do any exercises with the bag on the way back.

However, several witnesses say they saw [REDACTED] exercising Williams with the power bag. [REDACTED] saw Williams lift the bag above his head whilst ascending stairs, two repetitions. [REDACTED] saw him lift it about ten times, [REDACTED] believes he saw Williams lift it up, out and towards him, [REDACTED] saw Williams looking exhausted, struggling to cope with a slow jog. He did not see him raise his arms. [REDACTED] states "he looked knackered. His arms were locked holding the weight against the top of his legs and appeared to be struggling to jog".

[REDACTED] also saw Williams with the power bag, and every few steps he had to lift it above his head, four or five times. It was very hot. Williams looked tired to him. [REDACTED] also saw Williams lift the bag but on [REDACTED] command of "one". [REDACTED] also saw Williams lifting the bag in what he describes as a common form of 'beasting', from his experience in Germany.

Exhibit B, AGAI report  
[REDACTED]  
sworn evidence of [REDACTED]  
[REDACTED]

Exhibit B, AGAI report  
[REDACTED]  
sworn evidence of [REDACTED]  
[REDACTED]

Exhibit B, AGAI report  
[REDACTED]  
witness statements Wilts  
Police, [REDACTED]  
[REDACTED]

Exhibit B, AGAI report  
[REDACTED]  
witness statements Wilts  
Police, [REDACTED]  
[REDACTED]



**PROTECT-STAFF-DOWNGRADED**

█ spoke to Williams on the way back, asking why hadn't reported the blood in his urine before. Williams said he thought it would pass. He mentioned to █ he had tried to tell the RP staff but they wouldn't listen. Williams also told █ he had been out with the RPs prior to him being taken to the gym, and that he had not eaten that day (this was confirmed by the post mortem report). En route █ spoke to █ about athletics, and then continued towards the Guardroom. At the Guardroom he told Williams to put the bag down and returned his belt and beret, before informing █ about Williams' complaints (Pissing blood, he had been drinking at the weekend) and both agreed he should go to the Medical Centre.

█ says Williams looked like he had been "doing the London marathon". Williams was given a glass of water which █ told him to sip, but he just knocked it straight back. █ told █ to take a radio and escort Williams to the Medical Centre. █ and Williams walked out of the Guardroom toward the Medical Centre, Williams was 'walking fine and talking. He was looking a little bit pale'. They turned a corner from the Guardroom at which point Williams was said by █ to 'dive to floor, pulled his shirt out, unbuttoned it, started fanning himself with his beret' saying "I can't walk, I can't go on, I can't carry on, I need this, I need that". He refused point blank to move. █ then contacted █ by mobile phone at the Guardroom. █ was then joined by █ and █

At 1215 hrs █ was on duty in the Guardroom when he heard █ take a call and was asked to accompany him to attend █. He was with █ when he saw Williams on his back leaning on his right shoulder, legs extended, no beret on, shirt unbuttoned, and open. He had his left arm across his chest. As soon as Williams saw them, he began to sit up and then stand. Williams walked four or five steps to █ and put his arm around his shoulder. He was steady on his feet, but appeared red in the face, but 'talking fine'. █ heard █ ask Williams "are you bluffing?". █ himself describes Williams as saying "I can't go on █, I can't go on". █ replies "Williams you are pissing me off. Come on you're a fucking embarrassment, you're embarrassing me you're embarrassing yourself. The Medical Centre is there just up the hill now fucking get up". █ then tasked █ to get █ saw Williams get up unaided but then collapse again by a tree about 20 ft away. █ arrived a few minutes later and █ went back to the guardroom.

█ was driving past with █ having just left the Medical Centre, and saw Williams at the side of the road. He commented that "as we drove a little further I had second thoughts, it just didn't look right. So I said to Dye pull over and stop". █ ran back to where Williams and █ were located beneath the trees, and stated that Williams replied "I'm hammered" or "I've been hammered" and "I can't get up".

Exhibit B, AGAI report  
Blak █  
sworn evidence of █

Exhibit B, AGAI report  
█  
witness statement Wilts  
Police, █

Exhibit B, AGAI report  
█  
witness statement Wilts  
Police, █

Exhibit B AGAI report  
█  
interview under caution  
Wilts Police, █

Exhibit B, AGAI report  
█  
witness statement Wilts  
Police, █

In a previous statement [REDACTED] stated Williams said "I'm cooking up, I can't move my legs, I've been taking drugs and I feel dizzy and faint" or words to that effect. Of note is the fact that this was the only time drugs were mentioned by any witness of fact on that day. [REDACTED] also denies ever hearing this statement. [REDACTED] made several statements all of which differed, and his evidence at court was again inconsistent. His accounts directly contradicted accounts of several other witnesses, the accused and CCTV footage. [REDACTED] was described by the Crown Court Judge as a 'manifestly unreliable' witness due to his differing and clearly incorrect accounts.

[REDACTED] also gave evidence of [REDACTED] as "having a reputation in the Battalion for being a bit of an idiot...not a bloke you trust".

[REDACTED] attended the Medical Centre and informed [REDACTED] that Williams was laying half way up the hill towards the Medical Centre, complaining of stomach problems and could he go down and see him. [REDACTED] drove the short distance in the duty car and on arrival he asked Williams what the matter was, [REDACTED] and [REDACTED] were also on the scene at this time. [REDACTED] asked [REDACTED] if he could get Williams to a Doctor and to be kept informed of the situation and left. [REDACTED] described Williams as "sweating, flustered, out of breath, breathing heavily, I did not notice dryness to the mouth. He appeared to be tired, he was able to talk". Williams said "alright [REDACTED]", and [REDACTED] replied "alright mate what's wrong?". Williams stated "I have stomach pains. I've been shitting and pissing blood" or similar words. According to [REDACTED], Williams did not mention or at the very least did not hear Williams mention any 'beasting' or that he had taken any drugs. [REDACTED] asked Williams if he could get up. Williams did get up (in fact [REDACTED] says he got up and walked like he 'had never had a drink in his life' and looked and sounded quite normal. [REDACTED] checked his posture because of the symptoms of stomach ache and passing blood, thinking that if true, his posture would be affected. Williams' posture seemed fine. [REDACTED] feared he may be dehydrated because he was "hot, sweaty and flustered", it was a hot day and he "may have been doing exercises as a punishment due to his behaviour on Sunday morning", but did not know for sure if this was the case. [REDACTED] then told [REDACTED] to escort Williams 100 metres or so to the Medical Centre. He did not take him in his car as he feared Williams may become violent because of the incident he witnessed the previous Sunday morning with [REDACTED]. [REDACTED] also explained his reasoning on the basis that he was not insured to drive a prisoner in [his] car. [REDACTED] followed and observed from the car. [REDACTED] stated that the walk took around three minutes and Williams appeared to be walking 'fine'. CCTV footage shows Williams walking at a fairly brisk pace, but the footage was not in normal continuous time. Pte Williams entered

Exhibit B, AGAI report  
[REDACTED]  
witness statement Wilts  
Police, [REDACTED]  
[REDACTED]

Exhibit C (13 of 14),  
summing up HHJ Royce,  
dated 28 Jul 08, p.30 par  
C-E.

Exhibit A2, SIB  
Addendum report (2 of 4),  
interview under caution  
Wilts Police, [REDACTED]  
[REDACTED]

Exhibit B, AGAI report  
[REDACTED]  
witness statements Wilts  
Police, [REDACTED]  
[REDACTED]

[REDACTED]

Exhibit A2, SIB  
Addendum report (3 of 4),  
interview under caution  
Wilts Police, [REDACTED]  
[REDACTED]

[REDACTED]

Exhibit A3, CCTV  
evidence

the medical centre at 1217 hrs.

██████████ arrived separately from Williams and ██████████. He spoke to the ██████████ ██████████. ██████████ says ██████████ briefed her that a soldier had complained of passing blood in his urine. ██████████ also said the soldier had been 'beasted' that morning (which she took to be PT or strenuous foot drill). ██████████ directed ██████████ to conduct 'run-up'. ██████████ asked ██████████ to conduct 'run-up' checks on Williams prior to him being seen by a Doctor. ██████████ states that he spoke to ██████████ for five minutes, to brief her, including the events on Sunday morning. He advised her to have ██████████ present throughout any medical examination as Williams had been acting aggressively. ██████████ handed over the care of Williams to ██████████ at around 1225 hrs.

██████████ had seen Williams and ██████████ walk up the hill after hearing shouting. ██████████ was situated at the Admin room in the Medical Centre, and he presumed Williams was in some sort of trouble as he had no beret on (usually that means a soldier is under sentence). ██████████ states that he saw Williams from the window in his office, about 10 metres away; he described Williams as 'knackered', as if "he had just run the London Marathon" and "trying to suck air from every pore in his body". Williams was walking unassisted, yet swaying in short spells.

On the arrival of Williams in the Medical Centre, ██████████ instructed ██████████ to carryout 'run-ups' on Williams, ██████████ did not feel any sense of urgency in ██████████. Williams at this point was recovering, sweating but his breathing had slowed. ██████████ heard Williams repeatedly say in low voice "calm down, calm down", ██████████ thought he was speaking to the staff. He was breathing 'half as much as when ██████████ saw him outside', he wasn't flushed, eyes were normal. ██████████ and Williams accompanied ██████████ to the audiometry room of the Medical Centre, and ██████████ believes he was instructed to do 'run-ups' 'fit for detention', or in any event assumed that was what was being asked of him. 'Run-ups' would consist of height, weight, blood pressure and pulse, audio test, basic eye test and "a piss (urine) test for any blood" (not drugs) and a lifestyle questionnaire.

██████████ sat Williams down next to a sink and Williams asked for water. At this point ██████████ was still in the room. ██████████ turned the tap on and left it on. Williams cupped his hands together and used his cupped hands to raise water to his mouth or face. ██████████ completed some of the form which took around five minutes, with Williams responding to questions in a helpful manner.

After about 6-7 minutes, having checking his weight, and then height, Williams drinking water in between examinations, ██████████ then asked Williams to stand up so he could check his eyesight. Williams stood up and suddenly 'flipped'. He began throwing water around, and scooping a large amount of water, threw it

Exhibit A2, SIB  
Addendum report (3 of 4),  
interview under caution,  
Wilts Police, ██████████

Exhibit A2, SIB  
Addendum report (1 of 4),  
witness statement ██████████

Exhibit B, AGAI report  
██████████  
witness statement Wilts  
Police, ██████████

Exhibit A2, SIB  
Addendum report (2 of 4),  
interview under caution,  
Wilts Police, ██████████

██████████

██████████

Exhibit B, AGAI report  
██████████  
witness statement Wilts  
Police, ██████████

Exhibit B, AGAI report  
██████████  
witness statement Wilts  
Police, ██████████ and  
██████████



over himself. He shouted "fuck off or I'll knock your teeth out", "you're a cunt, you're a bastard" or words to that effect. His face was 'screwed up' as if "hate was pouring out of him", his face turning a deeper red. [REDACTED] tried to calm him, Williams looked at him, but [REDACTED] thought Williams "was a nutter" and had "lost the plot". Williams then started trying to hit [REDACTED] three or four times with clenched fists. [REDACTED] felt very threatened and grabbed Williams' wrist and shirt collar, he then twisted Williams' arm behind him and sat him in his chair. He did not need a large amount of force to do this. [REDACTED] did not feel any noticeably high body temperature of Williams. Williams struggled and swore initially, but then quietened down. Williams then began apologising. [REDACTED] let him calm down for a few minutes and told him to drink some water. [REDACTED] had never had this sort of experience with a patient before. [REDACTED] meanwhile had not given any support or assistance.

[REDACTED] then appeared at the door. [REDACTED] explained what had happened, and [REDACTED] told [REDACTED] to radio for the RPs. [REDACTED] could not get communications with his radio and left the room to use the telephone in reception to do this. On his return he sat on the chair in the corner and [REDACTED] then left. [REDACTED] was described by [REDACTED] as being annoyed that one of his medics had been assaulted. Williams at this point was back to being calm again.

A short time later [REDACTED] entered the audiometry room, angered, and shouted at Williams, swearing at him, telling him people were there to help him and that he was making matters worse for himself. This lasted around five minutes, [REDACTED] then asked [REDACTED] to leave so he could finish the tests.

[REDACTED] wanted to go to the toilet, and walked past Williams. Williams stood up and threw a punch at [REDACTED] and then grabbed him, pushing him over a table. Williams continued to attempt to head-butt [REDACTED] at one point biting him on the arm. [REDACTED] managed to roll and push him off. [REDACTED] pinned Williams to the wall, with Williams still struggling and trying to kick [REDACTED]. Williams was described as being 'worse than the first time', being full of hate, swearing and thrashing out. [REDACTED] subdued him in the same way as before this time putting his knee behind Williams and taking him to the floor, face down. [REDACTED] shouted at him to calm down, he thought Williams was 'going mental' and needed to go to the Military Mental Health Centre.

[REDACTED] had Williams lay on his stomach, legs to the left, whilst holding Williams' arm across his buttocks. [REDACTED] right knee was in the small of Williams' back to control him. Williams was still shouting and threatening [REDACTED], and kicking out with his feet. [REDACTED] still had no thoughts that Williams was suffering a heat injury. [REDACTED] didn't ask [REDACTED] to help as he did not trust him.

Exhibit A2, SIB  
Addendum report (2 of 4),  
interview under caution,  
Wilts Police, [REDACTED]

*ibid p. 145-148* and  
Exhibit B, AGAI report  
[REDACTED]  
interview under caution  
Wilts Police, [REDACTED]

Exhibit A2, SIB  
Addendum report (2 of 4),  
interview under caution  
Wilts Police, [REDACTED]



PROTECT-STAFF-DOWNGRADED

At this point [redacted] and [redacted] "burst into the room". Either [redacted] or [redacted] told [redacted] to step away or step back, [redacted] also told [redacted] to leave. Williams was still shouting. [redacted] took over in restraining him. Several persons present continually tried to reassure and calm Williams down. [redacted] was also visible in the room. [redacted] left the room and seeing [redacted] was upset tasked him to drive some samples to another medical facility in Bulford.

According to his statement [redacted] re-entered the room at approx 1245 hrs whereupon [redacted] told [redacted] to call the two RPs ([redacted] and [redacted]). [redacted] waited for them by the MRS entrance. The RP staff arrived at 1243 hrs.

**Note:** Timings given within witness statements are approximate, however the CCTV footage from the Medical Centre camera (Exhibit A3) included a digital clock display and therefore the timings shown are considered to be accurate.

[redacted] stated that he had returned to the Medical Centre at around 1225 hrs, after purchasing sandwiches when immediately upon his return he was told by [redacted] (who was covering for him as [redacted]) that a soldier (Pte Williams) had arrived who was complaining of passing blood in his urine having been 'beasted' earlier that morning. At this time Williams was undergoing 'baseline observations' (also known as run-ups).

Within a minute or so of being informed that Pte Williams was awaiting treatment, [redacted] made his way to the audiometry room, as he was walking towards the room he heard what sounded like a scuffle coming from inside, he waited a few seconds until the noise ceased before entering. Williams was on the ground in the corner facing the wall [redacted] states that present in the room were [redacted] and [redacted]. [redacted] attempted to examine Williams, however he was uncooperative, refused to stand up and refused to be touched. [redacted] recalled that Williams was lying on the floor and rolling from side to side preventing [redacted] from carrying out an examination or taking a pulse. [redacted] also stated that "Having touched him I was not concerned about his temperature. He was as I would have expected of a person who had been struggling". At this point he decided that Williams should be moved to a treatment room where there was better lighting and medical facilities.

[redacted] recalls that [redacted] wanted to get Williams on to a stretcher in order to carry out his examination but the stretcher was in another treatment room. He stated that he tried to get Williams to stand up, and when he wouldn't he said to [redacted] "Right show me where the treatment room is and I'll get him there". [redacted] put his arms underneath Williams' armpits

[redacted]  
[redacted]  
Exhibit B, AGAI report  
[redacted]  
witness statement Wilts  
Police, [redacted]  
[redacted] and Exhibit  
A3, CCTV evidence.

Exhibit A2, SIB  
Addendum report (1 of 4),  
witness statement Wilts  
Police, [redacted]  
[redacted]  
Exhibit B, AGAI report  
[redacted]  
witness statements Wilts  
Police, [redacted]  
[redacted]

Exhibit B, AGAI report  
[redacted]  
interview under caution  
Wilts Police, [redacted]  
[redacted] and Exhibit B, AGAI  
report [redacted]

**PROTECT-STAFF-DOWNGRADED**

and casually dragged him to the treatment area. [REDACTED] stated that [REDACTED] "did not use any violence or what I would consider any undue force, moving Pte Williams in the same way we would have moved any person without a stretcher". [REDACTED] also stated that when [REDACTED] tried to assist in the movement of Williams by grabbing his legs, [REDACTED] said "Don't do that Sir 'cause he might kick you", although whilst being moved, [REDACTED] stated that Williams was not struggling. When Williams had been relocated to the treatment room, [REDACTED] again attempted to take his pulse, temperature and blood pressure, but Williams remained uncooperative and resisted attempts to treat him, [REDACTED] concluded that it was not safe or possible to take a reading. Williams was 'verbalising' but not using words and because of his behaviour and demeanour, [REDACTED] considered that he may have mental health issues and sought the advice of someone more suitably qualified from the Community Psychiatric Nurse Department within the Medical Centre. He left the room and tried to call the Psychiatric Department but there was no answer.

At around 1230 hrs [REDACTED] had resolved to go to the Psychiatric Department and before he left, advised [REDACTED] to observe the situation but stay back, also present at this time was [REDACTED] and [REDACTED] maintained observation of Williams and another patient in the next cubicle. [REDACTED] remained in the room and could hear everything that went on, but could not see everything as she was alternating between cubicles, she provided a pillow to prevent damage to Williams head whilst he was on the floor. At approx 1235 hrs Williams was still thrashing, with a soldier sat over him. She heard someone threaten to use the handcuffs, and then heard [REDACTED] say "Go ahead cuff him". She saw the handcuffs applied, and left that cubicle at around 1240 hrs.

There is some confusion amongst all witnesses regarding the timing of events, CCTV footage collected as evidence during the Wilts Police investigation (Exhibit A3) gives the most accurate indication of the comings and goings of individuals at the entrance to the Medical Centre, and this source indicates that [REDACTED] and [REDACTED] entered the front door at approx 1244 hrs and therefore the handcuffs which were in the possession of [REDACTED], would have been applied to Williams shortly after that time. [REDACTED] stated that "the handcuffs were used at the last possible moment", on authority from [REDACTED] [REDACTED] disputes this stating that "[REDACTED] had called him to inform him that Pte Williams had been restrained and handcuffs were used. This happened after the use of handcuffs". He did not recall [REDACTED] calling him for authority to use handcuffs.

[REDACTED] had rung [REDACTED] regarding the use of handcuffs, and stated that [REDACTED] had said they could use them at the last safe moment if he was a danger to himself or others. A number of attempts had been made by [REDACTED] and others to get Williams to calm down but this proved unsuccessful, [REDACTED]

witness statements Wilts Police, [REDACTED]

Exhibit B, AGAI report [REDACTED] witness statement Wilts Police, [REDACTED]

Exhibit A3; Exhibit B, AGAI report [REDACTED], interview under caution Wilts Police, [REDACTED]

ibid p.38 Exhibit B, AGAI report [REDACTED] interview under caution Wilts Police, [REDACTED]

**PROTECT-STAFF-DOWNGRADED**

██████████ with the assistance of ██████████ then handcuffed Pte Williams to the front of his body. ██████████ had the rigid style handcuffs, ██████████ believed that all the RP staff had been properly trained in their use. Both sides of the handcuffs were needed as they couldn't calm Williams down.

██████████  
Exhibit B, AGAI report  
██████████  
witness statement Wilts  
Police, ██████████  
██████████

██████████ returned to cubicle 3 (where Williams was located) approximately 10 minutes later to find Williams sat on the bed supported by two servicemen, head slumped forward on his chest, eyes closed, and he was dribbling. She found his respiration was shallow and he was unresponsive to verbal stimuli. She saw a soldier dabbing cold water on Williams' face in an attempt to revive him.

