ARMY

SERVICE INQUIRY

ARMY PERSONNEL SERVICES GROUP

SERVICE INQUIRY INTO THE DEATH OF

A SERVICE PERSON DISCOVERED IN THEIR SINGLE LIVING ACCOMMODATION AT LARKHILL ON 15 DECEMBER 2021

PART ONE – THE REPORT

09 Jun 23

Service Inquiry Investigation – [redacted] Gnr [redacted] RA

1. The Service Inquiry (SI) Panel formally convened at Andover on 07 Jun 22 by order of Major General Ghika for the purpose of investigating the death of [redacted] Gnr [redacted] RA who died of Violent / Unnatural Causes in [redacted] Single Living Accommodation on 15 December 2021.

2. The following inquiry papers are enclosed:

   a. **Section 1** – Executive Summary.

   b. **Section 2** – Introduction.

   c. **Section 3** – Narrative of Events.

   d. **Section 4** – Findings and Analysis.

   e. **Section 5** – Recommendations.

   f. **Section 6** – Convening Authority Comments.

   g. **Section 7** – Reviewing Authority Comments.

   h. **Annex A** – Convening Orders and TORs.

   i. **Annex B** – Glossary.

President

Lt Col [redacted]

Panel Member

Maj [redacted]

Panel Member

SSgt [redacted]

09 June 2023

SECTION 1 – EXECUTIVE SUMMARY

Issue

1. On 30 May 22, GOC (LONDIST) directed a Service Inquiry convene to investigate the circumstances surrounding the death of [redacted] Gunner (Gnr) [redacted] who died of Violent / Unnatural Causes in Single Living Accommodation in Larkhill on 15 Dec 21.

2. This executive summary contains a synopsis of the main facts; a brief outline of the causal and contributory factors, and details of the main recommendation themes that have resulted from the Inquiry.

What happened?

3. Gnr [redacted] joined the Army in Mar 19 and undertook Junior Entry Basic Training at Army Foundation College (Harrogate), completing the 49-week 'long course'[1] and graduating in Feb 20 into the Royal Artillery (RA). She was then retained on the strength of the college in the rehabilitation platoon until Jul 20 whilst she overcame a lower limb injury. She was subsequently posted to 14 Regt RA in Larkhill in Aug 20 to undertake a 4-week Initial Trade Training course as an Uncrewed Aerial Systems operator. On completion of her training, she was posted within Larkhill to 47 Regt RA, from where she subsequently volunteered and was selected to serve as part of the Corps Engagement Team (CET) in RHQ RA. She took up her appointment in the CET in Feb 21 and was still serving there at the time of her death.

4. Gnr [redacted] finished her last day of work prior to Christmas leave on 14 Dec 21. She was due to join her family for Christmas but had decided to remain in Larkhill for a few days beforehand. On the evening of 14 Dec 21, she attended a party in the accommodation block where she was living at the time. The party commenced in the early evening in the common room, with a number of people present, during which a quiz was held and drinking games played. Gnr [redacted] was reported to have been in a happy mood for most of the evening. Later in the evening she was joined at the party by a married SNCO with whom she was conducting a secret relationship. After he left around midnight, others observed a marked decline in her spirits for reasons that have not been fully identified. At a later stage that night, she was seen crying in a kitchenette area within the accommodation block and told others she was upset over matters relating to her uncle's death by [redacted] which had occurred the previous year. She was last seen in the early hours of the 15 Dec 21 in her room at which point a flatmate noticed that she was visibly upset. She stated this was due to family problems and that she would explain the problems in the morning. She was last active on WhatsApp at 02.21hrs and her body was discovered in her room the following afternoon by concerned friends. All the available evidence suggests that Gnr [redacted], though this will be confirmed or otherwise by the Coroner.

5. It is noteworthy that Gnr [redacted] death came 'out of the blue' to her chain of command, none of whom were aware of any significant problems at the time. It has also been established that Gnr [redacted] was not in contact with any welfare services at the time of her death and did not have any diagnosed mental health issues, her only contact with the medical chain having been for routine matters.

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[1] For Royal Armoured Corps/Household Cavalry, Royal Artillery and some Royal Logistic Corps roles.

What causal and contributory factors have been identified?

6. The Inquiry identified two Causal and three Contributory factors in the death of Gnr [redacted] These are summarised below.

a. **Recipient of persistent unwelcome attention and behaviour**. Gnr [redacted] was exposed to an intense period of unwelcome behaviour from her immediate line manager, a Bombardier, over a period of approximately two months preceding her death. This behaviour stems from the fact that it appears he wanted a relationship with her and had developed feelings for her which were not reciprocated. Whilst this behaviour ended the week before her death, it appears that it continued to affect her and had taken a significant toll on her mental resilience and well-being. The panel's assessment of the evidence was that it is almost certain that this was a **CAUSAL** factor in her death.

b. **Death of Gnr [redacted] uncle and other family issues**. Extensive evidence suggests that Gnr [redacted] appeared to be struggling to come to terms with the death of her uncle [redacted] the previous year. She told friends that she felt guilt over his death and was experiencing intrusive dreams about the incident. It appears probable that she had a panic attack about her uncle's [redacted] a few days before her own death and she mentioned suicidal thoughts to a friend. She was also visibly upset and mentioned family problems and an issue surrounding her uncle's [redacted] in the days prior to her own death, including on the evening of 14 Dec 21. Prior to these events, she had also previously described other family problems to friends which were affecting her, some of which appear to have been connected to the effect of her uncle's death and some of which can be ascribed to other wider issues. The panel assessed that it is highly probable that the combination of these issues was a **CAUSAL** factor in her death.

c. **Relationship with a married SNCO**. In the final few weeks of her life, Gnr [redacted] had a sexual relationship with a married SNCO. Whilst the relationship itself was seemingly positive, albeit with an uncertain long-term future, the circumstances of trying to keep it secret from everyone else appears to have placed a significant strain on Gnr [redacted] Evidence suggests that she felt very conflicted about the relationship given the strong moral stance she had taken in instances where others had engaged in similar behaviour. It is notable that she had not told her family about the relationship nor deliberately discussed it with any other individual. It is assessed that the difficult circumstances of the relationship affected her state of mind and was likely to have been a **CONTRIBUTORY** factor.

d. **Difficult long-term relationship**. Gnr [redacted] had a long-standing relationship of approximately 20 months with a Bombardier which had ended in Nov 21 shortly before her death. Whilst many aspects of this relationship had been positive, it was also characterised by mistrust and repeated allegations of unfaithfulness on the part of the boyfriend. Whilst Gnr [redacted] and the individual were on amicable terms at the time of her death and continued to support each other, it was also observed by others that their prior relationship had significantly eroded Gnr [redacted] self-confidence and esteem over a prolonged period. The panel believe that the cumulative effect that the relationship's difficulties took on her is likely to have left her with less resilience to deal with other subsequent events and it is therefore likely that it was a **CONTRIBUTORY** factor.

e. **Alcohol**. Gnr [redacted] displayed signs of an unhealthy approach to alcohol, with episodes of binge drinking. There is some evidence that she may have increasingly turned to alcohol as a mechanism to cope with her other problems in the weeks prior to her death. On the evening of 14 Dec 21 she had consumed significant quantities of alcohol and had vomited from the effects of alcohol at least once; it is probable that it would have affected her decision-making ability that night and the panel therefore assessed that it is highly likely it was a **CONTRIBUTORY** factor.

7. **Effect of limited Regimental Duty experience**. The panel also noted the limited experience of Regimental Duty that Gnr [redacted] possessed, due in significant part to the effect that COVID-19 restrictions had on Gnr [redacted] career from Mar 20 onwards. Due to the amount of time she spent at home during national lockdowns and periods when she was instructed to work from home, it was noted that this would have severely curtailed her experience of in-barracks working practices, ethos and routine within a typical Regiment. It was the opinion of the panel that this limited Regimental Duty experience is likely to have restricted her knowledge of the Army's typical approach to individual problems, including medical and welfare provisions, and may have therefore affected the way in which she responded to some of the factors to which she was exposed. In addition, the direct effect of COVID-19 restrictions is likely to have reduced the ability of the chain of command to monitor individuals as closely as may otherwise have been achieved in barracks. There are too many variables and permutations to reliably predict how individual events may have been different if it was not for COVID-19 restrictions affecting her Regimental Duty experience and so it has not been singled out as a factor, but it was the opinion of the panel that it is likely that it adversely exacerbated the response to some of the causal and contributory factors identified during the Service Inquiry.