Exhibit B, AGAI report  
██████████  
witness statement Wilts  
Police, ██████████  
██████████

A short time earlier ██████████ had left Pte Williams in order to obtain assistance from the Psychiatric Department (a short distance away) and spoke to two of the psychiatric nurses (CPN) and ██████████, which he states lasted around two minutes. He then returned to the treatment room accompanied by a civilian CPN whose name he did not know.

Exhibit B, AGAI report  
██████████  
witness statement Wilts  
Police, ██████████  
██████████

Having arrived back at the treatment room after about five minutes, ██████████ found Williams in a raised position propped against the bed, supported by ██████████ but now handcuffed to the front. ██████████ described Williams as "completely unresponsive and at this point I could see that his condition had seriously deteriorated since my leaving the room". ██████████ recalls at that time "the patient's face was turning cyanotic, that is his mouth and lips were turning blue due to hypoxia which is a lack of oxygen to the brain".

██████████

Exhibit B, AGAI report  
██████████  
witness statement Wilts  
Police, ██████████  
██████████

It was clear to ██████████ that Williams' condition had now become very serious, so with the assistance of ██████████, he moved Williams onto the examination bed. He called for the handcuffs to be removed, and this was done whilst ██████████ was treating Williams. On finding that Williams had no pulse at his wrist, chest or neck ██████████ called for help and an ambulance. ██████████ got an abu-bag to assist respiration and pulled the crash trolley into the cubicle. At this time the soldiers left the room and shortly after ██████████, ██████████ and ██████████ (all General Practitioners) arrived to assist ██████████ who had commenced Cardio-Pulmonary Resuscitation (CPR).

Exhibit B, AGAI report  
██████████  
witness statement Wilts  
Police, ██████████  
██████████

Exhibit B, AGAI report  
██████████  
witness statement Wilts  
Police, ██████████  
██████████

With the arrival of the other Doctors they immediately began to assist with the resuscitation and conducted CPR as a team. ██████████ asked for 1mg adrenalin (a heart stimulant) at 1301 hrs, and a pink canula was fitted. The patient was also intubated (to assist breathing). Electrodes were attached to Williams, but a non-shockable rhythm was detected by the heart start machine.

Exhibit B, AGAI report  
██████████  
witness statement Wilts  
Police, ██████████  
██████████

Exhibit B, AGAI report



**PROTECT-STAFF-DOWNGRADED**

A second dose of adrenalin was administered at 1308 hrs, and a third at 1313 hrs. The paramedics arrived at the cubicle at around 1315 hrs. [REDACTED] copied a piece of paper with Williams detail on it and this was handed to the paramedics. A fourth shot of adrenaline was given, together with an anti-opiate drug 'naloxone'.

[REDACTED] stated in his evidence to the SI that there are no ill-effects of an anti-opiate if no opiates have been taken. As the MRS was not an A&E department, analysis and treatment was difficult.

At some point a cardiac output was found, and Williams was then conveyed to Salisbury District hospital by ambulance. [REDACTED] was informed by a paramedic that Williams left with a pulse but he was not breathing without assistance. The ambulance left at 1328 hrs. Pte Williams was then treated by the paramedics en-route to Salisbury Hospital and then Hospital staff. On arrival at Salisbury District Hospital at 1405 hrs, his body was 'hot to the touch', his temperature being 41.7C, no ventilatory effort, with blood pressure being 60/20 (the norm being around 120/80). His consciousness was 3/15 (normal being 15/15. Measures were taken to cool him (ice packs, fan, and bladder irrigation) but he remained unresponsive. At 16.28 hrs on Mon 3 Jul 06 he was certified dead.

It should be noted that [REDACTED] had previously treated a heat casualty earlier the same day ([REDACTED]). He had asked [REDACTED] to assist. [REDACTED] was [REDACTED] at the time. A clear history was passed to [REDACTED] in that the soldier had complained of feeling unwell during physical activity, became confused and had been un-rouseable. The soldier was brought in by the supervising PTI. [REDACTED] quickly diagnosed a heat injury and treated him before the ambulance arrived. [REDACTED] describes [REDACTED] as acting 'with confidence and professionalism'.

[REDACTED]  
witness statement Wilts  
Police, [REDACTED]

[REDACTED]  
Exhibit A2, Addendum  
report (1 of 4), witness  
statement [REDACTED]  
[REDACTED] and  
Exhibit A3 - CCTV

Oral evidence from [REDACTED]  
[REDACTED] at Service  
Inquiry [REDACTED]  
[REDACTED]

Exhibit B, AGAI report  
[REDACTED]  
witness statement Wilts  
Police, [REDACTED]  
[REDACTED]

Exhibit D - Autopsy  
Report, Ref. No.  
06BP050Cr dated 12 Jul  
06, p.4

Exhibit B, AGAI report  
[REDACTED]  
witness statement Wilts  
Police, [REDACTED]  
[REDACTED];  
witness statement Wilts  
Police, [REDACTED]  
[REDACTED]. Oral  
evidence from [REDACTED]  
[REDACTED] at Service  
Inquiry [REDACTED]  
[REDACTED]

**TERM OF REFERENCE 1(c)**

**“Ascertain whether service personnel were on duty at the time of their employment as it related to the death of Pte Williams”.**

**Summary**

On 3 July 2006 Pte G Williams reported for duty after a period during which he was AWOL. As detailed earlier in this report, on this day he interacted with a number of individuals from his unit, from his initial appearance in Company lines until he was transported by ambulance to Salisbury Hospital, from Tidworth Medical Centre. For the purposes of addressing this TOR, it is considered by the panel that the key individuals whose actions may have influenced the outcome of this incident are;

[REDACTED]

**Findings**

All the aforementioned military personnel gave statements to either Wiltshire Constabulary or the Op ARROW SIB investigation regarding their involvement with Pte G Williams on 3 July 2006, which confirms their on duty status on that day.

1. [REDACTED] – was in his office at BHQ on that morning, where he conducted an interview with Pte G Williams and sent an email regarding the events of the evening of Sat 1 Jul 06. Exhibit A1, Vol 9, interview under caution Wilts Police, [REDACTED]
  
2. [REDACTED] – assumed his duties as [REDACTED] at the unit guardroom commencing at 0745 hrs on that morning, and continuing throughout the day including a number of contacts with Pte Williams. Exhibit B, AGAI Report [REDACTED] interview under caution Wilts Police, [REDACTED]
  
3. [REDACTED] – was at his place of work in the unit gymnasium when [REDACTED] brought Pte G Williams to the gymnasium for a PT session. He subsequently escorted Williams back to the guardroom when he complained of stomach pains and was also present later in the Medical Exhibit B, AGAI Report [REDACTED] interview under caution Wilts Police, [REDACTED]

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Centre where he assisted in restraining Williams.

4. [REDACTED] – was in the unit guardroom conducting his duties as [REDACTED] from 0900 hrs until approximately 1045 when as instructed by [REDACTED] he conducted a drill session with Pte G Williams. [REDACTED] handed Williams over to [REDACTED] at approx 1130 hrs at the guardroom, where he remained until leaving to attend a Cpls' Mess meeting at approx 11.50 hrs.  
[REDACTED]  
Exhibit B, AGAI Report  
[REDACTED] interview under caution  
Wilts Police, [REDACTED]  
[REDACTED]
5. [REDACTED] – was an infantry soldier who just happened to be on guard duty that morning from 0800 hrs to 1100 hrs within the unit guardroom. Whilst having a break from duty within the guardroom rest area, he was instructed by [REDACTED] to escort Pte Williams from the guardroom to the Medical Centre. [REDACTED] believes this to have taken place around 1200 hrs, but this timing is disputed by others.  
Exhibit B, AGAI Report  
[REDACTED] witness  
statement Wilts  
Police, [REDACTED]  
[REDACTED]
6. [REDACTED] – was initially acting as [REDACTED] conducting this duty in Barracks from 0900 hrs on Saturday 1 Jul 06, when he had cause to reprimand Pte Williams for his dress in the unit guardroom on Sunday morning and later that day entered Williams' room to ascertain why he had not returned to the guardroom as instructed. On Mon 3 Jul 06 at around 1050 hrs in the Tidworth Medical Centre, his usual place of work, [REDACTED] was approached by [REDACTED] who requested that he attend to Pte Williams who had collapsed outside.  
Exhibit B, AGAI Report  
[REDACTED] witness  
statement Wilts Police, [REDACTED]  
[REDACTED]
7. [REDACTED] – was on duty on Monday morning as duty Medic in Tidworth Medical Centre when he first observed [REDACTED] Williams and [REDACTED] through the window, shortly afterwards he was instructed [REDACTED] to conduct 'run-ups' on Pte Williams.  
Exhibit B, AGAI Report  
[REDACTED] witness  
statement Wilts Police [REDACTED]  
[REDACTED]
8. [REDACTED] – a member of the RP staff was attending a Cpls' Mess meeting when a telephone call was relayed instructing him to go to an incident at the Medical Centre. [REDACTED] later applied rigid handcuffs to restrain Williams in the Medical Centre.  
Exhibit B, AGAI Report  
[REDACTED] interview under caution  
Wilts Police, [REDACTED]  
[REDACTED]  
Exhibit B, AGAI Report  
[REDACTED] witness  
statement Wilts Police [REDACTED]  
[REDACTED]
9. [REDACTED] – was in Tidworth Medical Centre conducting his duties as the [REDACTED] when Pte Williams was brought to the Medical Centre.  
Exhibit B, AGAI Report  
[REDACTED] witness  
statement Wilts Police, [REDACTED]  
[REDACTED]

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The panel therefore finds that all the above named military personnel were on duty at the time of their involvement with Pte G Williams on 3 July 2006.

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**PROTECT-STAFF-DOWNGRADED**



**TERM OF REFERENCE 1(d)**

**“Establish the levels of training, relevant competences, qualifications and awareness of the individual(s) involved in the incident, including their knowledge of administrative action (e.g.AGAI 67), as well as formal disciplinary procedures at the time of the incident”.**

As in the foregoing paragraph the panel has determined the key personnel in relation to this TOR and have focussed on these individuals with regard to establishing their level of knowledge and relevant qualifications in order to conduct their duties at the time of the incident. The key individuals were;

[REDACTED]

**Summary**

[REDACTED]

Exhibit A1, 525879 [REDACTED]  
[REDACTED] training record  
extracted from JPA database,  
provided by [REDACTED]  
[REDACTED] APC Glasgow

[REDACTED] stated during his evidence that he had attended a specific AGAI 67 training event in [REDACTED], and that *“I felt it was sufficient to flag it up to us and it was our responsibility then to go away and when we arrived in our commands to make sure that if we conducted AGAI action then we had taken sufficient advice to do it properly”* also, *“So there were a group of people to provide advice so I was confident I knew who to go to if I needed that advice”.*

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry,  
[REDACTED]

**Findings**

The panel therefore concludes that [REDACTED] had the correct level of training, relevant competences, qualifications and awareness including knowledge of administrative action, as well as formal disciplinary procedures at the time of the incident in order to conduct the duties of [REDACTED]  
[REDACTED]

Summary

[REDACTED]

Exhibit AI, 551271 [REDACTED]  
[REDACTED] training record extracted  
from JPA database, provided by  
[REDACTED] APC  
Glasgow

In his evidence to the SI he stated that prior to taking on the role  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry,  
[REDACTED]

[REDACTED] found that the hand-over from his predecessor was somewhat lacking, he stated during interview *"It was an afternoon spent over a single side of A4 finishing off with never call me again. I don't know what I did to upset him but it was a short and sharp handover"*.

[REDACTED] went on to state *"I felt unprepared to be [REDACTED] if I am perfectly honest, and I don't use that as an excuse for anything that happened. I think it's more to do with the [REDACTED] side of the job [REDACTED] I felt unprepared for because that took up 60% or so of my time"*.

With regard to AGAI 67 training, [REDACTED] stated that his first exposure was when as [REDACTED] he was tasked with briefing the process to the Battalion in [REDACTED], he was subsequently given a similar presentation on his [REDACTED] course in Aug 2005.

[REDACTED] gave evidence to the effect that in his opinion he had completed all mandatory training and was quite clear on what was required in order to assume his duties [REDACTED]

Findings

The panel finds that [REDACTED] on being appointed to the position [REDACTED], had received training in line with what would have been considered the norm for a [REDACTED] at that time, and in [REDACTED] he attended the [REDACTED] which was mandatory pre-employment training (PET) for those assuming the duties [REDACTED]. It is accepted by the panel that the availability of courses and the number of candidates awaiting places may have led to many [REDACTED] being in post, some months before attending the course.

Exhibit AI, [REDACTED]  
[REDACTED] training record extracted  
from JPA database, provided by  
[REDACTED], APC  
Glasgow

It is clear from the evidence given by [REDACTED] that the hand-over he received from his predecessor was "somewhat lacking" and he was not prepared for the [REDACTED] aspect of the role, however he was confident in his own abilities and knew where to look for additional information if required with regard to

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry,  
[REDACTED]

discipline process and procedures.

With regard to AGAI 67 process, the panel finds that [REDACTED] would have been familiar with the requirements of AGAI 67 by virtue of having delivered the training package and also through his attendance at the [REDACTED] course in Aug 2005.

The panel therefore concludes that [REDACTED] had the correct level of training, relevant competences (albeit with limited knowledge of career management), qualifications and awareness including knowledge of administrative action, as well as formal disciplinary procedures at the time of the incident in order to conduct the duties of [REDACTED].

### Summary

[REDACTED] was [REDACTED] at the Tidworth Medical Centre on the day of the incident, at that time he was acting under the supervision of the [REDACTED], who was not present in the Medical Centre during the incident.

Exhibit B, AGAI Report [REDACTED]  
[REDACTED] witness statement  
Wilts Police, [REDACTED]

*ibid*

Exhibit AI, [REDACTED]  
[REDACTED] training record  
extracted from JPA database,  
provided by [REDACTED]  
[REDACTED] APC Glasgow

[REDACTED] declined the opportunity to attend proceedings as afforded by his status as an affected person under Reg 18 of the Service Inquiries Regulations and it was deemed unnecessary to call him as a witness due to prevailing circumstances and the fact that he had given statements to Wiltshire Constabulary in July 06, to which the panel had access.

### Findings

The panel heard that [REDACTED] as a [REDACTED] had the complete confidence of [REDACTED] whilst his mentor and supervising officer at the time of the incident. [REDACTED] had also successfully diagnosed and treated a case of heat illness in a soldier brought to the Medical Centre earlier that day.

Oral evidence from  
[REDACTED] at Service Inquiry,  
[REDACTED]

Exhibit B, AGAI Report [REDACTED]  
[REDACTED] witness statement  
Wilts Police, [REDACTED]

The panel concluded from the evidence given by [REDACTED] and [REDACTED] that [REDACTED] was an extremely capable [REDACTED] and that in [REDACTED] opinion; "the level of care that he gave was actually exemplary".

Oral evidence [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

It is not clear from the evidence received what knowledge [redacted] had regarding disciplinary and administrative procedures, however the panel concludes that at the time of the incident this was not an issue which influenced the outcome or had a bearing on the treatment given to Pte Williams.

The panel therefore concludes that [redacted] had the correct level of training, relevant competences, qualifications and awareness at the time of the incident in order to conduct the duties of [redacted] and [redacted] at Tidworth Medical Centre.

[redacted] Summary

[redacted] had assumed the appointment of [redacted] approximately 6 weeks before the death of Pte G Williams having previously held a number of different positions including [redacted] within the same Battalion.

[redacted]

With regard to AGAI 67 training, [redacted] stated that on assuming the role [redacted] he was given a folder containing relevant information from his predecessor [redacted] and later received a presentation from [redacted] at his own instigation. He also stated that he had received no formal training or presentations on other summary disciplinary procedures.

At the time he was satisfied that he had sufficient information to fulfil his duties, but whilst giving evidence he expressed the opinion that incoming [redacted] would benefit from a specific AGAI 67 presentation.

Findings

The panel therefore concludes that [redacted] had the correct level of training, relevant competences, qualifications and awareness including knowledge of administrative action, as well as formal disciplinary procedures at the time of the incident in order to conduct the duties of [redacted].

[redacted] Summary

[redacted] was the [redacted] at the time of the incident, having been posted to the unit in [redacted]. He began his career as [redacted]

[redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

Exhibit AI, [redacted] training record extracted from JPA database, provided [redacted] APC Glasgow

Oral evidence from [redacted] at Service Inquiry [redacted]

[redacted]

[redacted]

Exhibit AI, [redacted] training record extracted from JPA database, provided by [redacted]



before completing [REDACTED]  
[REDACTED]  
In the [REDACTED] had conducted a number of role-specific training courses and also [REDACTED] over a number of years commensurate with his [REDACTED]. He also achieved [REDACTED].

[REDACTED] stated at his Crown Court Trial that he had never attended an AGAI 67 briefing, although he did admit that he was familiar with both summary discipline and AGAI 67 processes.

[REDACTED] during evidence to the SI detailed the training and career management required for individuals who wish to become qualified [REDACTED], which indicated that [REDACTED] had attended the necessary career courses to qualify for the post [REDACTED].

[REDACTED] claimed to be a qualified instructor in the use of rigid handcuffs, a qualification he allegedly obtained in [REDACTED] whilst [REDACTED]. Despite the absence of any paperwork or certificate to support the training, [REDACTED] believed this training qualified him to carry out cascade training to anyone, whatever the scenario, in the use of rigid handcuffs. [REDACTED] later in [REDACTED] carried out rigid handcuff training with members of the 2 R WELSH RP staff, and following the training he produced a signed letter of authority which he displayed in the guardroom, purporting to be a qualified instructor in Public Safety and Public Order (PSPO), having attended the Metropolitan Police Personnel Safety Course.

[REDACTED] declined the opportunity to attend proceedings as afforded by his status as an affected person under Reg 18 of the Service Inquiries Regulations and it was deemed unnecessary to call him as a witness due to the fact that he had given statements to Wiltshire Constabulary in July 06, and [REDACTED], to which the panel had access.

**Findings**

It is apparent to the panel that [REDACTED] had the necessary knowledge, qualifications and experience to fulfil the requirements of the position of [REDACTED], and that he had at least a working knowledge of the disciplinary and administrative processes within 2 R WELSH at that time.

The Panel finds that [REDACTED] however did not have the necessary qualification to teach rigid handcuff training as claimed, which was discovered as a result of the SIB investigation and detailed in their 1<sup>st</sup> Interim Report dated 20 Mar 09.

[REDACTED] APC  
Glasgow

Exhibit C (8 of 14), evidence under oath [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Exhibit B, AGAI Report [REDACTED] Service Police 1<sup>st</sup> Interim Report [REDACTED]

Exhibit B, AGAI Report [REDACTED] letter [REDACTED]

Exhibit B, AGAI Report [REDACTED] Service Police 1<sup>st</sup> Interim Report [REDACTED]

Summary

[REDACTED]

Exhibit B, AGAI Report [REDACTED] sworn evidence of [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Exhibit A1 [REDACTED] training record extracted from JPA database, provided by [REDACTED] APC Glasgow

[REDACTED] stated during his Crown Court appearance and in his RMP statement [REDACTED] that the whole Battalion received a brief on AGAI 67 by [REDACTED] in early 2005 whilst the unit was still in Paderborn. He also stated that he was tasked to deliver an AGAI 67 presentation on at least two different occasions.

Exhibit A1, Vol 4, SIB witness statement, [REDACTED] and Exhibit B, AGAI Report [REDACTED] sworn evidence of [REDACTED]

[REDACTED] under cross examination responded at some length indicating his understanding of the AGAI 67 process with regard to minor sanctions.