What themes of recommendations have been identified?

8. A total of **18** recommendations have been identified by the Inquiry to be taken forward to the Defence Lessons Identified Management System (DLIMS). Noting the unexpected nature of Gnr [redacted] death, the majority of the recommendations are focused across three areas as outlined below.

a. Those recommendations that would make the causal/contributory factors less likely to occur again in the future. Noting that some of the factors arose from unique circumstances that are not necessarily preventable, most recommendations in this area are focused on counteracting unacceptable behavioural issues and in countering the culture of excessive alcohol use that the Inquiry assessed to be present across elements of Larkhill.

b. Those recommendations that make it more likely that an individual in Gnr [redacted] situation in the future would be able to recognise their own needs; understand the full range of support that is available; know how to access that support and feel confident in reaching out to seek assistance.

c. Those recommendations that make it more likely that those around an individual in Gnr [redacted] situation would recognise the signs of emotional distress; know what to do and feel empowered with the duty and responsibility to act.

[redacted]
Lieutenant Colonel
President

09 Jun 23

SECTION 2 - INTRODUCTION

1. The purpose of this Service Inquiry is to establish the facts of what occurred in this incident and to analyse the factors identified so as to make recommendations to prevent recurrence. This section sets out how the report has been structured to meet this purpose and to explain the methodology and key terminology used in the document.

2. **Structure of Report**. The main body of the report has been structured as follows:

   a. **Section 3 – Narrative of Events**. This sets out an overview of the matters arising from the Service Person's (SP) career that are relevant to the incident. These matters are presented in chronological order as the panel considered that the timing and sequence of many of the occurrences is important to understanding the course of events. It is supported by a timeline at Appendix 1 which shows key facts and incidents during the final year of her military service.

   b. **Section 4 – Findings and Analysis**. This presents the key factors, as defined in para 3 below, including Causal and Contributory factors and their associated recommendations. This case is also characterised by the missed opportunities and lack of action taken in respect of the Service Person either asking for or being referred for support over some of the factors that arose. This section therefore also examines why certain things that might have been expected to occur, did not occur, and makes recommendations that are designed to prevent such inaction occurring again.

   c. **Section 5 – Recommendations**. This collates together all the recommendations arising in Section 4 as a summary to aid those responsible for implementing and assuring the recommendations.

3. **Definitions**. The purpose of this Service Inquiry is to identify factors that led to the death of the SP, so as to make recommendations to prevent recurrence. Once identified, such factors have been assigned to categories according to the following definitions:

   a. **Causal Factor(s)**. Those factors which, in isolation or in combination with other causal factors and contextual details, led directly to this incident. Therefore, if a causal factor was removed from the event sequence, the death of the SP would not have occurred.

   b. **Contributory Factor(s)**. Those factors which made the incident more likely to happen. That is, they did not directly cause the incident. Therefore, if a contributory factor was removed from the incident sequence, the event may still have occurred.

   c. **Aggravating Factor(s)**. Those factors which made the final outcome of the incident worse. However, aggravating factors do not cause or contribute to the incident. That is, in the absence of the aggravating factor, the event would still have occurred.

d. **Other Factor(s)**. Those factors which, while present, played no part in the incident in question but are noteworthy in that they could contribute to or cause a future incident or accident. They form the basis for additional recommendations or observations.

4. **Probabilistic Terminology**. The probabilistic terminology detailed below shows the terms used throughout this report to state levels of certainty in relation to factors identified, or opinions and conclusions reached by the panel.

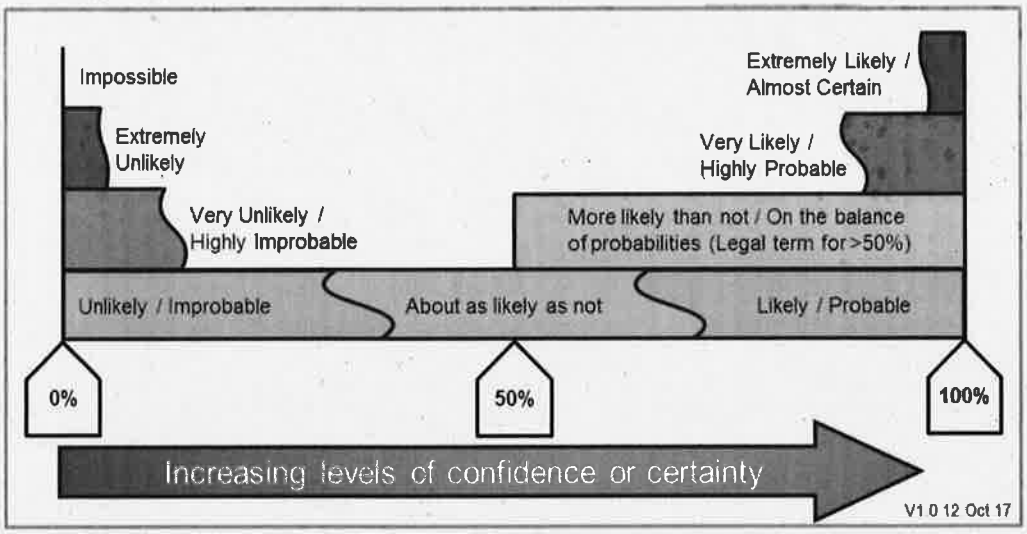


Fig 1 – Probabilistic Terminology

5. **Evidence**. The panel took evidence from all four units with whom the SP had served during her career, all of which were supportive and proactive in the assistance that they gave to the Inquiry. Documentary evidence was provided by all units and the panel also has access to extensive electronic records from the SP's mobile phone that were provided by her family. Verbal and written evidence was obtained from a total of 50 personnel who had involvement with the SP during her career. Where documentary evidence has been referenced in the report it is referred to by the file identifier, document number and the page which is cited (eg J/31/12 – 'File J, Document Number 31, page 12'). Verbal evidence given by witnesses are referred to by the file identifier, transcript number and page from which the evidence is drawn (eg. K/T12/34 – 'File K, Transcript number 12, page 34'). Witnesses themselves are referred to in the report by a Witness Cipher number (eg. 'Witness 12'). Where deemed useful to understand the context of an event, the rank and appointment of the witness is also given. To aid understanding of the report, the following is a summary of the witnesses interviewed and how they were known to the SP:

a. **Witnesses 1 – 8**. Instructors and trainees with whom the SP served during Junior Entry Basic Training at AFC(H) and during Initial Trade Training in Larkhill.

b. **Witnesses 9 – 20**. Colleagues and friends at 47 Regt RA with whom the SP served, including some who lived in the same SLA block as her.

c. **Witnesses 21 – 25**. Key individuals who formed part of the SP's chain of command in 47 Regt RA or were in key Regimental appointments.

d. **Witnesses 26 – 40**. Members of RHQ RA, including those who were part of the CET alongside the SP (Witnesses 32 – 40).

e. **Witnesses 41 – 45**. Key individuals who formed part of the chain of command within 14 Regt RA or were in key Regimental appointments.

f. **Witnesses 46 – 50**. Individuals who were unknown to the SP but from whom evidence was sought as the nature of their appointment has given them access to information relevant to the Inquiry.

SECTION 3 – NARRATIVE OF EVENTS

TOR1 – What happened? Establish the facts surrounding [redacted] Gnr [redacted] death, incorporating those relevant from her full career history, including their time at Army Foundation College (Harrogate).

ARMY FOUNDATION COLLEGE (HARROGATE) – JUNIOR ENTRY BASIC TRAINING COURSE (MAR 19 – FEB 20)

1. The SP started her Army career on 17 Mar 19, commencing the 49-week Junior Entry Basic Training course at AFC(H). She came from a close-knit family who were supportive of her decision to join the Army. Witnesses all described a lively, likeable and caring individual who, whilst she disliked some of the academic aspects of the course, thrived on the challenges of being in the Army and performed well. Witnesses commented that she was always positive and upbeat and took a full part in all activities. K/T12/5 L/T8/3

2. The only notable incidents whilst at AFC(H), were that Witnesses 2 and 18 stated that the SP occasionally suffered from panic attacks. The most severe of these occurred on 25 Jan 20 when the SP had to be carried to the medical centre and was retained overnight. There is no explanation as to what caused the panic attack on that occasion, though witnesses stated other panic attacks appeared to be stress related. It is notable that whilst this panic attack was not related to any of the causal or contributory factors identified by the Inquiry, the physical symptoms bore striking similarities to a panic attack she later suffered on 9 Dec 21, and which was on that occasion linked to a causal factor. It is the opinion of the panel that the panic attacks may indicate one way in which the SP was prone to react to stress. K/T12/9 L/T8/4

ARMY FOUNDATION COLLEGE (HARROGATE) – REHABILITATION PLATOON (MAR 20 – JUN 20)

3. The SP graduated from AFC(H) in mid-Feb 20 but remained on the strength of the AFC(H) rehabilitation platoon whilst she recovered from an injury she had sustained in training. Around Mar 20, the SP began a relationship with Witness 5, a Bombardier, who had been posted to AFC(H) in Dec 19 as an instructor and had been one of the staff in the SP's company. The relationship seems to have begun shortly after she graduated from her course but whilst she was on the AFC(H) rehabilitation platoon strength and so still technically at the college. I/6/1 K/T17/4

4. On 23 Mar 20, the UK government's 'National Lockdown' came into force in response to the emergence of COVID-19. As a result, the SP was sent back to her family home on 'COVID leave' from 28 Mar – 31 May 20. She was given guidance to continue her rehabilitation at home and was monitored remotely by AFC(H). Witness 5 was also sent on COVID leave and appears to have spent most of the time with the SP living at her family's home. The SP returned to AFC(H) very briefly after COVID leave and left the I/3/1 K/T17/5

rehabilitation platoon on 5 Jun 20 having successfully overcome her injury.

ROYAL SCHOOL OF ARTILLERY – INITIAL TRADE TRAINING (JUL 20)

5. The SP was posted to the Royal School of Artillery on 30 Jun 20 for a short period to undertake Initial Trade Training as an Uncrewed Aerial Systems operator. This was a 4-week course which was heavily affected by COVID-19 force protection restrictions. Trainees were isolated in 'households' with a small number of other trainees and were not allowed to mix with other households, with most training also being delivered online. Despite the restrictions, course instructors and other trainees all described the SP as being upbeat and engaging, and it seemed that she was looking forward to her subsequent posting to 47 Regt RA. L/T13/2 L/T11/3 L/T12/3

47 REGIMENT RA (AUG 20 – FEB 21)

6. On 3 Aug 20, the SP was posted within Larkhill Garrison to 57 Battery, 47 Regt RA and moved into Single Living Accommodation (SLA) in Block [redacted] Key events that occurred during her time in 47 Regt RA are related below: G/6/4 G/20/5

Death of SP's Uncle ([redacted] 20)

7. After arrival in 47 Regt RA, the SP departed on summer leave on 8 Aug 20. Later that same month her uncle died [redacted] Evidence suggests that the SP was shocked and upset by the loss of her uncle, especially as she had had a very strong relationship with him whilst she was growing up. Witness 23, the SP's Troop Commander, recalls that she was still on summer leave at the time of the death and that she approached the chain of command to request additional time off to attend the funeral, which was granted. K/T17/10 K/T21/3

8. The Troop Commander's recollection was that the SP stated she did not need any additional support following the death, just time to grieve with her family. The Troop Commander also cited the SP's strong and stable family background as a reassuring factor. As a result, the chain of command did not place the SP on the unit's Vulnerability Risk Management (VRM) register and there is no record to suggest she was referred to the Unit Welfare Department. Whilst she appeared to cope well at the time, a close friend and flatmate of the SP, Witness 16, stated that in retrospect he believed the SP did not really grieve at the time of the incident and thought that instead she felt she had to remain strong for her family. This latter view appears to be supported by subsequent events. K/T21/4 G/13/2 A/17/2

Start of relationship difficulties with Witness 5 (Nov 20)

9. Around Nov 20, the SP split up from Witness 5 following allegations that he had been unfaithful to her. They resumed their relationship approximately a week later, but this period marked the start of a difficult twelve-month period characterised by repeated allegations of unfaithfulness on the part of Witness 5. This situation appears to have been exacerbated by the fact that they were conducting a long-distance relationship, given that Witness 5 was still an instructor at AFC(H). Whilst it appears that they had a strong underlying relationship, evidence suggests this and subsequent incidents began to have a negative effect on the SP's self-esteem and resilience over the months that followed. K/T11/19 L/T16/10 K/T7/27 K/T25/6 F/19/120

Selection for the Royal Artillery Corps Engagement Team (Nov 20)

10. The SP's Troop Commander stated that the SP had always been keen to grasp all the opportunities that the Army had to offer, especially with regards the chance to travel. It appears that whilst she got on well in 47 Regt RA, the SP was disappointed by the impact that COVID-19 restrictions had had on the opportunities within 47 Regt RA to deploy on exercises or operations. In late 2020, the SP became aware of an opportunity to join the Royal Artillery's Corps Engagement Team (CET) and duly attended a selection process on 24 Nov 20. Despite her junior status, she proved well suited to the role, performing extremely well during the selection process and being selected for the team with a start date of 15 Feb 21. G/7/11 K/T21/3 K/T9/29 G/7/38

Remaining tenure in 47 Regt RA (Nov 20 – Feb 21)

11. The SP's remaining tenure in 47 Regt RA continued to be affected by COVID-19 restrictions following the introduction of the second National Lockdown over the period 6 Nov – 2 Dec 20, and the imposition of National tiered restrictions from 6 Jan 21 onwards. Due to this, she was sent home on 'COVID leave' for some of this period, and also took annual leave from 12 Dec 20 – 10 Jan 21. As a result, the panel observed that she had only very limited experience of Regimental Duty by the time she left 47 Regt RA. F/7/3

12. Despite her relatively short time in 47 Regt RA, she formed strong friendships with the 47 Regt RA personnel with whom she shared a flat in her SLA, all of whom were supportive, friendly and protective towards her. Due to this, on assuming her appointment within the CET, which was also located in Larkhill Garrison, she applied for and was granted permission to retain her room in the 47 Regt RA SLA. K/T11/7 G/8/1

CORPS ENGAGEMENT TEAM, RHQ RA (FEB – DEC 21)

13. The SP took up her appointment in the CET in Feb 21. The CET was a 10-person team of soldiers embedded within RHQ RA. It

was led by a Senior Non-Commisioned Officer (SNCO), with the SO2 Engagement in RHQ RA 'double-hatted' as the Officer Commanding (OC) of the team. When the SP took up her post, the work of the team was still significantly affected by COVID-19 restrictions and most of the engagement events until Jul 21 were conducted virtually. Some of this period was spent working from home and some based in barracks but with tasks still being delivered remotely. The SP reportedly made a very positive start in her role and was naturally adept at the work. Witnesses commented that she was quite quiet at first but integrated well into the team and she appeared to be getting on well. Key events of her posting in the CET are recounted below: D/2/1 K/T18/12 K/T3/11 K/T5/4 K/T7/9

Evidence of Emerging Problems (Apr – Jun 21)

14. In early 2021, evidence of emerging problems came to the attention of some of the SP's friends and colleagues. It is notable that as she confided across a range of individuals, few people appeared to be aware of the full extent of these problems at the time. There is no evidence the SP sought any help for these problems beyond confiding in her friends, nor did anyone raise any concerns about her.