Exhibit B, AGAI Report [REDACTED] sworn evidence of [REDACTED]

The panel heard evidence from [REDACTED] HQ PM(A) on the training given on the RP course and the duties of RP staff around the time of the incident, he stated *"The restraint training at the time, they had no training at that time on control and restraint or personal protection, however they were taught the use of mechanical restraints. Over that period the Imprisonment and Detention (Army) Rules 1979 stipulated that the only mechanical restraints that could be used was the swivel and curve handcuffs, which as a mere explanation was two ratchet handcuffs joined together with a chain and is not the rigid cuffs which are used by Service Police, and we used to teach how to apply that. The hands-on personal protection aspect was never taught but is now, sir"*. He further clarified the RP role as; *"At the time of the training this was the role of them to administer*

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]





was fulfilling his [REDACTED] role on behalf of 2 R WELSH at his place of duty within the Medical Centre. He went on to clarify that on prior occasions he was [REDACTED] but the role had ceased.

[REDACTED] stated to Wilts Police that he had received heat injury training on his [REDACTED] course but that he had not received any specific training since. He went on to say that he had received no refresher (medical) courses since he completed [REDACTED].

[REDACTED] from DMSTG in Keogh Bks, one of the instructors responsible for delivering CMT training now, described the training given to Combat Medical Technicians (previously Regimental Medical Assistants) through Class 3 to Class 1 and their varied roles and responsibilities. [REDACTED] also stated that CMT/RMAs should receive refresher training as part of pre-deployment or in-house training, however [REDACTED] maintained he had received no such training.

[REDACTED] at the time of the incident, in his evidence to the panel stated with regard to the role [REDACTED] in Tidworth Medical; *"My view of the medics was that they were basically glorified first aiders"*. He went on to say *"That's my opinion, and I was quite happy for them to deal with simple strains, bruises, minor things which normally would be dealt with by a first aider"*.

A review of [REDACTED] actions on Mon 3 Jul 06, was conducted by [REDACTED] and [REDACTED] representing AMD, and their report dated 14 Sep 09 described [REDACTED] actions as 'reasonable' and 'entirely appropriate'

[REDACTED] declined the opportunity to attend proceedings as afforded by his status as an affected person under Reg 18 of the Service Inquiries Regulations and it was deemed unnecessary to call him as a witness due to the fact that he had given statements to Wiltshire Constabulary and the SIB investigation on a number of occasions, to which the panel had access.

### Findings

It is apparent to the panel that [REDACTED] had achieved the necessary knowledge, qualifications and experience to fulfil the requirements of the position of [REDACTED] within his unit, however that expertise had been diminished due to 'skill fade' as a result of him receiving no formal medical refresher training after he qualified in [REDACTED], and the type of administrative work he carried out on a daily basis within Tidworth Medical Centre.

The Panel finds that [REDACTED] actions in relation to Pte Williams on Mon 3 Jul 06, which were evaluated in an AMD report were in accordance with his role as a [REDACTED], and appropriate under the circumstances.

Wilts Police, [REDACTED]  
[REDACTED]

Exhibit A2, Addendum Report (3 of 4) interview under caution Wilts Police, [REDACTED]  
[REDACTED]

Oral evidence [REDACTED] at Service Inquiry [REDACTED]  
[REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]  
[REDACTED]

Exhibit A2, Addendum Report (1 of 4) Report Concerning the Actions of [REDACTED]  
[REDACTED]

Exhibit A2, Addendum Report (3 of 4) interview under caution Wilts Police, [REDACTED]  
[REDACTED]



[REDACTED]

Exhibit A1, Vol 4, SIB witness statement, [REDACTED]

Exhibit A1, [REDACTED] training record extracted from JPA database, provided by APC Glasgow

[REDACTED] as a member of the unit RP staff was called to the Tidworth Medical Centre along with [REDACTED] to assist in the restraint of Pte Williams who had become violent and aggressive whilst undergoing examination. [REDACTED] at the behest of [REDACTED] applied rigid handcuffs in order to restrain Williams who remained uncooperative.

**Findings**

[REDACTED] had attended and passed the pre-requisite RP NCO course and had the necessary experience in order to fulfil the role of Regimental Policemen as specified in unit SOPs. He had also attended and passed a [REDACTED] and the [REDACTED] course in which he achieved a competent (green) grading in all respects, the Panel therefore concluded that he will have gained sufficient knowledge of the AGAI 67 process and disciplinary procedures as a result.

[REDACTED] Exhibit A1, Vol 18, Bn Standing Order No.47 – Regimental Policeman; Exhibit R, S/F 4; Oral evidence of [REDACTED] at Service Inquiry [REDACTED]

However the Panel finds that [REDACTED] mistakenly believed that he held a qualification which authorised him (and other RP staff) to use rigid handcuffs, which was not the case. On an earlier occasion, [REDACTED] had conducted a training session for the RP staff in the use of rigid handcuffs, and subsequently produced a typed letter titled 'New Hand Cuff Training' in which the individuals participating were named as having carried out the training. It was established during the SIB investigation that [REDACTED] had 'falsely purported himself to be a Metropolitan Police trained instructor in Personal Safety and Public Order (PSPO), and as such was authorised to train the 2 R WELSH RP staff in the use of rigid hand cuffs'. At the time of the incident, the use of handcuffs training given on the RP NCOs course was based on the swivel and curve handcuffs only.

Exhibit B, AGAI Report [REDACTED] Hand Cuff Trg letter dated 13 Jun 06; Exhibit B, AGAI [REDACTED] Service Police 1<sup>st</sup> Interim Report [REDACTED] Oral evidence of [REDACTED] PM(A) at Service Inquiry [REDACTED]

The Panel concluded that [REDACTED] was in no way culpable in his use of the rigid handcuffs.

Exhibit B, AGAI [REDACTED] interview under caution Wilts Police, [REDACTED]

**Summary**

[REDACTED]

Exhibit A2, Addendum Report (2

[REDACTED]  
[REDACTED] During his interview under caution with Wilts Police he described his duties as "you assist the nurse that assists the doctor".

At the time of the incident he was employed as a [REDACTED] [REDACTED] within the Tidworth Medical Centre, and was fulfilling the role of [REDACTED]. On the arrival of Pte Williams in the Medical Centre he was instructed by [REDACTED] to conduct run-ups on Williams, which [REDACTED] described as "taking and recording of a persons pulse and blood pressure as well as 'Real Expiratory' test.... a urine sample which is checked for sugars, alkalines and other substances.... and a small life-style questionnaire".

### Findings

[REDACTED] contact with Pte Williams on 3 Jul 06 was consistent with his role as [REDACTED] for which he had passed the relevant qualification in Feb 2006. He had attempted to conduct 'run-ups' as directed by [REDACTED] but had met with some violent resistance from Williams. The panel finds that [REDACTED] had the necessary qualifications and experience to fulfil the requirements of the position of a [REDACTED] under supervision of the duty medic. The panel also concludes that as a [REDACTED] will not have received formalised training on disciplinary proceedings but would have been familiar with the AGAI 67 process as a result of briefings given to the Bn at various times as heard during evidence at the SI proceedings.

### Summary

[REDACTED] was a [REDACTED] who just happened to be on guard duty within the unit guardroom on the morning of Monday 3 Jul 06. It was in this capacity that he was instructed to escort Pte Williams from the guardroom to Tidworth Medical Centre.

### Findings

[REDACTED] was instructed to escort Pte Williams from the guardroom to the Medical Centre, which he did by the most direct route on foot. A short distance from the Medical Centre Williams stated that he could not go any further, and collapsed on the ground, [REDACTED] contacted the guardroom to seek

of 4) interview under caution  
Wilts Police, [REDACTED]  
Exhibit A1, 24842126 [REDACTED]  
[REDACTED] training record extracted  
from JPA database, provided by  
[REDACTED] APC  
Glasgow

Exhibit B, AGAI Report [REDACTED]  
[REDACTED] witness statement  
Wilts Police, [REDACTED]

Exhibit A2, Addendum Report (1  
of 4) Standing Orders for Duty  
Medic - undated  
*ibid* - Duty Medic Competencies  
- undated

Exhibit C (11 of 14), sworn  
evidence of [REDACTED]

Exhibit A1, [REDACTED]  
[REDACTED] training record  
extracted from JPA database,  
provided by [REDACTED]  
[REDACTED] APC Glasgow

Exhibit C (11 of 14), sworn  
evidence of [REDACTED]



assistance. When [REDACTED] arrived at the scene [REDACTED] was further tasked to get [REDACTED] from the Medical Centre to attend to Williams.

[REDACTED] having been instructed to escort Pte Williams to the Medical Centre by [REDACTED], fulfilled this and subsequent tasks set him by [REDACTED], with no apparent neglect or failure on his behalf. There were no prerequisites or particular skills required of [REDACTED] in fulfilling these tasks and therefore the panel finds that he had sufficient knowledge and skills to fulfil the tasks given on that day. The panel also concludes that [REDACTED] would not have received formalised training on disciplinary proceedings but would have been familiar with the AGAI 67 process as a result of briefings given to the Bn at various times, as heard during evidence at SI proceedings.

### **Recommendation**

Personnel should attend relevant pre-employment training prior to assuming their appointment (or within a specific period) in order to address what appears to be somewhat of a consistent trend in this case which demonstrates otherwise.

**TERM OF REFERENCE 1(e)**

**"Whether there was any identifiable shortfall in training or standards with regard to any individual, system or process involved in the incident e.g. heat injuries awareness, methods of restraint etc".**

**FACTS ASCERTAINED**

**SOURCE**

**AGAI 67**

**Summary**

AGAI 67 was introduced in 2002. A thorough revision resulted in Edition 2 being issued in Jan 05. Edition 2 introduced Minor Administrative Action, quantified the effects of Major Administrative Action and brought Formal Warnings and Removal from Appointment into the same document. Training on Edition 2 was delivered in the form of Army wide road shows throughout 2004 and introduced to a variety of officer and soldiers career courses, including CLM, from 2005. Since then there have been several minor amendments. At the end of 2006 DPS(A) conducted a practitioners' review of the AGAI 67 process and it was subsequently thoroughly restructured as well as revised. Edition 3 was subsequently issued in Apr 08. The current version is Edition 4.

**Two ways in which misconduct could be dealt with and a 'Third Way'**

In 2006 there were only two ways in which misconduct by a soldier in a military environment could legally be dealt with. The first was administrative action under AGAI 67 and the second was disciplinary action under the Army Act 1955.

Based on compelling evidence the Panel concluded that at the time of Pte Williams' death, and in the months leading up to it, a third way of discipline, which was not compliant with military administrative or disciplinary policy, was being used by some members of 2 R WELSH.

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Email [REDACTED]

Exhibit A1, Vol 1, witness statement Wilts Police [REDACTED]

Exhibit C (1 of 14), sworn evidence [REDACTED]

Exhibit A1, Vol 1, witness statement Wilts Police, [REDACTED]

Exhibit A1, Vol 1, sworn evidence of [REDACTED]

Exhibit A1, Vol 4, SIB  
witness statement, [REDACTED]

Exhibit A1, Vol 4, SIB  
witness statement, [REDACTED]

Exhibit C (13 of 14), Judge's  
Summing-Up dated 29 Jul  
08, p.37-B to p.42-C

Oral evidence from [REDACTED]  
[REDACTED] at Service  
Inquiry [REDACTED]

### **The Incident**

On the morning of 3 Jul 06 Pte Williams was subjected to punishment in the form of a period of drill and PT. These were illegal punishments in that they were not sanctions awarded under AGAI 67 or punishments awarded as a result of disciplinary action taken under the Army Act 1955.

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]

Exhibit A1, Vol 1, significant  
witness interview Wilts  
Police, [REDACTED]

Exhibit A1, Vol 4, SIB  
witness statement, [REDACTED]

Exhibit A1, Vol 3, witness  
statement Wilts Police, [REDACTED]

Exhibit C(13 of 14), Judge's  
Summing-Up dated 29 Jul  
08, p.14-B to p.20-E

### **Role of [REDACTED] in the Incident**

As a result of his guests being 'soaked' by a fire extinguisher and then subjected to threatening behaviour from Pte Williams during the evening of Sat 1 Jul 06, [REDACTED] by his own admission, allowed himself to wrongly become personally involved in the subsequent action taken against Williams when he returned to duty on Mon 3 Jul 06.

Exhibit A1, Vol 9 Interview  
under caution Wilts Police,  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]

**PROTECT-STAFF-DOWNGRADED**

By instructing [REDACTED] to bring Pte Williams to his office 'hot and sweaty' or words to that effect, and then removing Pte Williams' cap badge he sent an ambiguous message to the RP staff and through them the [REDACTED] which set the conditions which resulted in the un-sanctioned punishments being inflicted upon Pte Williams.

**Findings**

On the evidence available it is the finding of the Panel that [REDACTED] made a number of errors of judgement in the way he handled Pte Williams in that:

- he decided to interview Pte Williams himself. Although there is nothing wrong with this procedurally, given the circumstances of the event and his personal interest in it, he would have been more sensible to have waited until the RSM was available to see Pte Williams.
- he ordered Pte Williams to remove his cap badge which is not a recognised sanction even if he had been dealt with correctly. It was also humiliating which is contrary to AGAI 67.
- he ordered Pte Williams to write letters of apology to his guests before the correct administrative or disciplinary process had been completed. Writing letters may have been an appropriate course of action but only when due process had been correctly followed.
- he gave ambiguous direction to the RP staff as to what they should do with Pte Williams which led to Pte Williams being subjected to unauthorised punishment.

Exhibit B, AGAI Report  
[REDACTED] Interview  
under caution Wilts Police,  
[REDACTED]

Exhibit A1, Vol 28 – Annex  
C to AGAI 67 para.8

Oral evidence of [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

**2 R WELSH Disciplinary Record**

In their evidence given to SI, the then [REDACTED] and [REDACTED] explained that it was particularly difficult time for Bn and their disciplinary record was the worst in the Brigade.

Oral evidence [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service  
Inquiry  
[REDACTED]

The Panel noted that the Bn had had a very disruptive and demanding 18 month period beginning with an Arms Plot from



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Germany to Tidworth in early 2005, followed by a 6 month tour in Iraq from Apr-Oct 05. POTL was followed by 6 weeks of BOWMAN conversion in early 2006 which disrupted the Bn's command structure leaving soldiers less well supervised than normal for weeks at a time, particularly at the JNCO and SNCO level. The Bn then underwent amalgamation to form 2 R WELSH whilst preparing for a 6 week exercise in BATUS prior to another 6 month tour of Iraq in late 2006, only 11 months since they had returned. This programme put enormous pressure on all ranks and the Bn as a whole. With so much time away and two op tours within 11 months of each other, perhaps it is not surprising that discipline was an issue within the Battalion. The Panel noted that perhaps AGAI 67, which became policy just prior to the Bn's move from Germany and in the lead-up to their subsequent Iraq deployment, might not have been afforded the priority it would have otherwise been given. In any event, such policy changes inevitably take time to bed in, at least culturally, and especially for the more 'old school' SNCOs.

### Use of AGAI 67 by 2 R WELSH

Evidence indicates that the 2 R WELSH was using AGAI 67 in 2005 from its inception and throughout 2006.

The RMP identified a peak in AGAI sanctions immediately following Pte Williams' death.

Despite this evidence [REDACTED], told the SIB investigation that; "the AGAI system was paid lip service, the physical discipline was used as an alternative to the AGAI system".

### Training of 2 R WELSH in AGAI 67

The former [REDACTED] and RP staff had all been introduced to AGAI 67 and the use of administrative action, which by Jul 06 had been Army policy for over 18 months. [REDACTED] gave a presentation to the Battalion on AGAI 67 in Feb 05, then as [REDACTED], but without any formal training. [REDACTED] was responsible for the delivery of AGAI 67 training to the JNCOs' cadre and the remainder of the Battalion. On reflection [REDACTED] felt that he should have taken a more active role in this training.

p.18-3A

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence [REDACTED]  
[REDACTED] at Service Inquiry

Exhibit A1, Vol 27 - Records of Minor Sanctions awarded in 2 RRW (latterly 2 R WELSH) between 1 Jan 06 and 31 Dec 06

Exhibit A1, Vol 29 - Records of Minor Sanctions awarded in 2 RRW (latterly 2 R WELSH) between 10 Mar 05 and 15 Dec 06

Exhibit A1, Vol 4, SIB witness statement [REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence from [REDACTED]  
[REDACTED] at Service

Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Both [REDACTED] and [REDACTED], told the Panel that their knowledge of the administrative process was sketchy and they felt ill prepared in this area prior to and on assumption of appointment. Neither [REDACTED] had received formal training in AGAI 67 as part of [REDACTED], and [REDACTED] could not recall receiving any formal training. Both [REDACTED] told the Panel that [REDACTED] should undergo employment training, to include AGAI refresher training, prior to assumption of appointment.

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Initially the Panel was inclined to agree with the suggestion of RSM pre-employment training, but on reflection concluded that the limited AGAI 67 awareness in 2 R WELSH in 2006 was a result of the ongoing transition from the 'old way' (pre-AGAI 67) to the 'new way' (post-AGAI 67) compounded by their busy schedule and not therefore a failing in the training. Instruction in AGAI 67 has since been included on many career and promotion courses, including CLM, since 2005. Every RSM now in post will have received instruction on AGAI 67 on CLM and it's included on most officer career courses including at RMAS.

Oral evidence [REDACTED] at Service Inquiry [REDACTED]

DTrg has recently conducted a Formal Training Needs Analysis for WO1s who have been in appointment for 3 years. Of the 500 respondents, which included all RSMs and COs in the Army, 60% did not feel there is a requirement for any further WO1 training assuming CLM had been completed. Of the other 40% some believed there is a need to attend some form of Senior Warrant Officers' course which is already available in the form of the Higher Warrant Officers' course.

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

**Physical Training as a Sanction**

AGAI 67 lists the authorised minor sanctions which includes; 'Skills training and *appropriate physical training* may be included if the serviceman's failings warrants it'. This is the only reference to physical training. There is no specific mention made of Drill or PT which the Panel concluded is ambiguous.

Exhibit A 1, Vol 28 – Annex C to AGAI 67 par.11a(4)

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On questioning witnesses as to whether they thought PT was an authorised sanction there were differing opinions; [REDACTED] said it is, but all other witnesses, including the [REDACTED] and current [REDACTED] and [REDACTED] did not believe it is. Other than [REDACTED] none of the witnesses could come up with a scenario when PT would be a suitable sanction. There was agreement among all witnesses, other than [REDACTED], that should a soldier transgress during a period of PT then he or she should be awarded a sanction that befits the failing eg. late for parade, insubordinate, wearing a watch etc none of which would attract a sanction of PT, as the PT would not be restorative or rehabilitative. Should the soldier be deemed as lazy or prove to be shirking or below the necessary level of fitness during PT then a more suitable course of action would be to place him or her on remedial PT or reconditioning PT if he or she is recovering from an illness or injury.

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence [REDACTED]  
[REDACTED] at  
Service Inquiry [REDACTED]

Oral evidence [REDACTED]  
[REDACTED] at Service  
Inquiry [REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

In order to ensure that soldiers maintain the required levels of fitness to do their job, the RAPTC is keen to promote PT as constructive and something that soldiers should want to do and take personal ownership of. Clearly using PT as a punishment would undermine this aspiration.

**Findings**

1. It is the finding of the Panel that the Regimental Police (RP) Staff and PTI subjected Pte Williams to physical activity which had not been sanctioned under AGAI 67 or AA 55. There is no evidence to suggest they were directly ordered to do so, but the actions of the [REDACTED] in giving [REDACTED] an ambiguous instruction to bring Williams to him 'hot and sweaty' and later in removing Williams' cap badge clearly set the conditions for the actions which followed.

2. The Panel, after very careful consideration of the issue of what knowledge the chain of command had of a 'third way' of disciplining soldiers, notes that there is a substantial conflict of evidence over the issue. However, although the Panel has seen and heard a substantial body of evidence detailing apparently widespread, public and regular use of the 'third way' in 2 R

WELSH at that time, the Panel finds on the balance of probabilities that the chain of command, due in part to the pressures on the unit at the time, were ignorant of this going on. This the Panel finds was a failing on the part of the chain of command of 2 R WELSH.