15. Around Apr 21, probably around the time of her birthday, the SP was seen upset and crying in work. She told colleagues that she had received proof that her boyfriend, Witness 5, had been unfaithful to her again. Witnesses stated that it appeared to have a significant impact on her and it is the first time at which she is known to have been upset about it in the workplace. K/T7/35 K/T12/19

16. At around the same period, witnesses also state that she was upset about family matters at home. On the 12 May 21, the SP had messaged Witness 18, a close friend in 47 Regt RA, stating *"my family is a mess"*. Evidence suggests that some of this issue may have been related to ongoing problems relating to the earlier death of her uncle and some to other wider family problems about which she had made some people aware. On occasions, she requested to return home to her family due to ongoing problems. Witnesses believed that she saw herself as a counsellor to her family and that this placed a strain on her, particularly as she was based a long way from her family home. A/10/1 K/T12/22 K/T18/21

Recipient of Unwelcome Sexual Behaviour (Jul 21)

17. On 12 Jul 21, the SP deployed on Exercise THORNEY ADVENTURE. This was a water sports package delivered for RHQ RA personnel at the Army Inshore Sail Training Centre on Thorney Island. On the evening of 12 Jul 21, a social event was held at which personnel were permitted to bring their own drinks. No formal bar hours were in force and personnel continued to drink until the early hours of the morning until a point at which only the SP and a Warrant Officer were left in the bar. At this point it appears that the D/2/3 K/T19/5 K/T5/26

Warrant Officer made an unwarranted and unwelcome sexual advance on the SP. The effect on the SP was that she rapidly left the scene and hid in toilets nearby at which point she phoned a friend in Larkhill, Witness 16, to explain what happened. She then returned to the female accommodation to collect her possessions before spending the remainder of the night sleeping in her car. Whilst in her car she phoned another friend from 47 Regt RA, Witness 18, who she knew was on guard duty and asked them to remain on the phone for the remainder of the night until they knew she was safe in the morning. K/T25/7 K/T12/16

18. The SP was discovered in the morning in her car by a Junior Non-Commissioned Officer (JNCO) colleague in the CET who reported the incident to the chain of command of RHQ RA. The chain of command took the incident seriously, but the evidence suggests that the correct reporting process was not followed. The unit took action under AGAI 67[2] but the appointed Investigating Officer did not carry out his own investigation and whilst advice on discipline action was sought by RHQ RA, this was done verbally and not in writing. As a result, the discipline advice was based on a version of events from which certain key details appear to have been accidentally omitted. K/T5/27 K/T10/3 K/T20/4 K/T15/13-14

19. The Warrant Officer was subsequently awarded a minor sanction under AGAI 67 and in addition was instructed to write a letter of apology to the SP. Whilst the SP appeared to be happy with the outcome at the time, there is some evidence to suggest that she may have subsequently lost some confidence in the chain of command as a result of the way it was handled. It is the opinion of the panel that this is possibly a factor that may have influenced her failure to report other events that happened subsequently. B/18/1 B/19/1 B/20/1 K/T9/28 K/T25/10 K/T20/7

Multiple Issues Emerge (late Oct – early Dec 21)

20. Oct 21 marked the start of a number of interwoven events which began to have a severe impact on the wellbeing of the SP. By this stage, national COVID-19 restrictions had eased and the CET had been able to resume normal business, deploying small teams on recruitment events around the country. The SP deployed on a number of these events, usually with a small team that included Witness 33, a Bombardier, who was her immediate line manager. Despite their difference in age and rank, it appears that the SP formed a close friendship with Witness 33 and that they confided in each other about problems which they each faced in their own lives. During this period multiple issues began to emerge in quick succession for the SP as outlined below: D/2/6 F/19/135

a. **Initial incident with Witness 33**. On 19 Oct 21, whilst the SP was deployed on a task in Cardiff she phoned a friend, Witness 38, with concerns because her line manager, Witness

[2] Army General Administrative Instructions, Volume 2, Chapter 67, Administrative Action.

33, had seemingly made an unwelcome advance on her and confessed to wanting a relationship with her. Witness 38 gave the SP advice, including how to make it clear that she did not feel the same way. WhatsApp communications between Witness 33 and the SP over the remainder of October appear to indicate that they were able to resume their friendship, though this seemed to mark the start of an intense period in which Witness 33 unleashed upon the SP details of his own [redacted] The SP appeared genuinely concerned and responded by promising to stand by him as a friend to help him through his difficulties. F/19/110 F/19/62

b. **Family Problems**. Over the same time period in late October, it appears that the SP was also experiencing problems at home. On 22 Oct 21, Witness 33 sent a message in which he referred to her apparent family problems and the fact that she was due to depart on leave to go home. On 1 Nov 21, having returned from leave, the SP messaged Witness 33 about an incident at home saying *"Honestly, I feel like my family are crumbling right in front of my eyes"* and saying that she felt she would inevitably grow apart from some family members as a result. Other messages by the SP over the following few days refer to instances of being unable to sleep and to being unhappy. F/19/62 A/14/2 F/19/87 K/T18/21 F/19/117

c. **Breakup with Witness 5**. During late October and early November, the SP's relationship difficulties with Witness 5 reached a culminating point. Around late October, she had discovered another incident in which he had allegedly been unfaithful to her and about which she seems to have been distraught. Having agonised over what to do, she finally split up with Witness 5 on 12 Nov 21, telling him in a message that *"I can't do this anymore, mentally and physically, I'm drained"* and referring to the *"constant battle"* that she had gone through over the past year. F/19/140

d. **Problems with Witness 33 intensify**. The breakup of the SP from Witness 5 appears to mark an increased intensity in the frequency with which Witness 33 contacted the SP through phone calls, voicemails and messages from mid-November onwards. These communications were a mixture of friendly exchanges; messages concerning Witness 33's [redacted] and increasingly, messages that appear to show he craved a relationship with her. The effect on these latter messages on the SP is clear and she messaged him on 15 Nov 21, stating "*you can't keep doing this to me….I've just got out of a relationship & now I feel like I'm in one again*". Despite what at times was clearly unwelcome attention from Witness 33, the SP appeared to feel compelled to offer him close support out of continued concern for his [redacted] It is clear from discussions that she had with friends that she thought Witness 33 was at risk [redacted] During November there were frequent F/19/88-326 F/19/189 F/19/189

exchanges of calls and messages between the SP and Witness 33, often in the early hours of the morning, concerning his [redacted] K/T11/16

e. **Further family issues**. In late November, there were signs she was still preoccupied with family issues and what seem to be unresolved issues relating to her uncle's death by [redacted] the previous year. Precise details are unknown, but other witnesses in her flat were aware that she was suffering ongoing problems relating to her uncle's death and one witness had overheard a family member offering to get counselling for her in relation to this. She had also discovered that her grandfather had been admitted to hospital and was upset that her family had delayed telling her about it. F/19/205 K/T16/28 L/T17/4

f. **Secret Relationship**. During November, simultaneously to some of the events above, she also started a secret relationship with Witness 20, a married SNCO. Witness 20 had become known to her through a mutual friend and they had begun a sexual relationship in early November. Whilst the relationship appears to have been amicable, later evidence suggests that the strain of keeping it secret may have deeply affected the SP. The only individual who appears to have been aware of this relationship at the time was Witness 33 to whom she had inadvertently let slip the details. Witness 33 appeared to use this information to make her feel guilty about what she was doing. L/T5/15 K/T16/5 A/20/7 F/19/231

g. **Tensions rise between SP and Witness 33**. By the first week of December, evidence suggests the SP was struggling with the ongoing situation with Witness 33. Whilst still trying to support his [redacted] her tolerance of his desires for a relationship with her appeared to have reached a limit and she sent him messages stating "*it's not normal how you feel…..but I can't be there to support you with it because the way you feel for me is the main issue & I can't handle it anymore*" and "*it's weighing me down*". F/19/311

21. **Effect of problems on the SP**. By early December, the SP was concurrently dealing with the multitude of problems outlined above. Her flatmates had noticed that she had become increasingly tired and irritable, and some thought she was consuming more alcohol than usual. She had told many of her flatmates about Witness 33's actions and some urged her to report the matter, but she refused, potentially because she was concerned about the detrimental effect it might have on his [redacted] Some were also aware of some of her other problems, but felt her preference was to seek support from her family. Whilst some personnel in the CET had observed strange behaviour by Witness 33 towards the SP, most were unaware of the messaging and phone calls and seemingly did not recognise the gravity of what they observed. None of the SP's friends or colleagues reported her issues to the chain of command and RHQ RA remained largely unaware of the problems K/T11/17 L/T5/8 K/T6/54

she was experiencing. Given the problems that the SP faced, it is the opinion of the panel that by the first week in December she was probably already in a very vulnerable state.

Deployment on Engagement Task in Newbury (6-7 Dec 21)

22. On 6 Dec 21, the SP deployed on an engagement task to Newbury. Her line manager, Witness 33, was the individual in charge of the CET tasking roster and had assigned himself, the SP and another colleague to deploy on the task. They were tasked to run a series of stands in different locations over the course of the week and the task was scheduled to last until 10 Dec 21. In the event, the SP only deployed for the first two days due to the incidents that took place on the task: D/2/8

a. **Breakdown in working relationship**. The SP's colleague who deployed with them stated that there was tension between Witness 33 and the SP from the outset of the task. Her colleague stated that neither individual seemed capable of conducting their duties on their display stand effectively and they described Witness 33 as exhibiting bizarre behaviour and felt that he was attempting to follow the SP around at all opportunities during the event. The team was staying in a hotel overnight and the SP was located in a room next to Witness 33, whilst their colleague was located elsewhere in the hotel. The SP later told friends that she feared that the allocation of rooms had been deliberately manipulated by Witness 33 so as to place himself next to her. K/T6/38 K/T25/12

b. **SP tells Witness 33 she is leaving the task**. The situation reached a climax on the evening of 7 Dec 21, at which point the SP sent Witness 33 a message stating firmly that she wanted to be removed from the task that evening as she could no longer cope with his behaviour towards her. In a message that she drafted to send to him she described his thoughts towards her as "*possessive and psychotic*", though she later deleted these words, possibly out of fear of what effect it may have had [redacted] In the message she did send to him she described feeling trapped by his actions and stated she had spoken to her family about the situation and that they were genuinely worried for her. Her message explained that she had been reduced to tears and stated that "*the truth is I'm struggling to deal with all this, it's taking a huge toll on my mental health for many personal reasons. I need time out*". J/7/4 F/19/323 F/19/324

c. **SP collected from task**. The SP had spoken earlier in the evening to a friend and colleague, Witness 38, who offered to drive to Newbury to collect her. The SP appeared afraid for her own safety and phoned her father before she left her hotel room and asked him to stay on the phone until she had safely passed through reception. On arrival, Witness 38 found her hiding by the side of the hotel and stated that she was trembling and K/T7/16 J/7/4 K/T7/44

shaking. Witness 38 drove the SP back to her SLA flat in Larkhill.

d. **SP arrives back at SLA.** On arrival back in her SLA she spent some time talking to her flatmate and close friend, Witness 16, and explained what had happened. Other witnesses that were present report that she was still shaking and crying at that point. She showed Witness 16 a screenshot that she said was of a diary that Witness 33 had been writing that she believed contained mentions of her. She stated that she had told secrets to Witness 33 and that she was now afraid that he was writing about them in his diary and would reveal the information. K/T25/12 F/12/1-12 K/T25/12

e. **SP encouraged to report the incident.** Soon after the incident the colleague and friend who had collected her from Newbury, Witness 38, tried to persuade her to report the actions of Witness 33, but by this stage she had received messages from him stating that he was going to take immediate steps to remove himself from the CET permanently. As a result, she stated that the situation was resolved and did not need reporting. As the JNCO in charge of the task, Witness 33 would ordinarily have been expected to report the absence of the SP but as he was implicated in the events, it appears that he choose not to do so. No other individuals who knew of the situation reported it and the chain of command remained unaware of both what had happened on the task and of the fact that she had chosen to remove herself. K/T7/16 F/19/326 K/T9/29

Meeting with Witness 5 at Costa Coffee (morning of 9 Dec 21)

23. Soon after her return from the Newbury task, the SP met up with her ex-boyfriend, Witness 5, in Costa Coffee in Larkhill. It is believed that this meeting took place on the morning of 9 Dec 21. The SP was aware that Witness 5 had returned to Larkhill from his AFC(H) posting and seemingly wanted to 'clear the air' with him. This meeting seemed to mark the resumption of an amicable friendship between them. Witness 5 stated that he could tell she was deeply upset about something when they met and seemed to want to talk about something, but she was not forthcoming about the details at the time and he did not probe any further. K/T17/21 K/T25/6 L/T16/4

Panic Attack (evening of 9 Dec 21)

24. On the evening of 9 Dec 21, the SP went to Amesbury with friends and attended the leaving function of her old Troop Commander in 47 Regt RA. Witnesses stated that she became quite drunk and was behaving erratically at times. On return to her SLA she suffered what appeared to be a panic attack. She seemingly lost the use of her legs whilst on the stairs and had bitten down on her lip, causing an injury. She was supported to her room and she phoned her ex-boyfriend, Witness 5, to ask him to come across to her SLA to help her, later telling friends it was because he knew her L/T5/13 K/T25/22

past history and was best placed to assist. Witness 5 stated that he had to spend several hours calming her down and that she eventually went to sleep around 0500hrs in the morning. No medical help was sought and the incident was not reported to the chain of command. L/T16/2

Conversation with Witness 16 – 'Night Terrors' (10 Dec 21)

25. At some stage following the panic attack, she had a conversation with her flatmate, Witness 16, about having 'night terrors'. It is thought that this conversation may have taken place on 10 Dec 21. She described having had repeated incidents of waking up each night having sweats and nightmares, in which she saw images of her dead uncle. She intimated that her panic attack the previous evening was linked to one of these instances. She also alluded to having had suicidal thoughts herself. This is the only known incident in which she intimated about suicidal thoughts to another individual. Witness 16 reassured her and offered support, but did not report any concerns to anyone else. K/T25/16

SP's conversation with her mother (11 Dec 21)

26. On 11 Dec 21, the SP posted a message on her family's WhatsApp group saying "*anyone want to phone me*" along with a sad crying emoji. Her mother phoned her and the SP said she was still upset over the situation with Witness 33. Her mother offered her reassurance and they then discussed the fact she would soon be home for Christmas. F/18/3 J/7/5

Stand Down for Christmas Leave (morning of 14 Dec 21)

27. The CET was stood down for Christmas leave on the 14 Dec 21. The team had all been due to attend an RHQ RA Christmas lunch but this was cancelled due to the national situation around the emerging COVID-19 Omicron variant. Instead, the major in charge of the CET, Witness 29, gathered the team in RHQ RA to speak to them prior to Christmas leave. The majority of the team was present with the exception of Witness 33, who most people believed had departed the team for [redacted] or [redacted] reasons. Witness 29 thanked the team for their efforts and recalls a discussion with the SP in which she volunteered to research options for obtaining new branded jackets for the CET during her leave. The SP was seemingly ready for leave and had packed her car with Christmas presents but had told others that she intended to stay in Larkhill for the first few days of leave. K/T8/55 K/T9/30 K/T8/53 K/T9/30

SLA Block Party (evening of 14 Dec 21)