3. The Panel finds therefore, that although on the balance of probabilities, the RP staff were aware of AGAI 67, indeed the [REDACTED] instructed AGAI 67 to the Bn and the [REDACTED], by reason of [REDACTED] on 3 Jul 2006 setting the conditions, and the chain of command's failure to grasp and then properly address the outmoded practice of inflicting unsanctioned physical punishments upon soldiers, the RP staff felt they had authority and freedom to act in this way; a third way.

4. The Panel finds that there needs to be an unequivocal statement in AGAI 67 to explain that misconduct in a military environment can only be dealt with in accordance with AFA 06 or AGAI 67.

5. The Panel finds that clarification on the definition of physical training is required in AGAI 67.

6. The Panel finds that there had not been a shortfall in the chain of command's training but more a shortfall of standards by [REDACTED] on 3 Jul 2006, and more widely the chain of command of 2 R WELSH, in failing to identify a 'third way' as being regularly employed, which directly led to their consequent failure to grasp the problem and put a stop to such physical sanctions being imposed on soldiers in 2 R WELSH outwith AGAI 67 or AA55.

7. The Panel finds that there was a shortfall in standards on the part of the RP Staff on 3 Jul 06 in subjecting Pte Williams to unsanctioned physical punishment in the form of a period of drill and PT, albeit that due to the failure of the 2 R WELSH CoC to identify and stop such outmoded practices, the RP staff felt they had authority and freedom to act in this way; a third way.

### **Recommendations**

1. An unequivocal statement should be included in AGAI 67 Vol 2:

'There are only 2 components to the Army's Discipline System; AFA 2006 and AGAI 67. Any sanctions or punishments awarded without following the proper process are illegal. Those awarding punishments outside these processes must be subject to investigation with a view to disciplinary and/or administrative action'.

(Extract taken from DPS(A)'s policy letter written the day after the completion of the trial).

2. This sentiment of only 2 components to the Army's

Exhibit G -  
Unofficial Sanctions and  
Punishments  
D/DPS(A) 3/331 dated 8  
Aug 08.



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Discipline System should also be clearly stated in all discipline training; in one easily understood slide for example.

3. If it is decided that PT remains a permissible sanction under AGAI 67, this must be expressly stated along with an explanation of when it would be appropriate to award it as a sanction, and under which of the six stipulated sanctions at para 8 of Annex C to AGAI 67. (For example in a training environment it is currently permissible to use 'Wake Up Exercises' as a form of 'Remedial Training' in accordance with the various extant policies in the ARTD)

Exhibit A1, Vol 28 – Annex C to AGAI 67 para.11

4. Drill is an acceptable sanction under 'Extra Tasks or Duties' but it should be conducted in a recognised, planned and structured manner, preferably in a squad, by a qualified drill instructor. This should be articulated in AGAI 67.

*ibid*

**Regimental Police Staff - training and duties**

**Summary**

Based on the evidence available the Panel concluded that a period of 'punishment drill' to which Pte Williams was subjected on the morning of 3 Jul 06, was conducted by RP staff from 2 R WELSH.

Exhibit B, AGAI report [redacted] interview under caution Wilts Police, [redacted]

Exhibit B, AGAI report [redacted], interview under caution Wilts Police, [redacted]

Exhibit C (13 of 14), Judge's Summing-Up dated 29 Jul 08, p.14-B to p.20-E

There is no evidence that Pte Williams had been awarded drill as a sanction under AGAI 67 or a punishment under AA 55.

**Training**

Historically Regimental Police attended the RP NCOs course at the MCTC and at Roussillon Barracks, Chichester. In Apr 06 the RP course became obsolete and a new course was introduced called the Unit Custody Staff course.

Oral evidence from [redacted] HQ PM(A) at Service Inquiry [redacted]

Unit personnel given the responsibility to supervise detainees are known as Unit Custody Staff (UCS). The supervision of detainees and the operation of Service Custody Facilities (SCF) historically fell upon 'Regimental Policeman' (RP). Since Apr 06, the RP course has been obsolete and was replaced by the

Exhibit M - Handwritten notes from [redacted] Oral evidence from [redacted] at Service Inquiry [redacted]

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Unit Custody Staff Course (UCSC). Since the introduction of the Corporate Manslaughter and Corporate Homicide Act 2007 (CM&CHA 07) significant work has been undertaken to mitigate risk by reducing the number of licensed SCFs. There are currently 22 SCFs licensed and operating worldwide. The manning of these facilities varies from those that are provided by the owning unit, Garrison facilities being overseen by the Military Provost Staff (MPS), those which are manned by local unit personnel (Tidworth and Bulford) and facilities being operated by FTRS personnel (MCTC). There is no standardisation in relation to the manning of a SCF. Qualified unit RP staff (UCS) assist with the day to day running of SCFs. RP staff without the UCS training cannot work in a SCF.

The training of UCS is very comprehensive and it has further enhanced the Army's custodial practices. The current policy and training courses for UCS are listed at Exhibit M ( [redacted] notes). Those RP NCOs employed in units who have no opportunity to supervise detainees can best be described as general duty NCOs with no additional qualifications to those of any other NCO in their unit.

The aim of the Unit Custody Staff course is to train personnel in both operational and firm base detention. Those RP NCOs who have no responsibility for detainees will be unlikely to attend and thus have no formal training.

**Role of Regimental Police in the future**

This brings into question the current role of RP staff within the unit. The Panel recognised that the role of an RP was historically to maintain standards and discipline as well as conduct general duty tasks at the behest of the RSM. However without specific training they do not necessarily have the tools to carry out their duties in a safe or legal way.

The introduction of AGAI 67 empowers all JNCOs and puts the responsibility for the maintenance of discipline, throughout the unit, on the chain of command. Add to this the fundamental change to unit custodial arrangements and the Panel observed that the days of the RP as the upholders of unit discipline are over. Additionally the Panel agrees with the Custody SME that the use of the word 'Police' in their title is anachronistic and misleading. RP staff have no formal police powers, and there is also a risk that being referred to as 'police' risks JNCOs overstepping the mark in terms of their actual authority and role.

The Panel recognised there is a need for a unit to have a small team of dedicated NCOs to carry out non-custodial duties on behalf of the RSM. Their training should include escort duties for occasions such as CO's Orders and escorting soldiers under sentence from the unit lines to a SCF.

**Findings**

1. It is the finding of the Panel that with the demise of the

[redacted]

Exhibit M – Handwritten notes from [redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

[redacted]

[redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

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former RP NCO course there is a training gap for RP staff generally.

2. The Panel finds that the title 'Regimental Police' is outdated and that the RP staff need re-branding.

### Recommendations

1. With the demise of the former RP NCO course today's RP NCOs who have no responsibility for detainees will be unlikely to attend the Unit Custody Staff (UCS) course and thus they will have no formal training. The Panel concluded that a review into the role and training of RP staff needs to be conducted as a matter of priority.

2. The title Regimental Police is dated. The title of UCS must be adopted for all those personnel supervising detainees or providing units with a detention function. For those personnel not supervising detainees a new name for the RSM's staff should be found.

3. The Panel are aware that the Custodial team at HQ PM(A) are currently staffing a paper to recommend the introduction of a badge so that UCS are easily recognisable. This would be a positive step in introducing a move away from the old RP mindset. The Panel fully endorses this initiative.

### Roles and responsibilities of key personnel in a unit

#### Summary

For administrative and discipline procedures to function correctly in a unit every member of the chain of command must understand his or her part in the process. Training is one aspect of this, but there needs to be at least one reference document which sets out roles and responsibilities against which peoples' performances can be measured.

#### Battalion Standard Operating Procedures (SOPs)

Although 2 RRW's SOPs, dated Sep 05, contained orders for Bn appointment holders (SO No 2) and WOs, Senior NCOs and Soldiers (SO No 3), no specific mention is made of their responsibilities in the administrative action or the disciplinary processes. And there is no record of any of the Bn appointment holders having job specifications.

2 R WELSH's current SOPs do not include all the roles and responsibilities or orders for key personnel. Unit SOPs are

Exhibit A1. Vol 30 -2 RRW's SOPs SO No.2 and No.3 dated Sep 05

Oral evidence [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

undergoing a re-write and [REDACTED] informed the Inquiry that amended Bn SOPs will include roles and responsibilities for Bn appointment holders.

**Job Specifications**

None of the Bn key posts have job specifications. The only reference available are the roles and responsibilities found on the front page of an individual's OJAR or SJAR.

Whilst their individual responsibilities appeared to be understood by the [REDACTED] in 2006 and the same can be said of the current incumbents, the Panel observed that unless roles and responsibilities are formally articulated and captured there will be room for confusion and possibly error.

**Findings**

1. The Panel finds that there was a shortfall in standards with regard to [REDACTED] actions on the 3 Jul 06, and that this set the conditions for the chain of events which ultimately led to the death of Pte Williams.
2. It is the finding of the Panel that there is a requirement to standardise, formalise and articulate the responsibilities of unit key appointments.
3. The Panel finds that there was a gap in this area within 2 R WELSH in 2006.

**Recommendations**

1. All unit key appointments; CO, 2IC, Adjt, RSM, SSA and RP Staff should have job descriptions which should include mention of their responsibilities in relation the discipline process and specifically AGAI action. This is an Army wide requirement.

[REDACTED]  
Exhibit K - Flag A, Extracts from 2 R WELSH SOPs dated 15 Nov 11

Oral evidence from [REDACTED] at Service Inquiry  
[REDACTED]

Exhibit K - Flag E Infantry Officer Regimental Duty Responsibilities for JPA OJAR, dated 12 Jan 09

Oral evidence from [REDACTED] at Service  
[REDACTED]

Oral evidence from [REDACTED] at Service Inquiry  
[REDACTED]

Oral evidence from [REDACTED] at Service Inquiry  
[REDACTED]



2. The duties, roles and responsibilities, particularly in relation to AGAI 67 action and the disciplinary process, of all unit key appointments should be included in Unit SOPs Army wide.

**Heat awareness**

**Summary**

Heat was a contributing factor in Pte Williams' death. On 3 Jul 06 the temperature in Tidworth was recorded as 27 degrees centigrade. However ambient temperature alone does not give the WBGT index which also measures wind speed and humidity (see WBGT below).

Given that 2 R WELSH had recently returned from Iraq, where temperatures could exceed 50 degrees centigrade, the Panel were satisfied that the Bn's understanding of the risks of exercising in heat were reasonably well understood. Worryingly the Iraq experience might have given the unit a false sense of risk associated with heat, believing that 27 degrees presents no risk in comparison to those temperatures they experienced in Iraq.

The Panel focussed on the following aspects in relation to heat:

1. General awareness and level of training for all personnel.
2. Awareness and training of PTIs.
3. Awareness and training of Combat Medical Technicians.
4. Awareness and training of Regimental Medical Officers.
5. Wet Bulb Globe Test (WBGT)

**a. General heat awareness and level of training for all personnel.**

Given the nature of recent operations in hot climates the Panel concluded that the general awareness throughout the Army of the risks of exercising in heat is reasonable but possibly could be better.

Training on the treatment, including signs and symptoms of cold / heat injuries is given annually as part of level 1 and 2 - MATT 3 (Battlefield Casualty Drills) training package. Additional training is given to personnel deploying to hot climates as part of their pre-deployment training. On the balance of probability the Panel were satisfied that 2 R WELSH were given both forms of training in 2005/06 and therefore their awareness should have

Exhibit D – Autopsy Report,  
- Supplementary Report,  
Ref No. 06BP050Crsup  
dated 19 Jan 07

Exhibit A1, Vol 21 - Met  
Office Report for Middle  
Wallop and Larkhill  
Exhibit AF - Annex A to JSP  
539, para.3

Oral evidence from [redacted]  
[redacted] at Service  
Inquiry [redacted]

Oral evidence from [redacted]  
[redacted] at Service  
Inquiry [redacted]

Oral evidence from [redacted]  
[redacted] at Service Inquiry  
[redacted]

MATT 3 training syllabus -  
[redacted]

Oral evidence from [redacted]  
[redacted] at Service  
Inquiry [redacted]

been as good as was expected of an infantry unit at that time.

However on the basis of the evidence given by [REDACTED], a specialist in heat injury from the MOD's Environmental Medicine Unit (EMU), it would seem that the understanding of the effects of heat injuries in cold or temperate weather, as a result of excessive exercise, is not well understood in the Army or indeed generally. [REDACTED] explained that heat illness can occur on a freezing day if the body's core temperature reaches an excessive level and is unable to cool down quickly enough.

**Findings**

1. The Panel was informed by [REDACTED] that he had no knowledge of the MATT 3 training package and had no input to its content. It is the finding of the Panel that in order to provide further assurance that the Army's heat awareness training, delivered as part of MATT 3 (BCD), is as effective as possible, the EMU should be invited to contribute/comment on MATT 3 content.
2. It is the finding of the Panel that there may have been a shortfall in the training and awareness of the effects of heat illness within 2 R WELSH in 2006 but this would have been the case across the Army.

**Recommendation**

The Panel recommends that the MOD's EMU is invited to provide assurance of MATT 3 (BCD).

**b. Heat awareness and training of PTIs.**

The Panel was informed by [REDACTED] that all Class 1 PTIs are trained in the use of WBGT and how to apply the Heat Stress Index as part of their risk assessment. PTIs are also trained in Emergency First Aid at Work. The Panel was also informed that not every unit has ready access to WBGT readings and many rely on a weather and temperature report from the Met Office which does not take account of humidity levels. (see WBGT below).

[REDACTED] also stated that PTIs are trained to undertake dynamic risk assessments, which include the risks to training associated with temperature – hot or cold. Peters stated that in any event, a WBGT reading is very localised, and is only ever a

Exhibit AF – JSP 539  
Climatic Injuries in the  
Armed Forces Prevention  
and Treatment 2003  
(D/AMD/113/26)

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence [REDACTED]  
[REDACTED] from [REDACTED]  
[REDACTED] at Service  
Inquiry [REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service  
Inquiry [REDACTED]

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guide to the overall risk assessment on the day and for a particular area.

The Panel was pleased to note 2 R WELSH's current CO's Physical Development Directive which refers to Army policy for the prevention and treatment of climatic injuries – JSP 539, and 'gold plated solution' of having what the panel termed a 'heat sentry' at the main gate to warn individual runners of heightened heat states/risks.

**Findings**

1. The Panel finds that there was no shortfall in the training or qualifications held by [REDACTED] in 2006 in relation to his position as [REDACTED].
2. The Panel finds that there was a shortfall in standards on the part of [REDACTED] who the Panel finds falsely purported to be a Metropolitan Police trained instructor authorised to train 2 R WELSH RP staff in the use of rigid hand cuffs.
3. The Panel noted that investigations were conducted into [REDACTED] who was purported to have given [REDACTED] WGBT readings over the telephone on the day of the incident. The Panel chose to discount this evidence as it has no relevance to the TORs of the SI.

**c. Heat awareness and training of [REDACTED]**

[REDACTED] alerted [REDACTED], a qualified RMA1 (now superseded by CMT), to a problem with Pte Williams who had collapsed 100m from the Medical Centre. [REDACTED] attended Williams and was informed by him that "I've stomach pains and I've been pissing and shitting blood" (or words to that effect).

The Panel was advised that it is not normal practice for an MO or CMT to leave the MRS to deal with a situation such as Pte Williams collapsing, but not altogether surprising. An MRS is not staffed or equipped to be an A&E facility. MOs are trained to preserve life until the patient can be seen by a suitably qualified doctor or consultant. The correct procedure in response to an individual collapsing should be to dial 999 and call a civilian ambulance.

Exhibits H and I  
2 R WELSH's CO's  
Physical Development  
Directive and Physical  
Development Programme

Annex D of Findings within  
this report ([REDACTED])

Exhibit B, AGAI Report  
[REDACTED], Service Police  
1<sup>st</sup> Interim Report [REDACTED]  
[REDACTED]

Exhibit B, AGAI report [REDACTED]  
[REDACTED], witness  
statement Wilts Police, [REDACTED]  
[REDACTED]

Exhibit A2, SIB Addendum  
report, [REDACTED],  
interview under caution,  
Wilts Police, [REDACTED]  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED]  
Tidworth MRS at Service  
Inquiry [REDACTED]  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

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██████████ was ██████████ and as such was trained and qualified to conduct assessment of patients with a view to identifying the seriousness of the condition as opposed to a diagnosis. On the basis of his quick assessment of Pte Williams, ██████████ concluded that he was fit to walk to the MRS (less than 100m) where he could be given a fuller examination.

██████████ training in heat awareness was the same as any other soldier, i.e. MATT 3 (BCD). RMA / CMT1s do not receive any extra training in heat illness. However given his experience as a medic, including deployment in Iraq, it is reasonable to assume that he, as with any qualified CMT1, would recognise the symptoms of heat injury. (See CMT training below).

But a diagnosis is determined by the individual's analysis of the overall situation, accounts of what happened by bystanders (the history), and the symptoms presented by the patient themselves. Several expert witnesses told the Inquiry that about 80% of any diagnosis is derived from the patient's presentations of symptoms i.e. the history.

There are two types of CMTs in the Army – those in the RAMC and Regimental CMTs (previously RMA) i.e. Soldiers and NCOs in a unit trained as CMTs. The Panel concluded that although CMTs were sufficiently trained to undertake their duties in 2006 their training has improved considerably since then, in particular the introduction of refresher training.

The scope of clinical practice within which a CMT operates is set out in DGAMS' Policy Letter 8 Nov 07.

The CMT1 course was updated in Sep 07 and CMTs are now issued with a CMT Handbook - Medic's Primary Health Care Treatment Protocols 1<sup>st</sup> Edition has been issued.

Exhibit AI, 24823136 ██████████  
██████████ training record sheet extracted from JPA database, provided by ██████████  
APC Glasgow

Oral evidence from ██████████  
██████████ at Service Inquiry

Exhibit A2, SIB Addendum report (3 of 4) interview under caution, Wilts Police

██████████ and ██████████  
Oral evidence from ██████████  
██████████ at Service Inquiry

Oral evidence from ██████████  
██████████ at Service Inquiry

Oral evidence from ██████████  
██████████ at Service Inquiry

Oral evidence from ██████████  
██████████ at Service Inquiry

Exhibit P -  
DGAMS' Policy Letter –  
Scope of Practice for CMTs and Regimental CMTs –  
D/AMD/705/5/4 dated 8 Nov 07

Exhibit O -  
Combat Medical Technician Class One, Training Documentation



**Findings**

1. [REDACTED] had undergone all the training required of a CMT1 in 2006, however this had been diminished to a certain degree by 'skill fade' since he qualified [REDACTED]. As a CMT he would have received no formal training in heat illness other than the mandatory annual training tests that every soldier completes. The Panel heard during evidence that 2 R WELSH had recently returned from an Op Tour in Iraq and was preparing to deploy to Canada, and for that reason there was a heightened awareness of heat illness signs and symptoms amongst members of the unit. It is therefore the finding of the Panel that [REDACTED] as a result of his training and experience would have at least a 'working knowledge' of heat illness signs and symptoms and also the treatment required.

2. The Panel also finds that the evidence suggests that the symptoms presented by Pte Williams on that day, were not those obviously associated with heat illness and therefore finds there was no shortfall in training or standards on behalf of [REDACTED] in his dealings with Williams.

3. The Panel heard that with regard to the CMT role in general, that over recent years there has been a 'professionalism' of the CMT Cadre with improved continual professional development and mandated refresher training now taking place. So the situation has improved considerably.

4. The Panel also noted the intent for the Army to phase out the Regt CMT to be replaced, down to sub-unit level, by RAMC personnel. This will finally complete the professionalization of the Medic Cadre and is fully endorsed by the Panel.

5. It is the finding of the Panel that there was a shortfall in the training of CMTs in 2006 due to the lack of refresher training but this has now been rectified.