28. The SP had previously spoken to a flatmate, Witness 9, about holding a quiz and block party on the evening of 14 Dec 21. Block members had been invited, as well as personnel from other K/T11/29

accommodation blocks, some of which had been invited by the SP herself. Notable incidents from the block party are recounted below:

a. **Commencement of the party**. The party commenced around 1800hrs in the ground floor common room of the accommodation block. A quiz was held for which the SP acted as the quizmaster. Witnesses report that it was a lively and good-spirited party at which there was Karaoke and drinking games played. The SP was reported as being in high spirits and a very happy mood. K/T11/29 L/T4/4

b. **Conversation with Witness 19**. Around 2100hrs, the SP spoke to a friend, Witness 19, who was present at the party. The Inquiry noted that Witness 19 [redacted] Witness 19 stated that on the evening of the block party the SP had approached them and said that she had problems of her own and that she would come and talk to them the following day about it. Witness 19 considered this unusual as, whilst she had given her support previously, she had never spoken about having problems herself. L/T15/3 L/T15/5

c. **Welfare check by Witness 22**. Around 2130hrs, a Warrant Officer, Witness 22, was leaving a function in the WOs and Sgts' Mess when they noticed the party at Block [redacted] and decided to conduct a welfare check. Whilst outside the block they noticed the SP run to the bushes where she vomited from the effects of alcohol. Witness 22 asked a JNCO who was present to ensure that someone kept an eye on her that evening but noted that she was in good spirits on re-entering the block. At 2136hrs the SP messaged Witness 20, stating that the Warrant Officer had just seen her being sick due to the fact she had had to drink a pint of spirits, wine and beer. J/6/2 L/T17/7

d. **Arrival of Witness 20**. Witness 20, with whom the SP was conducting a secret relationship, had also been at the WOs and Sgts' Mess function. At 2235hrs, she messaged him and asked him to come across to the block party; he subsequently arrived at the party at approximately 2300hrs. He joined the party in the common room and mixed with those present, including the SP. He observed that the SP was in a good mood, though had clearly been drinking and at one stage he witnessed her sniffing or licking vodka from a table. A/20/4 L/T17/8

e. **Private Conversation with Witness 20**. About an hour after he arrived, the SP asked to have a private conversation with Witness 20 in her room. As Witness 16 returned to the party from his own accommodation block, he observed the SP and Witness 20 leaving the common room and going to her room via the fire escape. Witness 20 remembers talking to the SP about how their relationship had grown over the previous weeks and L/T17/9

that they discussed seeing how they felt about matters when they returned from Christmas leave. He recalls that the SP spoke about having family problems at home and that she stated they would talk about it further in the morning. It is believed they were in the SP's room for approximately 15 – 30 minutes before they then left, at which point Witness 20 left the party and returned to his own accommodation. Witness 20 believes that the SP may have been annoyed by the fact that he was leaving the party and that she had wanted him to stay. K/T25/28

f. **Change of mood in the SP**. Immediately after the SP returned to the party, Witness 16 saw her sat with another friend, Witness 10, at which point he overheard her say "*Fuck it, let's just get drunk*". Witness 16 and other witnesses all noticed that her mood became more despondent and downcast from that moment onwards. Witness 16 believes that the SP carried on drinking at the party for another 30-40 minutes before going upstairs to her flat. K/T25/28 K/T26/9 K/T25/30

g. **Communications between the SP and Witness 20**. A series of messages and phone calls took place between the SP and Witness 20, the last of which was a call at 0150hrs which lasted 10 minutes. Witness 20 cannot recall the details as he was intoxicated with alcohol, but he recalled that most of the calls were of short duration except the last one and that during one call she had asked him to return to her. The last call was initiated by the SP who phoned from a friend's room where she had apparently gone so she could make the call in private. Due to his own alcohol intake, Witness 20 was unable to recall precise details, but believes that the SP's mood was possibly quite downbeat and quiet at the time. A/20/1

h. **Last known phone communications**. The SP was last active on WhatsApp at 0221hrs and she phoned her father at 0222hrs via FaceTime to tell him that she loved him. It was not unusual for the SP to contact her parents late at night and thus her actions did not raise any concerns. A/20/1 J/7/13

i. **Last known movements**. Witness 16 states that by about 0230hrs the party had ended and he had gone upstairs to continue drinking with another flatmate, Witness 11. Whilst there, he saw the SP leave her own room and go down into the kitchenette area to put some washing on which he thought was unusual. Witness 11 had also gone to the kitchenette to get something at the same time. Witness 11 and another individual, Witness 10, both recall an incident during the evening in which they observed the SP tearful and upset in the kitchenette over the death of her uncle and it is possible that this incident may have occurred at this time, though Witness 10 believes it may have happened sometime earlier. After the SP left the kitchenette she returned to her room and Witness 16 went and knocked on her door because he was concerned about her. She K/T25/30 L/T1/8 K/T26/6

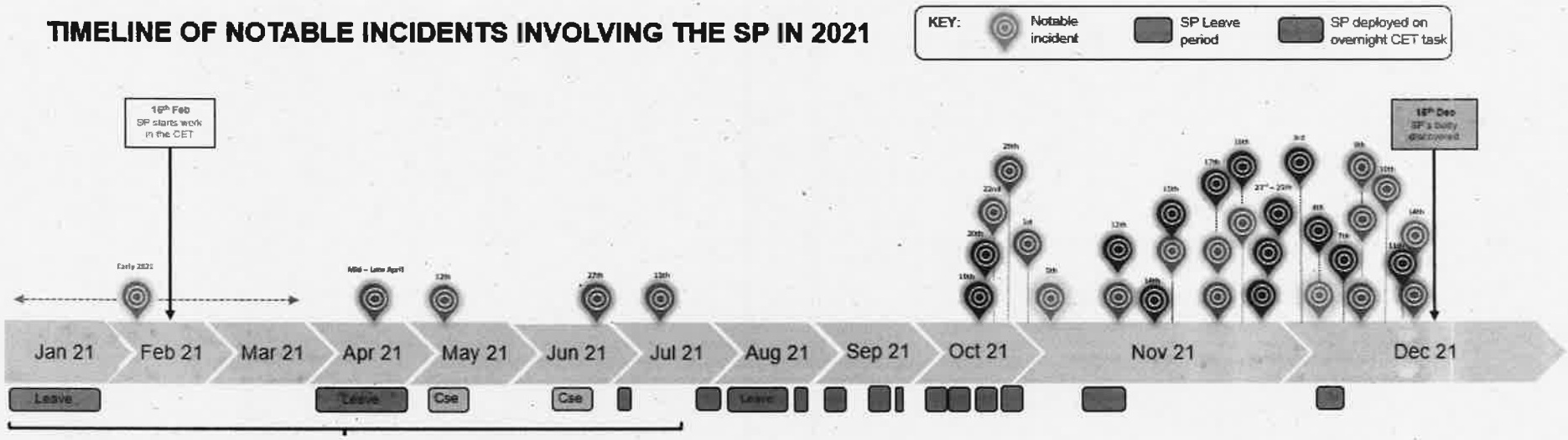
answered the door and he entered her room to talk to her. He could see that she was emotional about something which she stated was to do with her family. She appeared upset and gave Witness 16 a hug, but despite further questioning the SP would not explain any further details, though promised she would tell him in the morning. He then left the room and heard her lock her door. K/T25/32

Concerns for the SP (15 Dec 21)

29. Concerns for the SP began to mount the following day as friends and family noticed that she had not been active on WhatsApp since 0221hrs and this was unusual for her. Family members raised concerns with a flatmate, Witness 9, with whom they were in contact, who in turn spoke to Witness 20 who had also become concerned over the lack of contact. A master key for the accommodation block was obtained with the assistance of the Regimental Orderly Officer and they entered her room at 1615hrs and discovered her lifeless body. A/2/29 A/6/1

Appendix 1
to Section 3

TIMELINE OF NOTABLE INCIDENTS INVOLVING THE SP IN 2021



Relationship – Witness 5

- Mid – Late Apr 21 - SP receives message(s) from a female alleging Witness 5 has been unfaithful
- 27 Jun - Witness 5 has a car crash
- Approx 29 Oct - SP told of another incident of alleged unfaithfulness by Witness 5
- 12 Nov – SP ends relationship with Witness 5
- 16/17 Nov - SP arranges to avoid CET duty during AFC(H) visit to avoid seeing Witness 5
- 9 Dec (am) - SP meets Witness 5 and is observed to be upset
- 9 Dec (pm) - SP calls Witness 5 to support her following a panic attack

Relationship – Witness 20

- 5 Nov – SP and Witness 20 begin sexual relationship
- 4 Dec – Witness 20 turns up drunk to SP's room and SP is concerned by personal matters that he tells her

Family Matters

- Early 2021 – SP tells Witness 5 that she is having intrusive dreams about her uncle's death
- 12 May – SP messages a friend stating "*her family is a mess*"
- 22 Oct – Witness 33 refers to SP's 'family problems' in a message
- 1 Nov – SP tells Witness 33 that she feels her family are "*crumbling*"
- 17 Nov – SP states she had been stressed, including matters to do with "*home*" and her uncle
- 19 Nov – SP belatedly finds out her grandfather is in hospital
- 9 Dec – SP has a 'panic attack' at night
- 10 Dec – SP talks to a witness about her panic attack and intimates it was about her uncle
- 14 Dec – SP mentions to several people about family problems and is observed crying about an issue related to her uncle