**Recommendation**

The Panel concludes that all unit personnel and medical staff should be familiar with the limitations of the local military medical facilities and the circumstances when they should call 999. As such this should be included as part of unit SOPs and any organisational induction training.

**d. Awareness and training of Medical Officers (MOs).**

The Panel was given evidence that MOs are either General Duties Medical Officers or General Practitioners (GPs) dependent on the stage of their professional training. As such

Exhibit N -  
Medic's Primary Health  
Care Treatment Protocols  
1<sup>st</sup> Edition Army Code No  
64256

Exhibit A2 Addendum  
Report (3 of 4), Interview  
under caution Wilts Police,

[REDACTED]  
Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

[REDACTED]  
Oral evidence from [REDACTED]  
[REDACTED] at Service  
Inquiry

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

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they are only qualified and trained to preserve life of a seriously ill patient so the patient can then be taken to an A&E equipped hospital.

Evidence suggests that it was not obvious to [REDACTED] in the Tidworth Medical Centre on 3 Jul 06 what was wrong with Pte Williams when he first saw him. On the basis of the history of Pte Williams' irrational behaviour given to him combined with Pte Williams' aggressive attitude in the MRS, [REDACTED] concluded that Pte Williams needed to be sectioned before he could treat him. It was not clear to [REDACTED] that Pte Williams had recently undergone physical exercise and therefore may be suffering from heat illness.

The Panel were satisfied, on the basis of the evidence available, that [REDACTED] was correctly trained and a fully competent GP. Although he had spent 6 months in A&E Salisbury Hospital as part of his training, the recognition or treatment of heat injuries is not covered within GP training.

As part of the Post Graduate Medical Officer's (PGMO) Course, which is mandated for all first appointment military medical officers, the prevention, recognition and treatment of heat injuries is now taught. [REDACTED], an MOD leading authority on heat illness, lectures on the PGMO course.

[REDACTED] gave evidence that there has been a big improvement in the general awareness and treatment of heat illness across the board throughout Defence and that JSP 539 (Climatic Injuries in the Armed Forces Prevention and Treatment 2003) had been updated and the changes have enabled all medical personnel to better deal with and treat heat illness.

**Finding**

[REDACTED]

Exhibit B, AGAI report [REDACTED], witness statement Wilts Police, [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Exhibit AC –  
Post Graduate Medical Officer's Training Documentation Training Objective 5.3 – p.2-6 and p.4-44

Exhibit AA –  
E-mail [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Exhibit AF –  
JSP 539 Climatic Injuries in the Armed Forces Prevention and Treatment 2003 (D/AMD/113/26)

1. It is the finding of the Panel that there were no shortfalls in the training or standards of the MOs on duty in the Tidworth Medical Centre on 03 Jul 06.

2. The MOs involved in dealing with Pte Williams initially misinterpreted his symptoms and did not treat him for heat illness due to being given an incomplete history.

**Recommendation**

Whilst acknowledging that all military MOs receive training in heat injuries on the PGMCO course, the Panel concluded that heat illness should be included on the GP Refresher Courses as part of the GP Emergencies Day.

Exhibit AE –  
Dept of General Practice  
GP Refresher Course  
31 Oct - 4 Nov 11

Exhibit AA –  
Email [REDACTED]

**e. Wet Bulb Globe Temperature (WBGT).**

The WBGT provides a reading which takes account of ambient temperature, wind speed and humidity. The significance of the humidity level is that it gives an indication of the ability of the body's sweat to evaporate. The most severe heat injuries result from the body's inability to cool down for which sweating and the evaporation of the sweat is vital. The WBGT measurements are very localised and readings can vary as close as 100 metres. The reading has to be taken where exercise is due to take place e.g. on training areas as well as in barracks and in the gymnasium. Currently where WBGT equipment is unavailable units rely on the Met Office for the temperature each day. According to [REDACTED] this is insufficient because the Met Office only provide the ambient temperature.

Oral evidence from [REDACTED]  
at Service Inquiry  
[REDACTED]

Oral evidence from [REDACTED]  
at Service Inquiry  
[REDACTED]

The Panel noted that all Class 1 PTIs are trained in the use of WBGT measurements.

Oral evidence from [REDACTED]  
at Service Inquiry  
[REDACTED]

[REDACTED] told the Inquiry that the number of soldiers presenting with heat injuries has steadily dropped over recent years. He attributes this to a combination of education, improved training of PTIs, an improved general awareness due to recent operations in hot climates and improved training of MOs to which the EMU contributes.

Oral evidence from [REDACTED]  
at Service Inquiry  
[REDACTED]

[REDACTED] also explained the difficulty in detecting heat illness – how someone can be normal to the touch but have a very high core temperature, and that whilst anxiety is a symptom, as is aggression, there can be moments of absolute lucidity. In the Panel's opinion this may explain, in part, why Pte Williams' symptoms of heat injury were not immediately identified.

Oral evidence from [REDACTED]  
at Service Inquiry  
[REDACTED]

**Findings**

1. The Panel finds that every major unit/gymnasium should have their own WBGT which in turn must be used in the location where exercise is due to take place.
2. It is the finding of the Panel that there was no shortfall in the training of the 2 R WELSH in the use of the WBGT in 2006.

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

**Recommendation**

Every major unit gymnasium should have its own WBGT which in turn must be used in the location where exercise is due to take place.

**Drugs awareness**

**Summary**

The autopsy report identified a number of illegal substances in Pte Williams' body, including ecstasy. The Pathologist concluded that Pte Williams' death was due to the combined effects of exertion, hyperthermia, restraint and recent use of ecstasy.

Exhibit D – Autopsy Report, Supplementary Autopsy Report dated 19 Jan 07, Ref. No. 06BP050Crsup

Exhibit C(13 of 14), Judge's Summing-Up dated 29 Jul 08, p.45-G

The Panel were keen to explore the measures that were in place in 2006 to deter soldiers from drug misuse, drug detection and compare policy then with that of today.

**a. Training and Policy**

The Army's Policy now and in 2006 is based on the misuse of Drugs Act 1971 (which criminalises certain specified drugs), and the policy within JSP 835 – 'Alcohol and Drugs Misuse'. In 2006 the Army's Policy was contained in AGAI 64 vol 5 Instruction 4.

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

Substance misuse training is based on three pillars: Prevention, Deterrence and Regulation. All soldiers were given alcohol and drugs literature at the start of their basic training and received presentations during training. Soldiers under training were routinely given a Compulsory Drugs Test (CDT) after their first 6 weeks in training, after their first leave.

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]



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A zero tolerance policy was adopted by the Army in 1994. Drug misuse was taught as part MATT 6 'Values and Standards'. The Early Intervention Programme was running in 2006 but suspended due to the lack of funds in 2009. This programme was educational and gave selected offenders a second chance. In 2006 the CDT programme sought to visit every major unit at least once a year for a 100% check and all recruits during basic training.

### b. Changes since 2006

Since 2006 the following documents have been produced:

- A Commander's Guide to alcohol and drugs misuse
- Alcohol and Drugs – the facts
- A British Soldier's Values and Standards (reproduced to make it more user friendly for soldiers)

In 2008 the policy for CDT changed with every major unit subjected annually to 8 CDTs; one 100% check and up to another 7 checks for which 50-100 personnel are randomly selected.

### c. Detection

Based on the evidence available the Panel concluded that Pte Williams took a number of ecstasy tablets in the week prior to 3 Jul 06. He reportedly took these in his room in barracks whilst listed as AWOL and evidence suggests that some of his colleagues witnessed him take them. The Panel wished to confirm whether those personnel who came into contact with Pte Williams on Sun 2 Jul and Mon 3 Jul 06 should have recognised that he had recently used ecstasy.

The Panel was told that military MOs receive no specific training for recognition of drug use. MOs only deal with CDT results and do not come into contact with habitual drug users in the Army. The Panel was also advised that there would be no noticeable signs of ecstasy use 12 hours after the event. The Panel therefore concluded that the only way to identify drug use 12 hours after the event is;

- 1) for the individual to declare use
- 2) for a third party who witnessed the use to report it
- 3) for a targeted CDT operation against those suspected of drug use or returning AWOL personnel as a matter of routine.

### Findings

1. It is the finding of the Panel that the policy, necessary training and education were in place to assume that Pte

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

Exhibit V – Document  
AC 63974

Exhibit W – Booklet  
AC 64243  
Exhibit Z – Booklet  
AC 63812

Oral evidence from [REDACTED]  
[REDACTED] at Service  
Inquiry [REDACTED]

Exhibit C (13 of 14), Judge's  
Summing-Up dated 29 Jul  
08, p.11-A to D and p.43-D  
to p.44-B

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

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Williams was aware of the risks, both to his health and career, by misusing drugs. As part of his basic training Pte Williams would have received drug misuse literature and attended drugs awareness lectures. He was subjected to CDT twice whilst at ITC Catterick; on 20 Jun 05 and 22 Aug 05, testing negative on both occasions. There is no record of Pte Williams being part of a CDT during his time with 2 R WELSH.

[REDACTED]

Exhibit X – CDT Results  
25204919 Pte Williams G

2. The Panel also finds that on 3 Jul 06, no one in 2 R WELSH or the Tidworth Medical Centre who came into contact with Pte Williams, could reasonably have been expected to have detected the fact that he had ecstasy and other substances in his system.

3. The Panel further finds that there was no shortfall in training for the prevention or deterrence for the misuse of drugs in 2006. However 2 R WELSH clearly had a problem with the numbers of soldiers misusing drugs which would indicate that there were shortfalls in personal standards.

Oral evidence from [REDACTED]  
at Service Inquiry

Oral evidence from [REDACTED]  
at Service Inquiry

**Recommendations**

It is the opinion of the Panel that the following issues need to be addressed in future policy:

1. Consideration should be given to the means by which a soldier can report his own misuse of drugs without the risk of dismissal from the Service.

2. The introduction of targeted CDT for individuals the chain of command or MO believes to be at risk, such as a returning absentee. This would balance the individual's rights with the CO's duty of care to others within his unit (including the drug taker himself).

3. Consideration should be given to reintroducing the Early Intervention Programme to enable the education of selected individuals and to give the chain of command an alternative to 'zero tolerance'.

Oral evidence from [REDACTED]  
at Service Inquiry

Oral evidence from [REDACTED]  
at Service Inquiry

**Use of Rigid Handcuffs**

**Summary**

When Pte Williams became violent in the MRS he was physically restrained by a number of NCOs including the RP

Exhibit A1, Vol 3, witness statement [REDACTED]

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staff who, at one point, used mechanical restraints (rigid handcuffs). The Pathologist concluded that restraint contributed to Pte Williams' death.

Evidence would suggest that none of the RP NCOs were properly qualified in the use of mechanical restraint with rigid handcuffs although they thought they were, having been trained by [REDACTED] in Jun 06. In addition [REDACTED] displayed a certificate in the guardroom which he believed validated the training and therefore the qualification.

**Training**

The Panel noted that the use of rigid handcuffs was not, and still is not, taught as part of any PTI training syllabus. However [REDACTED] training record would indicate that he achieved specialist qualifications in;

- 1) Arrest and Restraint Techniques Instructor – Dec 2000
- 2) Personal Safety and Public Order Instructor – Oct 2003

The Panel noted that prior to 2006 use of rigid handcuffs was not taught as part of RP or custodial training, it is however now included on the Unit Custody Staff (UCS) course.

**Findings**

- 1. Although [REDACTED] training record indicates that he has achieved relevant specialist qualifications, the Service Police 1<sup>st</sup> Interim Report casts substantial doubt on the authenticity of [REDACTED] claim to have the necessary qualifications to teach the use of rigid handcuffs to others.
- 2. It is the finding of the Panel therefore, that RP staff were not qualified to use of rigid handcuffs at the time of the incident.
- 3. The Panel found that unless an RP NCO, or any other NCO, has attended the UCS course they will not be trained in

dated 4 Jul 06, p.7 of 9

Exhibit C(13 of 14), Judge's Summing-Up dated 29 Jul 08, p.31-D and p.45-G

Exhibit D - Autopsy Report – Supplementary Report dated 19 Jan 07, Ref. No. 06BP050Crsup

Exhibit B, AGAI Report [REDACTED], New Hand Cuff Trg letter dated 13 Jun 06; Exhibit A1, Vol 4, witness statement [REDACTED]

Exhibit B, AGAI Report [REDACTED] Interview under caution Wilts Police [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Exhibit A1, [REDACTED] training record sheet extracted from JPA database, provided by [REDACTED], APC Glasgow

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Exhibit B, AGAI report [REDACTED], Offences Under AGAI 67, Service Police 1<sup>st</sup> Interim Report [REDACTED]

the use of rigid handcuffs.

### Recommendation

The Panel concluded that unit RP staff should not be expected to use rigid handcuffs and therefore there is no requirement to train them in their use. Only qualified UCS who have attended the UCS course should use rigid handcuffs.

## Dealing with a violent patient

### Summary

In examining the competence of the medical staff (MOs and CMTs (see above) in the Tidworth Medical Centre in 2006 and present day, the Panel concluded that the one aspect of medical staffs' training that would merit attention is the knowledge of what to do in the event of a patient becoming violent.

### Training

No military medical staffs, MOs or CMTs, receive any training in handling a patient who becomes violent. When Pte Williams' became violent the RP were called and it was they who restrained him. The Panel were advised that dealing with a violent patient would never be something a GP, therefore a MO, would be called upon to do. The response by a civilian GP to a patient who becomes violent would be to distance him/herself from the patient, put a barrier (door) between the patient and anyone else who is at risk and call the CIVPOL.

Exhibit B, AGAI Report  
[REDACTED], witness  
statement Wilts Police, [REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED] B

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED] F

### Findings

1. The Panel finds that response to a violent patient is a grey area that merits attention.
2. It is the finding of the Panel that there was not a shortfall of training or standards in relation to dealing with a violent patient, the Medical Centre staff did the right thing calling the RPs. In the event calling the RMP or CIVPOL would have been



a better course of action as they are professionally trained in methods of restraint.

**Recommendations**

The Panel recommend that local / induction training for all Medical Centre staff (MOs, nurses, CMTs and reception staff) should include instruction for 'actions on' the event of a patient becoming violent which should be to call the Service Police, CIVPOL or the MOD Police – these 'actions on' should be included in all Medical Centre SOPs.

**Absentee Policy**

**Summary**

Pte Williams was officially posted as Absent Without Leave (AWOL) from 14 Jun 06 to 4 Jul 06. However, although posted AWOL, evidence shows he was on camp, but avoiding duty. It is entirely possible to avoid detection on camp (Lucknow Barracks) as there is no method of checking when a soldier has returned to duty by way of swiping in or being checked off by the guard. There are at least three main entrances to Tidworth Garrison, and Pte Williams occupied individual accommodation. It is not uncommon for other soldiers to be unaware that a person is still posted AWOL.

**a. AWOL Policy**

A soldier in 2 R WELSH who is listed as AWOL for 5 days or more has the contents of his/her room 'boxed up' and the room secured. This is done at the 5 day point because the majority of soldiers who go absent do so for less than 5 days.

**Finding**

The Panel found that the practice of 'boxing up' rooms of a long term absentee (more than 5 days) was not carried out in 2006 by 2 R WELSH, but it is now common practice.

**b. Multi-unit occupancy Accommodation**

The Panel noted that with the current increase of multi-unit

Exhibit AI, 25204919 Pte G Williams conduct sheet extracted from JPA database, provided by [REDACTED], APC Glasgow

Exhibit B, AGAI Report [REDACTED] witness statement Wilts Police, [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED]

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occupancy of single soldiers' accommodation (SSA) in shared Barracks, it is proving very challenging for units to provide the necessary duty of care and day to day monitoring of soldiers in their accommodation compared to single occupancy barracks where sub-units and platoons have their own discreet blocks.

**Finding**

It is the finding of the Panel that the challenges presented by multi-unit occupancy accommodation are something that should be factored into policy concerning future SSA and by those responsible for the allocation of SSA.

**c. Returning Absentee**

Evidence shows that Pte Williams was known to be in Lucknow Barracks by the [REDACTED] and the [REDACTED] over the weekend 1-2 Jul 06 yet was not recorded as returning from absence until Mon 3 Jul 06. Not only had he been involved in the incident with [REDACTED] guests on the Sat evening but on Sun 2 Jul, Pte Williams reported for a guard duty he had taken payment to perform (although still AWOL [REDACTED] had paid Pte Williams to carry out the duty for him).

**Finding**

Whilst acknowledging it was over the weekend and Lucknow Barracks is a multi-occupancy camp with a number of exits, the Panel observed that the procedures by which duty personnel identify an absentee during a stand down period were not in place, particularly as Pte Williams had been to his own Guardroom. The Panel concluded that it would not be unreasonable to expect the duty officer, NCOs and Guardroom personnel to be aware of whom the Battalion's absentees are.

The Panel found that procedures for monitoring returning absentees need tightening in 2 R WELSH and potentially across the Army, particularly during out of hours. The Panel advise consideration should be given to measures such as having a list of absentees available in Guardrooms or with duty personnel.

**d. Fit for duty**

Pte Williams was found to have ecstasy in his body which according to the Pathologist contributed to his death.

**Finding**

[REDACTED] at Service Inquiry [REDACTED]

Exhibit A1, Vol 6, witness statement Wilts Police, [REDACTED]

Exhibit B, AGAI Report [REDACTED] witness statement Wilts Police, [REDACTED]

Exhibit C (13 of 14), Judge's Summing-Up dated 29 Jul 08, p.45-G

Exhibit D - Autopsy Report – Supplementary Autopsy Report, dated 19 Jan 07, Ref. No. 06BP050Crsup

1. The finding of the Panel is that there was a shortfall of training and procedures in relation to dealing with a returning absentee, particularly during a stand down, in 2 R WELSH in 2006, however procedures have been significantly improved.

Oral evidence from [redacted] at Service Inquiry [redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

Oral evidence [redacted] at Service Inquiry. 15 [redacted]

2. Pte Williams had been AWOL for over two weeks during which time he took ecstasy. Given the difficulty of recognising that someone has taken ecstasy (see above in Drugs awareness), it's the finding of the Panel that it would be worth considering a policy by which a soldier returning from an extended AWOL (over two weeks) should be given a medical examination to ensure fitness for a return to duty. Although a medical examination would not necessarily identify drug use, it would give the soldier the opportunity to discuss any issues he/she may have with the doctor.

Exhibit AI, 25204919 Pte G Williams conduct sheet extracted from JPA database; provided by [redacted], APC Glasgow

Oral evidence from [redacted] at Service Inquiry [redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

**Recommendations**

1. Future policy for SSA and those responsible for SSA allocation should take account of the extra challenges presented to units in their ability to provide the necessary supervision and duty of care by splitting up sub-units in multi-unit occupancy accommodation.

2. The procedures by which duty personnel identify a returning absentee during a stand down period need tightening in 2 R WELSH and potentially across the Army. The Panel advise consideration be given to measures such as a list of absentees available in Guardrooms or with duty personnel.

3. Consideration should be given to introducing a policy for returning absentees to be given a medical examination to ensure they are fit for a return for duty.

Oral evidence from [redacted] at Service Inquiry [redacted]

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E-27

~~PROTECT-STAFF-DOWNGRADED~~



TERM OF REFERENCE 1(f)

“Establish whether Army policy regarding unofficial punishments existed at the time of the incident, if so was it sufficient and widely promulgated throughout 2 R WELSH, and whether if such policy exists now, it is sufficiently fit for purpose and widely promulgated throughout the Army”.

**FACTS ASCERTAINED**

**Summary**

In recognition that the only way to formally discipline a soldier was under the Army Act 1955, DPS (A) undertook the introduction of the AGAI 67 which resulted in Edition 2 being issued in Jan 05.

AGAI 67 Edition 2 introduced Minor Administrative Action, quantified the effects of Major Administrative Action and brought Formal Warnings and Removal from Appointment into the same document. This had the desired effect of formally empowering JNCOs and the chain of command to carry out administrative action against soldiers committing minor transgressions without having to resort to disciplinary action under Army Act 1955.

On the morning of 3 Jul 06 Pte Williams was subjected to punishment in the form of a period of drill and physical training (PT). These were illegal punishments in that they were not sanctions awarded under AGAI 67 Edition 2 or punishments awarded as a result of disciplinary action taken under the Army Act 1955.

**SOURCE**

Oral evidence from [redacted] at Service Inquiry [redacted]

Email [redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

Exhibit A1, Vol 28  
Annex C to AGAI 67 par.11

Oral evidence [redacted] at Service Inquiry [redacted]

Exhibit A1, Vol 1 witness statement Wilts Police, [redacted]

Exhibit A1, Vol 4 SIB witness statement, [redacted]

Exhibit A1, Vol 3 witness statement Wilts Police,

[REDACTED] Crown Court Trial summing up HHJ Royce, dated 29 Jul 08, p.14-B to p.20-E

### Two forms of discipline

With the introduction of AGAI 67 Edition 2 in 2005 there were only two ways in which misconduct by a military person could be dealt with. The first was administrative action under AGAI 67 and the second was disciplinary action under the Army Act 1955.

Based on compelling evidence the Panel concluded that at the time of Pte Williams' death, and in the months leading up to it, a third way of discipline, which was not compliant with military administrative or disciplinary policy, was being used by some members of 2 R WELSH.

Exhibit A1, Vol 1 witness statement Wilts Police,

[REDACTED]

Exhibit C (1 of 14) sworn evidence,

[REDACTED]

Exhibit A1, Vol 1 witness statement Wilts Police,

[REDACTED]

Exhibit A1, Vol 1 sworn evidence,

[REDACTED]

Exhibit A1, Vol 4 SIB witness statement,

[REDACTED]

Exhibit A1, Vol 4 SIB witness statement,

[REDACTED]

Exhibit C (13 of 14), Crown Court Trial summing up HHJ Royce, dated 29 Jul 08, p.37-B to p.42-C

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

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Although those in authority within the CoC in 2 R WELSH [REDACTED] at the time of Pte Williams' death denied knowing there was a third way operating within the Bn, based upon the compelling evidence presented there clearly was. The 2 R WELSH chain of command's ignorance of this, and consequent failure to prevent it, is dealt with at pages E-6 to E-7 and F-6 to F-7.

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry 9 [REDACTED]

**Training on AGAI 67 in 2006**

In the lead up to it being issued in Jan 05, training on AGAI 67 Edition 2 was delivered in the form of Army wide road shows for commanders throughout 2004, and was subsequently included on all career courses, including CLM, from 2005.

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

**Training on AGAI 67 in 2 R WELSH in 2006**

Evidence suggests that the former [REDACTED] and RP staff of 2 R WELSH in 2006 had all been instructed on AGAI 67 and the use of administrative action which, by Jul 06, had been Army policy for over 18 months.

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence [REDACTED] at Service Inquiry [REDACTED]

**PROTECT-STAFF-DOWNGRADED**

[REDACTED] had been instructed in AGAI 67 on his [REDACTED] course in Aug 05 and [REDACTED] had been briefed on AGAI 67 by [REDACTED] on assumption of appointment.

The emphasis was placed upon the chain of command to cascade the training throughout units. In 2 R WELSH evidence would suggest that it was the task of [REDACTED] to instruct AGAI 67 to other members of the Battalion.

Evidence indicates that the 2 R WELSH was using AGAI 67 in 2005 from its inception and throughout 2006.

Despite this evidence, [REDACTED], told the SIB investigation that; "the AGAI system was paid lip service, the physical discipline was used as an alternative to the AGAI system".

**Changes**

Since Edition 2 was issued in 2005 there have been several minor amendments to AGAI 67. At the end of 2006 DPS (A) conducted a practitioners' review of the AGAI and it was subsequently thoroughly restructured as well as revised. Edition 3 was subsequently issued in Apr 08. The current version is Edition 4.

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Exhibit A1, Vol 27 – Records of Minor Sanctions awarded in 2 RRW (latterly 2 R WELSH) between 1 Jan 06 and 31 Dec 06

Exhibit A1, Vol 29 – Records of Minor Sanctions awarded in 2 RRW (latterly 2 R WELSH) between 10 Mar 05 and 15 Dec 06

Exhibit A1, Vol 4 SIB witness statement [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Email [REDACTED]



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On 8 Aug 08, the day following completion of the trial, DPS (A) wrote a directed letter to the Army chain of command reminding the whole Army that there are only two ways of sanctioning misconduct; with administrative action under AGAI 67 or by disciplinary action under AA 55.

Oral evidence from [redacted] at Service Inquiry [redacted]

Exhibit G  
Unofficial Sanctions and Punishments  
D/DPS (A) 3/331 dated 8 Aug 08.

**Current Training**

Regular coverage of the Army's disciplinary processes occurs for officers and soldiers undergoing career progression courses from basic training through to Commanding Officer or Warrant Officer appointments. See Annex I to this report for more detail.

Oral evidence from [redacted] at Service Inquiry [redacted]

Annex I to this report; and Exhibits R & T

**Physical Training as a Sanction**

AGAI 67 lists the authorised minor sanctions which includes; 'Skills training and *appropriate physical training* may be included if the serviceman's failings warrants it'. This is the only reference to physical training. There is no specific mention made of Drill or PT which the Panel concluded was ambiguous.

Exhibit A1, Vol 28 – Annex C to AGAI 67, par.11a(4)

On questioning witnesses as to whether they thought PT was an authorised sanction there were differing opinions; [redacted] said it was, but all other witnesses, including the [redacted] and current [redacted] and [redacted] of 2 R WELSH did not believe it was. Other than [redacted] none of the witnesses could come up with a scenario when PT would be a suitable sanction. There was agreement among all witnesses other than [redacted] that should a soldier transgress during a period of PT then he or she should be awarded a sanction that befits the failing e.g. late for parade, insubordinate, wearing a watch etc none of which would attract a sanction of PT, as the PT would not be restorative or rehabilitative. Should the soldier be deemed as lazy or prove to be shirking or below the necessary level of fitness during PT then a more suitable course of action would be to place him or her on remedial PT or reconditioning PT if he or she is recovering from an illness or injury.

Oral evidence from [redacted] at Service Inquiry [redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

In order to ensure that soldiers maintain the required levels of fitness to do their job, the RAPTC is keen to promote PT as fun and constructive. Clearly using it as a punishment undermines this aspiration.

**Findings**

1. It is the finding of the Panel that there was no Army policy regarding unofficial punishments at the time of the incident. However with the existence of AGAI 67 and the AA 55, which articulated official punishments, it was implicit that anything outwith these two publications was unofficial. AGAI 67 Edition 2 had been in use for 18 months and was being extensively used by 2 R WELSH. The Panel therefore concluded that it was widely promulgated throughout the unit and as a result there was no excuse for the use of unofficial punishments.

2. It is also the finding of the Panel that the fact that a 'third way' was operating in 2 R WELSH tragically culminated in the chain of events concerning Pte Williams on 3 Jul 2006. This was not a failing in the chain of command's training, but rather [redacted] actions set the conditions. This then combined with the failure on the part of the chain of command of 2 R WELSH to realise this 'third way' was being regularly employed, directly led to their consequent failure to grasp the problem and put a stop to such physical sanctions being imposed on soldiers in 2 R WELSH outwith AGAI 67 or AA55.

3. Although clearly implied with the introduction of AGAI 67 Edition 2, there was no official source of information where it actually stated that there were only two methods of dealing with misconduct.

Oral evidence from [redacted]  
[redacted] at Service  
Inquiry [redacted]

Oral evidence from [redacted]  
[redacted] at Service Inquiry [redacted]

Oral evidence from [redacted]  
[redacted] at Service Inquiry [redacted]

Exhibit A1, Vol 28 - AGAI67  
Edition 2 Amdt 3 Jan 06;

Exhibit A1, Vol 27 –  
Records of Minor Sanctions  
awarded in 2 RRW (latterly  
2 R WELSH) between 1 Jan  
06 and 31 Dec 06;

Exhibit A1, Vol 29 –  
Records of Minor Sanctions  
awarded in 2 RRW (latterly  
2 R WELSH) between 10  
Mar 05 and 15 Dec 06

Oral evidence from [redacted]  
[redacted] at Service  
Inquiry [redacted]

Oral evidence from [redacted]  
[redacted] at Service Inquiry [redacted]

Oral evidence from [redacted]  
[redacted] at Service [redacted]

**PROTECT-STAFF-DOWNGRADED**

4. The Panel finds that with the regular training which now takes place throughout a soldier's and officer's career, the policy regarding unofficial punishments, as articulated by DPS (A) in his policy letter to G1 staff on 8 Aug 08, should be well understood and is widely promulgated throughout the Army.

Exhibit G - letter  
Unofficial Sanctions and Punishments  
D/DPS (A) 3/331 dated 8 Aug 08.

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

5. AGAI 67 lists the authorised minor sanctions which includes; 'Skills training and *appropriate physical training* may be included if the serviceman's failings warrants it'. This is the only reference to physical training. There is no specific mention made of Drill or PT which the Panel concluded is ambiguous.

Exhibit A1, Vol 28 – Annex C to AGAI 67 par.11a(4)

6. The Panel was presented with compelling evidence from [REDACTED], as well as other witnesses under oath, that AGAI 67 is fully understood and embraced by 2 R WELSH. [REDACTED] from HQ PM (A), who visits units across the Army, also described a 'culture change' over the last few years throughout the Army.

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] HQ  
PM(A) at Service Inquiry [REDACTED]  
[REDACTED]

**Recommendations**

1. Although clearly implied with the introduction of AGAI 67 Edition 2, and articulated by DPS(A)'s policy letter of 8 Aug 08, that unauthorised punishments are illegal, the Panel strongly recommends that the following paragraph, or similar words, is included in AGAI 67:

'There are only 2 components to the Army's Discipline System; AFA 2006 and AGAI 67. Any sanctions or punishments awarded without following the proper process are illegal. Those awarding punishments outside these processes must be subject to investigation with a view to disciplinary and/or administrative action'.

(Extract taken from DPS (A)'s policy letter written the day after the completion of the trial).

2. This sentiment of only 2 components to the Army's Discipline System should also be clearly stated in all discipline training; in one easily understood slide for example.

Exhibit G -  
Unofficial Sanctions and Punishments  
D/DPS (A) 3/331 dated 8 Aug 08.

**PROTECT-STAFF-DOWNGRADED**

3. If it is decided that PT remains a permissible sanction under AGAI 67, this must be expressly stated along with an explanation of when it would be appropriate to award it as a sanction, and under which of the six stipulated sanctions at para 8 of Annex C to AGAI 67. (For example in a training environment it is currently permissible to use 'Wake Up Exercises' as a form of 'Remedial Training' in accordance with the various extant policies in the ARTD)

Exhibit A1, Vol 28 - Annex C  
to AGAI 67 par. 11

4. Drill is an acceptable sanction under '*Extra Tasks or Duties*' but it should be conducted in a recognised, planned and structured manner, preferably in a squad, by a qualified drill instructor. This should be articulated in AGAI 67.

*ibid*



**TERM OF REFERENCE 1(g)**

**“Whether the death could reasonably have been prevented and if so by what means it could have been prevented”**

**FACTS ASCERTAINED**

The Autopsy Report (Supplementary Report) stated that there were four contributing factors which resulted in the death of Pte Gavin Williams;

Combined effects of; Exertion, Hyperthermia, Restraint and Recent use of Ecstasy

**Summary**

The Panel has concluded that the removal of any or all of these factors may have may have resulted in a different outcome on 3 Jul 06 and expands the effects of the contributing factors as follows.

**Exertion**

It is clear from the evidence that on the day of his death, Pte Williams was subjected to periods of strenuous physical activity as a form of punishment, outside the regulations laid down under AGAI 67. [REDACTED]

[REDACTED] gave evidence at the Crown Court trial stating that the main cause of Pte Williams' body generating excessive heat was the exercise he was subjected to on that day, and the conditions which existed (hot temperature).

**Finding**

The Panel conclude that had this punishment exercise not been conducted under these circumstances, Pte Williams' body temperature would not have risen to a dangerous level.

**SOURCE**

Exhibit D, Autopsy Report Supplementary Report Ref. No.06BP050Crsup dated 19 Jan 07, p. 6

Exhibit C (13 of 14), Sworn evidence of [REDACTED]

**Hyperthermia (Heat Illness)**

██████████ also stated in his evidence that the onset of hyperthermia was as a result of Pte Williams' raised body temperature and the increase of potassium in the body which probably occurred over a period of an hour from the time his body temperature exceeded 39.5 deg C.

**Finding**

The evidence produced in the numerous witness statements and court transcripts describes Pte Williams' displaying many signs of the onset of hyperthermia and therefore the Panel conclude that had these signs been recognised by any person involved in the incident during this time, remedial action could have been taken that might have prevented the fatal outcome.

**Restraint**

Having been taken to the Medical Centre in Tidworth and whilst 'run-ups' were being conducted, Pte Williams became aggressive and struck ██████████. These actions were mistakenly interpreted as a psychological disorder, and he was subsequently physically restrained at different times by at least three of the persons present at the Medical Centre; ██████████ (on one occasion with rigid handcuffs).

There are varied recollections on what actions were used in order to restrain Pte Williams; ██████████ states that; *"I continued to hold his right hand with mine and placed my right knee in the small of his back using my body weight to keep him on the floor"*.

██████████ recounts that; *"I then went down to him (Pte Williams). I then got his hand, his arm placed underneath where my foot and my knee was and applied slight pressure there so he couldn't move it"* and went on to say; *"as he was flailing, he turned over. I then went back down again and put my left leg over his right arm again like before..... ██████████ then put one of the handcuffs on his left arm which was holding the plinth"*.

██████████

Exhibit B, AGAI Report ██████████, witness statement Wilts Police, ██████████; ██████████; interview under caution ██████████

Exhibit B, AGAI Report ██████████ witness statement Wilts Police, ██████████

Exhibit B, AGAI Report ██████████ witness statement Wilts Police, ██████████

Exhibit B, AGAI Report ██████████ interview under caution Wilts Police, ██████████

**Finding**

The panel believes that in the given circumstances a certain degree of restraint was justified in order to prevent further injury to those present, including Pte Williams. It is difficult to conclude what else could have been done in the situation where the Doctor present – apparently lacking an accurate history of what had gone before, concluded that the patient was suffering from a psychological disorder.

Exhibit D, Autopsy Report Supplementary Report Ref. No.06BP050Cr sup dated 19 Jan 07, p.6

It is clear however that due to the aggressive way that Pte Williams resisted examination and the resulting restraint techniques applied by [REDACTED] and [REDACTED] contributed to the cause of death.

**Recent use of ecstasy**

Evidence collected during the Wilts Police investigation and supported in the Autopsy Report, indicates that Pte Williams was a recent user of the drug ecstasy and he may have been exposed to other illicit substances either actively or passively.

Exhibit D, Autopsy Report Supplementary Report Ref. No.06BP050Cr sup dated 19 Jan 07, p.3-6

Exhibit AG, witness statement Wilts Police, [REDACTED]

Exhibit AG, witness statement Wilts Police, [REDACTED]

**Findings**

The Panel conclude that had Pte Williams not taken an unknown amount of ecstasy in the period leading up to the punishment session on the morning of 3 Jul 06, his body may not have reacted in the way it did, which resulted in him developing hyperthermia. All the material witnesses, less [REDACTED], stated that at no time did Pte Williams admit to taking drugs. The Panel is of the opinion that had he done so, the way he was handled and therefore the outcome may have been different.

The Panel also concluded that had Pte Williams' colleagues reported his use of ecstasy to the CoC, the actions taken prior to 3 Jul 06 would have been different and Pte Williams may not have died on that day.

**Recommendation**

Soldiers need to be frequently reminded of the importance of reporting drug abuse not just for disciplinary reasons but for safety reasons as well, as evidenced in Pte Williams' case.

**Environmental**

In addition to the aforementioned contributing factors the environmental conditions on the day should be considered. [REDACTED] claims that he obtained a WBGT reading on the morning of 3 Jul 06 and that the temperature reading was 24°C (red) for the morning and 26°C (black) for the afternoon. Whilst the morning reading did not preclude physical training, the index was sufficiently high to warrant taking suitable measures to regulate the activity being conducted and to ensure ample water intake was maintained.

[REDACTED] and [REDACTED] all stated that Pte Williams was given water on a number of occasions and [REDACTED], during his evidence to the Crown Court proceedings, also confirmed that there were no indications of severe dehydration.

**Finding**

The Panel therefore conclude that dehydration was not a major factor in the death of Pte Williams and access to more water would not have had a major impact on his survivability, however the high temperatures and relative humidity on the day certainly did contribute to the onset of hyperthermia.

**Procedural**

The Panel heard that had Pte Williams been dealt with in the correct manner for his transgressions (AWOL, aggressive behaviour and drunk on duty), he would have been interviewed by [REDACTED], identified as the individual who was responsible for the various actions over the preceding weekend, and subsequently sent to his Company for [REDACTED] and [REDACTED] disposal. This would have resulted in either administrative action under AGAI 67 or more likely given the severity of the actions, summary dealing by [REDACTED].

**Finding**

The Panel concludes that the sequence of events on the morning of 3 Jul 06 highlight the importance of the disciplinary or AGAI process being followed correctly from the outset. It is the finding of the Panel, that had this occurred it is likely that the death of Pte Williams may well have been prevented.

**Opinion**

It is also the Panel's opinion that had Pte Williams undertaken any form of strenuous physical activity on that day, sanctioned or otherwise, given the unknown amount of ecstasy in his body

Exhibit B, AGAI Report  
[REDACTED] Service  
Police 1<sup>st</sup> Interim Report  
[REDACTED]

Exhibit C (13 of 14), Sworn  
evidence of [REDACTED]  
[REDACTED]

Exhibit B, AGAI Report  
[REDACTED] SIB  
witness statement, [REDACTED]  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]  
[REDACTED]

Exhibit D –  
Autopsy Report,  
Supplementary Autopsy  
Report,  
Ref.No.06BP050Cr sup,  
dated 19 Jan 07  
(Pathologist's summary  
Annex B p2 of this report)



the tragic outcome may well have been the same.

**Patient History**

The Panel heard from a number of witnesses on the importance of being given a full and accurate description of the patient's recent history and symptoms in order to make a correct diagnosis.

Oral evidence from [REDACTED] at Service Inquiry held [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

However in the case of Pte Williams although there is evidence to indicate that there was a passage of information between the people involved in his care, the information was predicated on Pte Williams' own assertion (made at different times to [REDACTED] and [REDACTED]), that he had been "*pissing and shitting blood*". No mention was made to the effect that he had been taking drugs.

Exhibit A2, Addendum Report (3 of 4), interview under caution Wilts Police, [REDACTED]

Exhibit B, AGAI Report [REDACTED] Interview under caution Wilts Police, [REDACTED]

This coupled with Pte Williams' actions over the preceding weekend, which had been observed or conveyed to [REDACTED], will have undoubtedly influenced what was conveyed by [REDACTED] to [REDACTED] and then to [REDACTED], when Pte Williams was subsequently brought to the Medical Centre on 3 Jul 06.

Exhibit A2, Addendum Report (3 of 4), interview under caution Wilts Police, [REDACTED]

Exhibit A2, Addendum Report (1 of 4), witness statement Wilts Police, [REDACTED]

Exhibit B, AGAI Report [REDACTED] witness statement Wilts Police, [REDACTED]

When Pte Williams later became violent and aggressive, and remained uncooperative during an attempt to examine him, [REDACTED] considered that he had reason to be concerned about Pte Williams' mental state. The Panel believes this was undoubtedly influenced by the 'patient history' which had been passed to [REDACTED] verbally by an extended chain of individuals using evidence from the previous 3 days and not just the morning of 3 Jul 06.