Miscellaneous

- 13 Jul – SP victim of inappropriate sexual conduct
- 9 Dec – witnesses see SP drunk and behaving 'erratically' on night out
- 14 Dec – SP vomits from alcohol at block party

Behaviours – Witness 33

- 19 Oct – Witness 33 expresses his feelings for the SP
- 20 Oct – First mentions by Witness 33 in messages of mental wellbeing issues to the SP
- 12 Nov – SP states in message that Witness 33 is "*100% the best friendship I've got*"
- 12 Nov – Witness 33 appears overjoyed that the SP has called off relationship with Witness 5
- 14 Nov – SP messages Witness 33 stating "*I feel like I'm getting myself in a big mess on this posting, and I don't want to be a part of it*"
- 15 Nov – SP messages Witness 33 "*I'm not going to lie to you am I but this has to stop now…*" in response to his feelings for her
- 17 Nov – SP messages Witness 33 stating "*You can't keep doing this to me* [name]*, because I feel guilty for it each time*" in response to his feelings for her
- 19 Nov – SP reminds Witness 33 that they are just friends
- 23/24/25 Nov – SP tells Witness that she doesn't share his feelings towards her
- 3 Dec – SP tells Witness 33 "*I don't want to say the wrong thing and tip you over the edge*"
- 4 Dec – SP messages Witness 33 about the effect of his constant messages stating "*I just feel like I need to get away from you for a little bit*"
- 7 Dec – SP leaves CET task due to Witness 33's behaviour
- 11 Dec – SP speaks to her family and is still upset about behaviour of Witness 33

SECTION 4 – FINDINGS AND ANALYSIS

TOR 2 – Examine the events prior to [redacted] Gnr [redacted] death, including the day of her death. Identify contributing, causal or other factors.

FINDINGS – CAUSAL AND CONTRIBUTORY FACTORS

1. This section of the report is divided into separate 'Findings' and 'Analysis' parts. This 'Findings' part sets out the conclusions of the panel regarding the causal and contributory factors that the Inquiry has identified. It revisits the relevant evidence raised in the narrative and draws on wider evidence given to the Inquiry.

2. The panel concluded that five factors collectively led to the death of the SP. It is notable in this case that the SP had no diagnosed mental health conditions and was not seeking support for any welfare matters from the chain of command, medical services or welfare services at the time of her death. AGAI 110 states that 'suicide and self-harm behaviours are complex and not always associated with mental illness, they often occur when life stressors converge to overwhelm the individual.' It is this situation that the panel believe occurred in this case. The panel believes that the SP's young age and relatively limited experience of the Army also made her more vulnerable to the combination of problems that she encountered. The evidence relevant to each factor and the conclusions drawn from it are presented below:

Factor 1 – The actions of Witness 33

3. The actions of Witness [redacted] between late October and early December 2021 appear to have had a profound effect on the SP. The relevant evidence and conclusions are considered below:

a. Witness 33's contact with the SP from late October onwards appears to have been a contrasting mixture of genuine friendship; cries of help over his own [redacted] and his expression of feelings of love for her. It is the opinion of the panel that this undoubtedly placed the SP in a very difficult position given that he was her line manager and she also feared for his [redacted] and what might happen to him. Despite the pressure he placed on her, the SP may have felt the need to maintain his friendship as she also made it clear in messages to him that he was one of the few people to whom she could speak to about some of her own problems. F/19/128 F/19/164

b. The SP believed Witness 33's [redacted] problems to be severe enough that she told friends that she had metaphorically [redacted] on at least one occasion. She appeared to fear for [redacted] and told friends that she would not be able to live with herself if something happened to him. He also seemed to make it clear to the SP that she was K/T25/11 K/T25/11

his main source of support, despite her urging him to seek other help. Witness testimony and phone records suggest that he frequently contacted her in the early hours of the morning and that she was often tired and irritable as a result. She linked her concerns for [redacted] to the loss of her uncle by [redacted] telling him in a message on 17 Nov 21 "*I was thinking of my uncle and worrying about you*" and later on 3 Dec 21 stating "*...It hits home because of my uncle & I don't want to say the wrong thing to tip you over the edge.*" This situation would have undoubtedly been a significant burden on the SP. F/19/311 K/T11/12 F/19/311

c. Witness 33's feelings towards the SP also had a significant effect. Witness 33 managed the workforce allocation for CET tasks and it is apparent the SP was selected for all the same tasks as Witness 33 during Nov – Dec 21. Some witnesses report that Witness 33 behaved oddly towards the SP whilst on some of these tasks and that she frequently appeared uncomfortable in his presence. At some stage in late 2021, Witness 33 briefly showed the SP a diary he was writing which he then refused to let her see properly. She began to fear that it contained inappropriate mentions of her and possibly matters in which she had confided to him in confidence. She also told other witnesses that she worried that he was tracking her movements via her mobile phone. In addition, some messages sent by Witness 33 have characteristics of controlling behaviour: in several messages to her he repeatedly sought reassurance that she was on her own and made it clear he could not bear the thought of her being with someone else because of his feelings for her. The SP at times responded by stating that he made her feel guilty and that she felt she could not talk to certain other males in the CET in his presence because of the effect she knew it had on him. D/2/7-8 K/T6/33 F/19/310 K/T11/12 F/19/261 F/19/211 F/19/210

d. The sheer intensity of the communications from Witness 33 also appears to have affected the SP. In Oct 21, Witness 33 sent her over one thousand WhatsApp messages and voicemails, followed by over three thousand six hundred in Nov 21. Whilst many of these messages were benign in nature, the sheer constancy of the contact seems to have worn the SP down, a fact that was noted by several of her flatmates. The SP's own feelings can be seen in messages she sent to Witness 33 stating, "*I can't give you my attention 24/7*" and "*24/7 your* [sic] *always messaging me...it's getting on my nerves...all these long messages etc it's all getting a bit too much.*" It is the panel's opinion that, despite the intensity of his communications affecting her, the SP is likely to have felt compelled to maintain contact because of her worry over his [redacted] and the constant need to be there to support him. K/T25/14 F/19/320 L/T1/4

4. **Conclusion**. The SP is believed to have last seen Witness 33 on 7 Dec 21 before she withdrew herself from the CET task in Newbury due to his actions towards her. She subsequently received F/19/327

messages from him stating that he was withdrawing himself from the CET. Whilst this seemed to mark the last contact between them, it is clear in her communications with her family on 11 Dec 21 that she was still deeply disturbed and affected by what had occurred. Having reviewed the evidence, the panel noted a clear decline in the SP's mental resilience and tolerance from mid-October onwards, coinciding with the start of her problems with Witness 33. Whilst the actions of Witness 33 ceased a few days before her death, it is assessed that the toll it took on her would have left her in a very fragile state from which she appears not to have recovered. As a result of this, the panel assessed that the actions of Witness 33 were almost certainly a **CAUSAL** factor in the death of the SP. J/7/5