**Findings**

From the evidence presented, the Panel concluded that the misrepresentation of Pte Williams' symptoms (urine in the blood), the emphasis put on his 'erratic' behaviour over the weekend and no mention of the recent use of ecstasy led ██████████ ██████████ to reasonably conclude that Pte Williams' did indeed have a psychological problem, and his actions in treating a patient with a psychological problem were wholly acceptable under the circumstances.

The Panel also conclude that on the evidence presented, the damage sustained by Pte Williams' prior to his arrival at the Medical Centre almost certainly precluded the effectiveness of any medical treatment available at that stage.

Oral evidence ██████████  
██████████ at Service Inquiry

Oral evidence from ██████████  
██████████ at Service Inquiry

**Emergency Health Care**

The SI was informed that Military Primary Health Care services, including Tidworth Medical Centre, do not have the necessary facilities to deal with medical emergencies, the correct action in these circumstances is to call 999 and ask for an ambulance.

Oral evidence from ██████████  
██████████ at Service Inquiry

Oral evidence from ██████████  
██████████ at Service Inquiry held

**Findings**

The Panel believe that had an ambulance been called when Pte Williams first complained of stomach pains, his chances of survival would have been greatly enhanced.

TERM OF REFERENCE 1(h)

"What lessons have been learnt as a result of this incident".

**FACTS ASCERTAINED**

**SOURCE**

**Lessons Learnt**

The Panel concluded that a number of important lessons have been learnt as a result of the death of Pte Williams.

**The need for a culture change in 2 R WELSH.**

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

The Panel was presented with compelling evidence from [REDACTED] and [REDACTED], as well as other witnesses under oath, that AGAI 67 is fully understood and embraced by 2 R WELSH. [REDACTED] from HQ PM(A), who visits units across the Army, also described a 'culture change' over the last few years throughout the Army.

Oral evidence from [REDACTED] at  
Service Inquiry

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

This is an extract from [REDACTED] oral evidence:  
*"I think the culture of the Battalion now is very much (that) we retain memory of that incident in mind all the time and certainly the culture I detected when I came into the job is that whatever we do we must do things correctly. And so everyone, as far as I can see, in terms of this sort of thing is very careful to make sure we do things correctly and make sure the policy is implemented absolutely correctly. So every time I listen to a staff parade or when I am waiting for someone to come in for the CO there is always a part of me that thinks that the soldiers are being marched across from the guardroom, yes that's fine. And so we're always cautious of that and I do walk the corridors and always keep my eyes open to make sure I see what is going on. It's something that's in the back of my mind and certainly in the back of most people's minds who have had an awareness of the incident that we just need to make sure we*

Oral evidence from [REDACTED] at  
Service Inquiry

are exactly correct in our message about it".

**Mitigating the risks of exercising in heat by 2 R WELSH.**

The Panel found that 2 R WELSH were relatively well versed in the risks associated with exercising in heat prior to the incident but since the incident they have enhanced their procedures by advertising the Wet Globe Bulb reading widely, including on a board outside the Guardroom. On particularly warm days the Br's policy is to position a 'heat sentry' on the barrack gate to provide heat warnings to all individuals partaking in physical exercise.

**Improvements made in training and awareness, across the three Services, of the risks of exercising in heat.**

The Panel heard from [REDACTED] from the MOD's Environmental Medicine Unit (EMU) that awareness of the Pte Williams' incident stimulated interest and further work in the effects of heat. He further stated that there has been a big improvement in the general awareness and treatment of heat illness across the board throughout Defence and that JSP 539 (Climatic Injuries in the Armed Forces Prevention and Treatment 2003) had been updated and the changes have enabled all medical personnel to better deal with and treat heat illness.

**Improvements in Heat Awareness for Military Medical Officers.**

As part of the Post Graduate Medical Officer's (PGMO) Course, which is mandated for all first appointment military medical officers, the prevention, recognition and treatment of heat injuries is now taught by [REDACTED].

**A reminder to the Army that there are only two ways a soldier can be disciplined.**

The Panel heard that on 8 Aug 08, the day following completion of the trial of three soldiers in relation to Pte Williams' death, DPS(A) wrote a directed letter to the Army chain of command reminding the whole Army that there are only two ways of sanctioning misconduct; administrative action under AGAI 67 or with disciplinary action under Army Act 55.

Extract from DPS(A)'s letter; "Unofficial Sanctions and Punishments"

"The purpose of this letter is to inform you that I have issued a policy letter to your G1 staff to make clear unauthorised punishments and sanctions are illegal, that the disciplinary

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]

Exhibit AF –  
JSP 539 Climatic Injuries in the Armed Forces Prevention and Treatment 2003 (D/AMD/113/26)

Exhibit AC –  
Post Graduate Medical Officer's Training Documentation Training Objective 5.3 – p.2 to 6 and p.4 to 44

Exhibit AA –  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]

Exhibit G  
Unofficial Sanctions and Punishments  
D/DPS(A) 3/331 dated 8 Aug 08.



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processes laid down in the Army Act 1955 and Army General Administrative Instruction 67 (AGAI 67) are to be adhered to, and to correct a weakness identified in AGAI 67, which might allow unauthorised sanctions to take place”.

### **Amendments to AGAI 67 to provide better assurance in the process of awarding administrative sanctions.**

The Panel heard that in response to the incident DPS(A) amended AGAI 67 to provide better assurance in the process of awarding administrative sanctions. A new procedure was introduced that required the awarding NCO to complete a tear off slip which was to be sent to the sanction supervisor to provide an audit trail of the sanction given, who it had been given to and who had authorised it.

### **A complete revision of AGAI 67.**

The Panel heard that since Edition 2 of AGAI 67 was issued in 2005 there have been several minor amendments to the AGAI. At the end of 2006, after the incident, DPS(A) conducted a practitioners' review of the AGAI and it was subsequently thoroughly restructured as well as revised. Edition 3 was subsequently issued in Apr 08. The current version is Edition 4.

## **Recommendations by Service Inquiry**

As a result of the Service Inquiry the Panel noted twenty three other lessons which form the basis of recommendations for further consideration. All these are also listed at the front of this Report under; 'Recommendations'.

### **AGAI 67**

1. A unequivocal statement should be included in AGAI 67 Vol 2:

'There are only 2 components to the Army's Discipline System; AFA 2006 and AGAI 67. Any sanctions or punishments awarded without following the proper process are illegal. Those awarding punishments outside these processes must be subject to investigation with a view to disciplinary and/or administrative action'.

2. This sentiment of only 2 components to the Army's Discipline System should also be clearly stated in all discipline training; in one easily understood slide for example.

3. If it is decided that PT remains a permissible sanction under AGAI 67, this must be expressly stated along with an explanation of when it would be appropriate to award it as a

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry

*ibid p.205-A to D and p.220-F to G*

[REDACTED] Document not produced as exhibit but included in part 2 of this Report, [REDACTED]

Annex E p7  
Annex F p8

Exhibit G  
Unofficial Sanctions and Punishments  
D/DPS(A) 3/331 dated 8 Aug 08.  
(Extract taken from DPS(A)'s policy letter written the day after the completion of the trial)

Exhibit A1, Vol 28, AGAI 67  
Annex C para 11

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sanction, and under which of the six stipulated sanctions at para 8 of Annex C to AGAI 67. (For example in a training environment it is currently permissible to use 'Wake Up Exercises' as a form of 'Remedial Training' in accordance with the various extant policies in the ARTD)

4. Drill is an acceptable sanction under '*Extra Tasks or Duties*' but it should be conducted in a recognised, planned and structured manner, preferably in a squad, by a qualified drill instructor. This should be articulated in AGAI 67.

*ibid*

### Regimental Police Staff

Annex E p9-p10

5. With the demise of the former RP NCO course today's RP NCOs, who have no responsibility for detainees, will be unlikely to attend the Unit Custodial Staff (UCS) course and thus they will have no formal training. The Panel concluded that a review into the role and training of RP staff needs to be conducted as a matter of priority.

6. The title Regimental Police is dated. The title of UCS must be adopted for all those personnel supervising detainees or providing units with a detention function. For those personnel not supervising detainees a new name for the RSM's staff should be found.

7. The Panel are aware that the Custodial team at HQ PM(A) are currently staffing a paper to recommend the introduction of a badge so that UCS are easily recognisable. This would be a positive step in introducing a move away from the old RP mindset. The Panel fully endorses this initiative.

8. The Panel concluded that unit RP staff are not expected to use rigid handcuffs and therefore there is no requirement to train them in their use. Only qualified UCS who have attended the UCS course should use rigid handcuffs.

Annex E p22

### Battalion SOPs

Annex E p11

9. All unit key appointments; CO, 2IC, Adjt, RSM, SSA and RP Staff should have job descriptions which should include mention of their responsibilities in relation the discipline process and specifically with regard to AGAI action. This is an Army wide requirement.

10. The duties, roles and responsibilities, particularly in relation to AGAI action and the disciplinary process, of all unit key appointments should be included in Unit SOPs Army wide.

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<b>MATT 3</b>	Annex E p13
11. The Panel recommends that the MOD's EMU is invited to provide assurance of MATT 3 (BCD).	
<b>Medical Emergencies</b>	Annex E p16
12. The Panel concluded that all unit personnel and medical staff should be familiar with the limitations of the local military medical facilities and the circumstances when they should call 999. As such this should be included as part of unit SOPs and any organisation's induction training.	
<b>Training of Medical Officers</b>	Annex E p17
13. Whilst acknowledging that all military MOs receive training in heat injuries on the PGMO course, the Panel concluded that heat illness should be included on the GP Refresher Courses as part of the GP Emergencies Day.	Exhibit AE – Dept of General Practice GP Refresher Course 31 Oct - 4 Nov 11  Exhibit AA – Email dated 1 Nov 11 1227hrs from [REDACTED] Instructor PGMO Course
<b>Wet Bulb Globe</b>	Annex E p18
14. Every major unit gymnasium should have its own WBGT which in turn must be used in the location where exercise is due to take place.	
<b>Drugs Misuse</b>	Annex E p21
15. DPS(A) should consider the means by which a soldier can report his own misuse of drugs without the risk of dismissal from the Service.	
16. The introduction of targeted CDT for individuals that the chain of command or MO believes to be at risk, such as a returning absentee. This would balance the individual's rights with the CO's duty of care to others within his unit (including the drug taker himself).	
17. Consideration should be given to reintroducing the Early Intervention Programme to enable the education of selected individuals and to give the chain of command an alternative to 'zero tolerance'.	Oral evidence from [REDACTED] [REDACTED] at Service Inquiry [REDACTED] [REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service  
Inquiry [REDACTED]

18. Soldiers need to be frequently reminded of the importance of reporting drug abuse not just for disciplinary reasons but for safety reasons as well, as evidenced in Pte Williams' case.

Annex G p3

**Medical Facilities' Staff Training**

Annex E p23

19. The Panel recommend that training for all Medical Centre staff (MOs, nurses, CMTs and reception staff) should include instruction on 'actions on the event of a patient becoming violent' and this should be included in their SOPs.

**Single Soldiers' Accommodation**

Annex E p26

20. Future policy for SSA and those responsible for SSA allocation should take account of the extra challenges faced by units by multi-unit occupancy of accommodation and the resulting splitting up of sub-units.

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]

**AWOL**

Annex E p25

21. The procedures by which duty personnel identify a returning absentee during a stand down period need tightening in 2 R WELSH and potentially across the Army. The Panel advise that consideration be given to measures such as a list of absentees available in guardrooms or with duty personnel.

Oral evidence from [REDACTED]  
[REDACTED] at  
Service Inquiry [REDACTED]

22. Consideration should be given to introducing a policy for returning absentees to be given a medical examination to ensure they are fit for a return to duty.

Oral evidence from [REDACTED]  
[REDACTED] at  
Service Inquiry [REDACTED]

**Training**

Annex D p12

23. Personnel should attend relevant pre-employment training prior to assuming their appointment (or within a specific period) in order to address what appears to be somewhat of a consistent trend in this case which demonstrates otherwise.



**TERM OF REFERENCE 1(i)**

**How and when are the AGAI 67 procedures taught and promulgated throughout the Army.**

**Summary**

[REDACTED]  
Directorate of Personnel Services (PS2) who was involved in the training and implementation of AGAI 67 throughout the Army during its roll-out and who was called as a subject matter expert relating to AGAI 67 matters from its inception to present day, and [REDACTED] working in the Directorate of Training (Army) with responsibility for career and professional development of soldiers between the rank of Private and Warrant Officer Class One, in their evidence to the Inquiry stated that AGAI 67 training is now delivered at a number of different stages within officers and soldiers' career paths.

**Officers**

1. An introduction to the AGAI 67 process is given during the Commissioning Course at RMAS, which consists of 1 x 45 min lecture. Written notes are also provided within the RMAS Discipline Command Handbook, given to each Cadet.
2. Professionally Qualified Officers attending the PQO course at RMAS also receive a 1 x 45 min discussion period covering all aspects of the Military Justice System and Administrative Procedures. Written notes are also provided within the RMAS Discipline Command Handbook, given to each student.
3. The Late Entry Officers' Course delivered at RMAS also provides a refresher brief on the Army's Discipline Procedure for all participants, consisting of a 1 x 45 min lecture.
4. AGAI 67 is also addressed in more depth on the All Arms Adjutants Course, where students are given 3 x 40 min presentations by [REDACTED] at SPSTS Worthy Down.
5. The Officer Commanding Discipline and Administration Course (OCDA) which may be delivered by Brigade HQs on behalf of DPS(A), or as part of role specific training courses. The AGAI 67 element consists of a single day of various presentations with 1 x 60 min lecture and 1 x 30 min of scenarios dedicated to Minor Admin Action (JSP 833 / AGAI 67).

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Exhibit R - S/F 1, Covering Letter from [REDACTED]

Exhibit R - S/F 1 Encl 2, Initial Officer Training, Army Ethos 9.

Exhibit R - S/F 1 Encl 8, PQO course programme

Exhibit R - S/F 1 Encl 9, LEOC commissioning course programme

Exhibit R - S/F 1 Encl 3 & 4, All Arms Adjts Course – course programme and copy of presentation slides.

Exhibit R - S/F 1 Encl 5 & 6, OCDA Course – course programme and copy of presentation slides.

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6. Commanding Officer Designate Course delivered at Warminster, the AGAI 67 brief is given by [REDACTED]

Exhibit R - S/F 1 Encl 7, CO Designate Course copy of presentation slides.

**Soldiers**

All new recruits undergoing Phase 1 training will receive a lesson on AGAI 67 procedures within the Common Military Syllabus (CMS) delivered throughout all Phase 1 training establishments, a copy of the lesson plan is contained within the folder produced by [REDACTED] as Exhibit R.

Exhibit R- S/F 1 Encl 1, Initial Soldier Training and Exhibit R – S/F 3 to 6

[REDACTED] stated that Command, Leadership and Management (CLM) training was introduced into the Army in 2004 and is mandatory for all soldiers seeking promotion, to attend at relevant stages of their career; AGAI 67 procedures are taught or refreshed at each stage of the CLM training process. [REDACTED] provided CLM Instructional Specifications (I Specs) for each stage of CLM training within the folder produced as Exhibit R. The CLM I Specs indicate the Key Learning Points (KLP) taught to soldiers in the classroom as well as practical based periods regarding AGAI 67 and other disciplinary procedures. The various CLM courses and KLPs are as follows;

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

1. Potential NCO CLM instructional specification states the enabling objective as; 'Apply Military Discipline', consisting of 4 x 40 min periods covering the object of Military Law, discipline as a function of leadership, AFA 2006, AGAI 67 and disciplinary action which can be taken by a JNCO.

Exhibit R S/F 3

2. Junior NCO CLM instructional specification states the enabling objective as; 'Maintain Discipline', consisting of 3 x 40 min periods revising the need for soldiers' adherence to the law (civil and military), lawful commands, identify the administrative action that can be taken by a JNCO and exercise powers of arrest.

Exhibit R S/F 4

3. Senior NCO CLM instructional specification states the enabling objective as; 'Uphold and Apply Military Discipline', consisting of 2 x 40 min periods revising the need for soldiers' adherence to law (civil and military), identify the administrative action that can be taken by a SNCO in accordance with AGAI 67 and identify the disciplinary action that can be taken by a SNCO in accordance with the Military Criminal Justice System.

Exhibit R S/F 5

4. Warrant Officers CLM instructional specification states the enabling objective as; 'Uphold and Apply Military Discipline', consisting of 5 x 40 min periods with the objective of equipping the individual to; instil discipline within the unit, ensure adherence to the Army policy on administrative action (AGAI 67), ensure correct disciplinary action is taken within the unit, ensure appropriate custody procedures are taken at unit level and ensure appropriate summary dealings procedures are taken at unit level.

Exhibit R S/F 6

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In addition to the CLM career courses, AGAI 67 and other disciplinary processes are covered in the 3 week Staff Support Assistant Course at SPSTS Worthy Down. AGAI 67 is given a full day consisting of presentations and scenarios.

**Findings**

The panel finds that AGAI 67 procedures are formally taught to all officers and soldiers during their initial training courses and at various points during their career progression, through presentations delivered at a variety of training establishments.

It is also evident that units or formations may on occasions choose to deliver presentations to JNCO cadres as part of devolved training or to other target audiences as is deemed necessary.

The panel therefore concludes that the AGAI 67 process is taught to all ranks at various times throughout an individual's career, is widely used and understood throughout the Army and its publications are readily accessed from a variety of sources

Exhibit R S/F 7

Exhibit R;  
Oral evidence from [REDACTED]  
at Service Inquiry [REDACTED]

and

Oral evidence from [REDACTED]  
at Service Inquiry [REDACTED]

Oral evidence from [REDACTED]  
at Service Inquiry [REDACTED]

**TERM OF REFERENCE 1(i)**

**“What actions have been taken or procedures implemented to prevent recurrence of this type of incident within the Army.”**

**FACTS ASCERTAINED**

**SOURCE**

**The Investigations, Trial and Inquiry**

In conducting this Inquiry it soon became very clear to the Panel that Pte Williams' death and the circumstances surrounding it sent shockwaves across the Army, and it lives in the Army's consciousness today. The seriousness with which the incident has been taken is reflected in the investigations and the civilian trial which followed:

1. A Criminal Investigation by Wiltshire Police from Jul 06-Apr 07.
2. A Crown Court Trial of three accused for manslaughter Jun 08-Jul 08.
3. A Criminal Investigation by RMP from Aug 08-Jul 09.
4. An AGAI Investigation by RMP Sep 09-Sep 10.
5. A Statutory Service Inquiry Nov 11-Feb 12.

**Wiltshire Police Investigation**

From the moment Pte Williams' death was reported to the Wiltshire Police on 3 Jul 06 they opened a criminal investigation with a number of suspects being arrested almost immediately. The investigation culminated in three accused; [REDACTED] being tried for manslaughter in Jul 08.

**Crown Court Trial**

The trial, which took place in Winchester and was presided over by The Hon Mr Justice Royce, concluded on [REDACTED] 08 and found the three accused not guilty.

**RMP Investigation**

The Wiltshire Police excluded the Service Police from their investigation so following the trial it was necessary for the RMP to conduct a second investigation in order to establish if any *military* offences had been committed in the lead up to Pte Williams' death. The RMP investigation lasted 12 months and included consideration of the evidence from the civil police investigation. It was the opinion of DDSP that given the verdict

Exhibit B, AGAI Report  
[REDACTED], Service Police  
1<sup>st</sup> interim Report [REDACTED]



of the Crown Court, there was no scope to pursue any further criminal charges against [REDACTED] as the defendants were within their rights to plead 'Double Jeopardy' and concluded that Administrative Action (AGAI67) would be the most appropriate measure against those acquitted.

### **AGAI Investigation**

When it was established that there was no possibility of criminal action against any individuals involved, an RMP investigation commenced with a view to taking administrative action against personnel implicated in the incident. The purpose of this investigation was to identify if any individual's conduct had fallen short of the normal standards expected of military personnel. This investigation, which took a further 12 months, resulted in two members of 2 R WELSH being subjected to administrative sanctions.

### **Statutory Service Inquiry**

Despite these three investigations and the trial it was nevertheless decided that it would be in the interests of the Army and the family to hold a statutory Service Inquiry. Given the large amount of evidence collected, it is not uncommon for a statutory inquiry to be dispensed with, and a non-statutory investigation to take place. However, in the circumstances, it was decided that a statutory Service Inquiry would be held which, among other things, allowed Pte Williams' family to be present.

### **Actions Taken and Procedures implemented**

As a result of Pte Williams' death the Panel heard that a number of specific actions have been taken and procedures implemented to prevent recurrence of this type of incident.

#### **1. A reminder to the Army that there are only two ways that misconduct can be dealt with.**

On 8 Aug 08, the day following completion of the trial, DPS(A) wrote a directed letter to the Army chain of command reminding the whole Army that there are only two ways of sanctioning misconduct; administrative action under AGAI 67 or with disciplinary action under Army Act 55.

Extract from DPS(A)'s letter; "Unofficial Sanctions and Punishments"

"The purpose of this letter is to inform you that I have issued a policy letter to your G1 staff to make clear unauthorised punishments and sanctions are illegal, that the disciplinary processes laid down in the Army Act 1955 and Army General Administrative Instruction (37 (AGAI 67) are to be adhered to, and to correct a weakness identified in AGAI 67, which might allow unauthorised sanctions to take place."

Oral evidence from [REDACTED] at  
Service Inquiry [REDACTED]

Exhibit G  
Unofficial Sanctions and Punishments  
D/DPS(A) 3/331 dated  
8 Aug 08.

**2. Amendments to AGAI 67 to provide better assurance in the process of awarding administrative sanctions.**

In response to the incident DPS(A) amended AGAI 67 to provide better assurance in the process of awarding administrative sanctions. A new procedure was introduced that required the awarding NCO to complete a tear off slip which was to be sent to the sanction supervisor to provide an audit trail of; the sanction given, who it had been given to and who had authorised it.

Oral evidence from [redacted] at Service Inquiry [redacted]

**3. A complete revision of AGAI 67.**

Since Edition 2 was issued in 2005 there have been several minor amendments to AGAI 67. At the end of 2006, after the incident, DPS(A) conducted a practitioners' review of the AGAI and it was subsequently thoroughly restructured as well as revised- Edition 3 was subsequently issued in Apr 08. The current version is Edition 4.

[redacted]  
Email [redacted]  
Document not produced as exhibit but included in Part 2 of this Report. Flag O

**4. The mitigation of the risks of exercising in heat by 2 R WELSH.**

The Panel found that 2 R WELSH were relatively well versed in the risks associated with exercising in heat prior to the incident but since the incident they have enhanced their procedures by advertising the Wet Globe Bulb reading widely, including on a board outside the Guardroom. On particularly warm days the Bn's policy is to position a 'heat sentry' on the barrack gate to provide heat warnings to all individuals partaking in physical exercise.

Oral evidence from [redacted] at Service Inquiry [redacted]

Oral evidence from [redacted] at Service Inquiry [redacted]

**5. Improvements made in training and awareness, across the three Services, of the risks of exercising in heat.**

[redacted] from the MOD'S Environmental Medicine Unit (EMU) at the Institute of Naval Medicine (INM) gave evidence that awareness of the Pte Williams' incident stimulated interest and further work in the effects of heat. He further stated that there has been a big improvement in the general awareness and treatment of heat illness across the board throughout Defence and that JSP 539 (Climatic Injuries in the Armed Forces Prevention and Treatment 2003) had been updated and the changes have enabled all medical personnel to better deal with and treat heat illness.

Oral evidence from [redacted] at Service Inquiry [redacted]

Exhibit AF - JSP 539 Climatic injuries in the Armed Forces Prevention and Treatment 2003 (D/AMD/113/26)

**6. Heat Awareness for Military Medical Officers.**

As part of the Post Graduate Medical Officer's (PGMO)

Exhibit AC -

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Course, which is mandated for all first appointment military medical officers, the prevention, recognition and treatment of heat injuries is now taught by [REDACTED].

Post Graduate Medical Officer's Training Documentation Training Objective 5.3 - p.2 to 6 and p.4 to 44

Exhibit AA -

Email [REDACTED]

**7. A culture change in 2 R WELSH and the Army.**

The Panel was presented with compelling evidence from [REDACTED] and [REDACTED], as well as other witnesses under oath, that AGAI 67 is fully understood and embraced by 2 R WELSH. [REDACTED] HQ PM(A), who visits units across the Army, also described a 'culture change' over the last few years throughout the Army.

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

Oral evidence from [REDACTED] at Service Inquiry [REDACTED]

**Finding**

The Panel conclude that three essential areas have been addressed with a view to preventing recurrence of this type of incident in the Army; AGAI 67, heat awareness training in 2 R WELSH, across the military and for military doctors and a change of culture in 2 R WELSH in particular and across the Army in general. Nevertheless the Panel also concluded that there is still more that could be done and its recommendations for further action that should be considered can be found at Annex H and **Flag G** to this Report.

**TERM OF REFERENCE 2**

“Other Matters”. The inquiry is to comment and express an opinion upon any other matters deemed by them to be relevant.

**1. Wiltshire Police Investigation.** It is apparent to the Panel that the Wiltshire Police were disadvantaged by not allowing the Service Police to assist them with their investigation. It presented them with a number of difficulties not least their lack of understanding of military language, processes and procedures which they have since acknowledged proved challenging and, in the Panel's view, undermined the effectiveness of their investigation. This meant that following the trial the RMP had to conduct a second investigation, which took another 12 months, in order to establish if any *military* offences had been committed in the lead up to Pte Williams' death. The Wiltshire Police gave full co-operation and access to all material evidence to the SIB investigation which might have been avoided had the SIB been involved in the initial investigation. Apart from potentially leading to successful prosecutions, a joint investigation from the outset would have saved a year's worth of work and the resulting additional stress on the accused and the family.

**2. Culture Change.** On the basis of all the evidence heard on oath and recounted anecdotally outwith proceedings, the Panel is totally convinced that there has been a significant culture change throughout the Army since Pte Williams' death. There is no doubt that there was a 'third way' of disciplining soldiers in 2 R WELSH, and most likely in many other units, prior to 3 Jul 06. However, 6 years on, Pte Williams' death is common knowledge and talked about throughout the Army – one RSM described the incident as sending 'shockwaves across the Army'. Through a combination of the amendments to AGAI 67 and improved training for all ranks, the Panel are confident that any officer or soldier in authority now will understand that there are only two ways of dealing with misconduct. This said, as the Panel has recommended, it would like to see amendments to AGAI 67 clarifying when and where physical training can be used as a sanction.

**SOURCE**

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]  
[REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]  
[REDACTED]



**RECOMMENDATIONS**

As a result of evidence given at the Pte G Williams Service Inquiry between 9 and 18 Nov 11, the Panel makes the following recommendations;

**AGAI 67**

Annex E p7  
Annex F p7

1. An unequivocal statement should be included in AGAI Vol 2 Ch 67 to the effect that;

'There are only 2 components to the Army's Discipline System; AFA 2006 and AGAI 67. Any sanctions or punishments awarded without following the proper process are illegal. Those awarding punishments outside these processes must be subject to investigation with a view to disciplinary and/or administrative action'.

Exhibit G  
Unofficial Sanctions and Punishments  
D/DPS(A) 3/331 dated 8 Aug 08.  
(Extract taken from DPS(A)'s policy letter written the day after the completion of the trial)

2. This sentiment of only 2 components to the Army's Discipline System should also be clearly stated in all discipline training; in one easily understood slide for example.

3. If it is decided that PT remains a permissible sanction under AGAI 67, this must be expressly stated along with an explanation of when it would be appropriate to award it as a sanction, and under which of the six stipulated sanctions at para 8 of Annex C to AGAI 67. (For example in a training environment it is currently permissible to use 'Wake Up Exercises' as a form of 'Remedial Training' in accordance with the various extant policies in the ARTD)

Exhibit A1, Vol 28, Annex C to AGAI 67 para.11

4. Drill is an acceptable sanction under '*Extra Tasks or Duties*' but it should be conducted in a recognised, planned and structured manner, preferably in a squad, by a qualified drill instructor. This should be articulated in AGAI 67.

*ibid*

**Regimental Police Staff**

Annex E p10

5. With the demise of the former RP NCO Course today's RP NCOs who have no responsibility for detainees will be unlikely to attend the Unit Custody Staff (UCS) course and thus they will have no formal training. The Panel concluded that a review into the role and training of RP staff needs to be conducted as a matter of priority.

6. The title Regimental Police is dated. The title of UCS must be adopted for all those personnel supervising detainees or providing units with a detention function. For those personnel not supervising detainees a new name for the RSM's staff should be found.

7. The Panel are aware that the Custodial team at HQ PM (A) are currently staffing a paper to recommend the introduction of a badge or emblem so that UCS are easily recognisable. This would be a positive step in introducing a move away from the old RP mindset. The Panel fully endorses this initiative.

8. The Panel concluded that unit RP staff should not be expected to use rigid handcuffs and therefore there is no requirement to train them in their use. Only qualified UCS who have attended the UCS course should use rigid handcuffs.

Annex E p23

**Battalion SOPs**

Annex E p11

9. All unit key appointments; CO, 2IC, Adjt, RSM, SSA and RP Staff should have job descriptions which should include mention of their responsibilities in relation the discipline process and specifically with regard to AGAI 67 action. This is an Army wide requirement.

10. The duties, roles and responsibilities, particularly in relation to AGAI 67 action and the disciplinary process, of all unit key appointments should be included in Unit SOPs Army wide.

**MATT 3**

Annex E p13

11. The Panel recommends that the MOD's Environmental Medicine Unit within the Institute of Naval Medicine is invited to provide assurance of MATT 3 (BCD).

**Medical Emergencies**

Annex E p16

12. The Panel concluded that all unit personnel and medical staff should be familiar with the limitations of the local military medical facilities and the circumstances when they should call 999. As such this should be included as part of unit SOPs and any organisational induction training.

**Training of Medical Officers**

Annex E p18

13. Whilst acknowledging that all military MOs receive training in heat injuries on the PGMO course, the Panel concluded that heat illness should be included on the GP Refresher Courses as part of the GP Emergencies Day.

Exhibit AE –  
Dept of General Practice  
GP Refresher Course, 31  
Oct - 4 Nov 11

Exhibit AA –  
Email [REDACTED]

**Wet Bulb Globe Temperature**

Annex E p19

14. Every major unit gymnasium should have its own WBGT which in turn must be used in the location where exercise is due to take place.

**Drugs Misuse**

Annex E p21

15. Consideration should be given to the means by which a soldier can report his own misuse of drugs without the risk of dismissal from the Service.

16. The introduction of targeted CDT for individuals the chain of command or MO believes to be at risk, such as a returning absentee. This would balance the individual's rights with the CO's duty of care to others within his unit (including the drug taker himself).

17. Consideration should be given to reintroducing the Early Intervention Programme to enable the education of selected individuals and to give the chain of command an alternative to 'zero tolerance'.

Oral evidence from [REDACTED]  
[REDACTED] at Service  
Inquiry [REDACTED]

Oral evidence from [REDACTED]  
[REDACTED] at Service Inquiry [REDACTED]

18. Soldiers need to be frequently reminded of the importance of reporting drug abuse not just for disciplinary reasons but for safety reasons as well, as evidenced in Pte Williams' case.

Annex G p3

**Medical Facilities' Staff Training**

Annex E p24

19. The Panel recommend that local / induction training for all Medical Centre staff (MOs, nurses, CMTs and reception staff) should include instruction for 'actions on' the event of a patient becoming violent which should be to call the Service Police, CIVPOL or the MOD Police – these 'actions on' should be included in all Medical Centre SOPs.

**Single Soldiers' Accommodation**

Annex E p26

20. Future policy for SSA and those responsible for SSA allocation should take account of the extra challenges presented to units in their ability to provide the necessary supervision and duty of care by splitting up sub-units in multi-unit occupancy accommodation.

**AWOL**

Annex E p26

21. The procedures by which duty personnel identify a returning absentee during a stand down period need tightening in 2 R WELSH and potentially across the Army. The Panel advise consideration be given to measures such as a list of absentees available in guardrooms or with duty personnel.

22. Consideration should be given to introducing a policy for returning absentees to be given a medical examination to ensure they are fit for a return for duty.

**Training**

Annex D p12

23. Personnel should attend relevant pre-employment training prior to assuming their appointment (or within a specific period) in order to address what appears to be somewhat of a consistent trend in this case which demonstrates otherwise.



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**CONVENING AUTHORITY COMMENTS ON THE SERVICE INQUIRY INTO  
DEATH OF 25204919 PTE WILLIAMS G 2R WELSH<sup>1</sup>**

1. Convening HQ: HQ 2 Div<sup>2</sup>

Comd: Maj Gen DAH Shaw

2. Timelines.

a. Date of Occurrence: 3 Jul 06

b. Date of Assembly of Inquiry: 8 Nov 11

c. Date of Inquiry declared Final: 12 Jun 13

3. **Affected persons.** The under-mentioned were identified as Regulation 18 (Potentially Affected) witnesses and accordingly were treated in accordance with Annex B to Chap 4 of JSP 832 and have been given the opportunity to comment on the report:

- a. [REDACTED]
- b. [REDACTED]
- c. [REDACTED]
- d. [REDACTED]
- e. [REDACTED]
- f. [REDACTED]
- g. [REDACTED]
- h. [REDACTED]
- i. [REDACTED]
- j. [REDACTED]

As a result of this Service Inquiry the CA considers that the character or reputation of the following has actually been affected by the findings:

- a. [REDACTED]
- b. [REDACTED]
- c. [REDACTED]

The findings have not identified any other affected persons or organisations through implication.

<sup>1</sup> CA comments law LFSO 3207 (Second Revisé) Annex E.

<sup>2</sup> D/DPS(A)/PS2/WILLIAMS/SI dated 19 Apr 12 directed transfer of Convening Authority to HQ Sp Comd.

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4. **Disciplinary and Administrative Action.** Wiltshire Constabulary conducted an investigation and charged the following NCOs with manslaughter but they were all acquitted at Winchester Crown Court on 31 Jul 08:

- o [REDACTED]
- o [REDACTED]
- o [REDACTED]

The SIB were then tasked to investigate any possible military offences committed by members of the Bn and/or whether there were grounds for AGAI action to be taken against those implicated in the incident. The following were reported by the RMP(SIB), but on 20 Oct 08, the Army Prosecuting Authority (or APA as it then was) directed that courts martial were not appropriate but recommended Summary dealing and/or AGAI action. In summary the following proceedings have been concluded:

- o [REDACTED]
- o [REDACTED]
- o [REDACTED]

The CA does not believe that there is a requirement to follow-up on administrative action now against any of those involved.

5. **Conduct of the Panel.** The Panel has been thorough and effective in its management of witnesses, administration of proceedings and has it met its TOR.
6. **Findings of the Inquiry.** The CA does concur with the findings of the Service Inquiry.
7. **Recommendations of the Inquiry.** The CA agrees with the recommendations. The recommendations have been circulated to appropriate stakeholders who have made comments for further consideration at Annex A.
8. **Summary.** This tragic incident that resulted in the death of Pte Williams has had enduring consequences for both his family and the reputation of the Army. The Service Inquiry has identified significant lessons of consequence that should further develop procedures and safeguards and so prevent recurrence. The CA has no further comments or observations to make and the Pte Williams Service Inquiry Report is hereby submitted as the Final Report to the Reviewing Authority.

[REDACTED]  
CJ Boag CB CBE  
Maj Gen  
General Officer Commanding

Annex:

- A. Stakeholders' comments on Pte Williams Service Inquiry Recommendations.

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SERVICE INQUIRY (SI) INTO THE DEATH OF 25204919 PTE G WILLIAMS 2<sup>ND</sup> BATTALION  
ROYAL WELSH ON 03 JULY 2006

CONVENING AUTHORITY	REVIEWING AUTHORITY
SP COMD	DPS(A)

BRIEF DESCRIPTION OF THE OCCURRENCE
Pte Williams had been posted AWOL from 2 Bn R WELSH on 14 Jun 06, but continued to utilise his SLA in Lucknow Bks, Tidworth. On 1 Jul 06 he was involved in a confrontation with guests of [REDACTED] who were attending the Officers Mess Summer Ball; on 2 Jul 06 he attempted to perform guardroom duty but was deemed unfit for duty (this duty was taken for payment and he was still AWOL). On 3 Jul [REDACTED] ordered the RP Staff to bring Pte Williams to him 'hot and sweaty', therein followed a period of [REDACTED]. After meeting with [REDACTED] a session of PT followed. Pte Williams fell ill during the PT session and was taken to the Medical Centre where he became aggressive and was consequently restrained. Pte Williams's condition deteriorated and he stopped breathing. Attempts were made to resuscitate him prior to being conveyed to Salisbury District Hospital. He continued to receive treatment however he remained unresponsive and was pronounced dead at 1628 hrs.
COMMENTS ON THE PROCEEDINGS OF THE PANEL
The SI followed high profile and lengthy investigations by the Wiltshire Constabulary; and subsequent Crown Court trial, and RMP SIB investigation. Further during the course of the SI, the Convening Authority was changed under Project Avanti to Sp Comd following the closure of 2 Div. The SI was conducted in accordance with the Convening Order and has met its TORs.
COMMENTS ON THE FINDINGS OF THE PANEL
The Panel interrogated the use of AGAI 67 within R WELSH and interviewed appropriate SME's relating to the various aspects of this incident. The Panel found that Pte Williams had been drinking and taking ecstasy in the days leading up to his death. The autopsy revealed that Pte Williams died of 'combined effects of exertion, hyperthermia, restraint and recent use of ecstasy'
COMMENTS ON THE RECOMMENDATIONS OF THE PANEL
The SI makes a total of 23 recommendations; all of which have been agreed by the Convening Authority. SO2 LL has reviewed these lessons and assigned them to the appropriate DLOD. These recommendations will be tracked through DLIMS and assured through CALS.
ADDITIONAL ACTION REQUIRED OF THE PANEL
Other than to implement and monitor the recommendations identified in the SI, no additional action is required.
REVIEWING AUTHORITY COMMENTS
<i>This was a tragic, regrettable incident A very comprehensive SI, drawn out but so long</i>

Rank, Name and Appointment:	DPS(A), Brig J P S Donnelly CBE
Signature:	[REDACTED]
Date:	23/1/15

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**ARMY**

**Army Headquarters  
Directorate of Personal Services (Army)**

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Telephone: [REDACTED]  
Military: [REDACTED]  
DII(F): [REDACTED]

Reference: D/DPS(A)/PS2/WILLIAMS

See Distribution

30 Sep 13

**SERVICE INQUIRY INTO THE DEATH OF 25204919 PRIVATE G WILLIAMS 2 BATTALION  
ROYAL WELSH ON 3 JULY 2006**

References:

- A. D/DPS(A)/PS2/Williams/25204919 dated 12 Nov 10
- B. SI Report dated 28 Feb 13
- B. HQ Sp Comd Convening Authority Comments dated 26 Jun 13
- C. Reviewing Authority Comments dated 27 Sep 12

1. The Service Inquiry (SI) into the death of Pte G Williams on 3 Jul 06 has now been reviewed by DPS(A) as the Reviewing Authority (RA) for the Army. The RA endorses the findings and recommendations of the SI Report and the Convening Authority's comments.
2. The recommendations of the Report have either been actioned or are still being worked. Monitoring will be carried out by [REDACTED] in SI Branch, PS2(A).
3. The SI is now formally closed. The Potentially Affected Persons should be advised by their chain of command.

{Original Signed}

[REDACTED]  
for DPS(A)

Distribution:

[REDACTED]  
G1 Sp Comd  
SI Sp Comd  
DIU  
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AIASC