Factor 2 – Loss of her uncle and other family problems

5. The SP appeared to be pre-occupied by matters relating to the death by [redacted] of her uncle and other family problems. The signs of these problems appear to have become ever more prominent in the months leading up to her death. The evidence that the panel felt most relevant is considered below:

a. At the time of her uncle's death in Aug 20, the SP appeared to cope well and neither sought nor appeared to need additional support. However, one witness reported that they thought she did not grieve properly at the time and may have felt the need to remain strong for her family. She later told witnesses she felt guilty about his death as she had fallen out with him the previous Christmas and whilst they had since spoken, she said they had never made up properly. She always kept a photo of him on the back of her phone and an Order of Service from his funeral in a prominent position in her room. A/2/8 K/T21/3 K/T18/19 K/T17/13 K/T11/33

b. Witness 5, who had been her long-term boyfriend until Nov 21, said she had told him in early 2021 that she was sporadically experiencing intrusive dreams at night in which she kept envisaging her uncle's death, even though she had not been present when it occurred. There is also a known incident in which she had to leave a display stand during a CET task because she became upset when a visiting schoolchild mentioned something related to [redacted] though the exact date of this incident cannot be established. During her time in the CET, she also reported family problems at home and witnesses gave evidence suggesting that she saw herself as a counsellor to the rest of the family. On occasions, she requested to leave work early to return home due to these problems and she made several mentions to friends about the impact these issues were having on her. K/T17/13 K/T25/18 K/T8/30

c. In messages from Oct 21 onwards, she makes repeated reference to her uncle and family problems, notably citing them as separate issues. She seems particularly upset by a family issue that occurred at home in late Oct 21 and which she K/T18/21

referred to in later messages. She also states that she *'broke down at home'* and made reference to having struggled at night with her thoughts. The issues with her uncle appear to become more prominent from late November onwards. She cites having issues relating to her uncle's death in several messages in late November and a witness believes that it was around this time that he overheard a family member offering to get the SP counselling in relation to this problem, though the SP declined the offer. On 10 Dec 21, the SP explained to a witness that she was having repeated night terrors about her uncle's [redacted] and intimated that she had had suicidal thoughts herself. The SP was seen on the night of 14 Dec 21 upset and crying about her uncle, possibly only a short while before her own death. She also mentioned family problems to a number of people during the block party that evening, in a manner which in the panel's opinion could be interpreted as having been a cry for help.

F/19/86
F/19/311
K/T16/28
K/T25/16
L/T1/8
L/T15/5

6. **Conclusion.** Given the extent of the evidence relating to her uncle and family problems and given that she seemed preoccupied with these matters in weeks leading up to her death, including on the evening of 14 Dec 21 itself, the panel's assessment is that it is highly likely these issues were a **CAUSAL** factor in her death.

Factor 3 – Secret relationship with a married SNCO

7. It is believed that the SP began a relationship with Witness 20, a married SNCO, around 5 Nov 21, shortly before her breakup with Witness 5. Whilst evidence suggests that they had a good relationship, albeit with an uncertain long-term future, the need to conduct the relationship in secret appears to have affected the SP. In addition, the moral emotions that his married status is likely to have evoked in the SP also appear to have taken a toll on her. The relevant evidence is considered below:

L/T5/15

a. Witness 20 became known to the SP through a mutual friend that he regularly visited in the SP's SLA block. They both conducted their relationship under the strain of having to conceal it from other personnel. Some friends repeatedly challenged the SP on whether she was in a relationship, but she continued to deny it and most people were seemingly not aware of it until after her death. On at least one occasion, Witness 20 turned up drunk to the SP's room at night and it is likely incidents like this would have compounded the pressure which the SP felt in keeping the relationship secret.

K/T11/24
K/T11/24
L/T5/12
F/19/305

b. Evidence suggests the SP had strong moral values and would therefore have probably felt very conflicted about being in a relationship with a married SNCO. She had seemingly fallen out with a close friend over the issue of extra-marital relationships, with a witness reporting she had said *"she would not be able to live with herself if she was a homewrecker"*. This is an indication of the strong moral stance she took on such

A/13/2
A/17/2

matters and therefore the confliction she may have felt about her own relationship with Witness 20. Other evidence also suggests she had seen the effect of infidelity on family members and this may have compounded her feelings about her own actions. The only individual who knew definitively that she was in a secret relationship was her line manager, Witness 33, and he appears to have used this information to elicit feelings of guilt from the SP. Not only did the SP have to contend with the difficultly of maintaining a secret relationship, but there is also some evidence that Witness 20 may have burdened her with some of his own problems. On 4 Dec 21, she described to Witness 33 in a message that she had been told something by Witness 20 about his personal circumstances that left her feeling "*so bad*" and had meant she returned from a night out with him to support him.

K/T25/38
L/T1/6
A/13/2
F/19/312

8. **Conclusion**. The panel assessed that the practical and moral difficulties associated with maintaining her relationship with Witness 20 is likely to have affected the SP. There is no indication that this factor had a direct bearing on the decisions she took on 14 Dec 21, though evidence for their interactions on that evening is largely dependent on the testimony of Witness 20 himself whose memory of the period cannot be fully relied upon. Testimony from Witness 20 contains some suggestion that she may actually have been appealing to him for help on that evening. In either case, the panel concluded that the secret nature of their relationship undoubtedly acted as another strain on the SP in her final few weeks and it is likely it was a **CONTRIBUTORY** factor in her death.

Factor 4 – Relationship with Witness 5

9. The SP began a relationship with Witness 5, who had been one of her instructors at AFC(H), in Mar 20. This became a long-term relationship and the relevant evidence is considered below:

a. The first few months appeared to be a very happy relationship, but they split up for a week in Nov 20 due to allegations he had been unfaithful to her. Over the next 12 months further allegations of wrongdoing on the part of Witness 5 followed, with the SP indicating to friends at one point that the number of such incidents was in "*double figures*". It appears that she discovered some of his transgressions because some of the other individuals involved with Witness 5 had contacted her and shared photos proving what had occurred. She told friends she was particularly upset as she received proof that Witness 5 had sent photos to other individuals which had been taken in the SP's own room and that he had also bought flowers for another female at a time when he owed the SP money.

L/T16/10
K/T25/5
K/T11/47
L/T5/19

b. Witnesses reported that Witness 5's actions affected the SP's self-confidence over a prolonged period. Some reported that she questioned if she was doing something wrong in the

K/T25/4

relationship and stated that it clearly affected her self-esteem. One close friend in whom the SP confided described the relationship with Witness 5 as "*toxic*", though other witnesses also noted positive bonds between them. Some evidence suggests that the SP may have planned to call off the relationship in Jun 21 but that she felt compelled to continue it further following a car crash and other difficult personal circumstances that Witness 5 encountered and through which she felt she had to support him. The SP finally called the relationship off on 12 Nov 21 stating to Witness 5 that "*I can't do this anymore, mentally and physically, I'm drained*". She was subsequently unable to face him when he visited Larkhill on 16-17 Nov 21 on an AFC(H) visit with junior soldiers and instead had to arrange to be excused the CET duty. K/T7/32 F/19/15 F/19/140 D/2/7 F/19/193

c. The SP was later able to reconcile her friendship with Witness 5. In late November she described Witness 5 to another witness as "*...a good person, just not a good boyfriend.*" and by the week before her death had resumed an amicable friendship with him. F/19/274

10. **Conclusion**. Whilst it appears that her previous relationship difficulties with Witness 5 were not seemingly affecting the SP at the time of her death, it seems likely that the prolonged difficulties she had experienced leading up to their split in mid-November had taken a significant toll on the SP. It therefore left her with poorer mental resilience than she might otherwise have possessed. As a result, the panel assess that it is likely it was indirectly a **CONTRIBUTORY** factor to her death.

Factor 5 – Alcohol

11. The SP showed many signs of an unhealthy approach to alcohol which appeared to be part of an accepted wider culture of excessive alcohol consumption by many of those around her. She had also consumed alcohol on the night of her death. The relevant evidence is considered below:

a. The SP demonstrated episodes of binge drinking and some colleagues reported that she had been occasionally unfit for work due to alcohol consumption the night before, though there is no evidence that any action was taken as a result. She also posted videos of herself being sick due to excessive alcohol consumption on social media and shared these with friends. It is the opinion of the panel that her drinking habits did not cause any concern to be raised as it was part of a normalised culture of excessive alcohol consumption amongst many of those with whom she socialised. K/T1/20 F/19/312 K/T11/37 F/19/285

b. Some witnesses state that she drank more in the final few weeks of her life, with one witness stating that her alcohol intake was "*excessively high*" and that she "*would often be drinking* A/17/3

heavily on 3-4 consecutive nights." Some of her drinking episodes at this time also appear to be associated with incidents of erratic behaviour. It is the opinion of the panel that this behaviour reflects the stress that she was under at the time. There is no evidence that anyone raised any concerns over her drinking habits at any stage. L/T5/14

c. On the evening of 14 Dec 21, she had seemingly drunk heavily and had taken part in drinking games during which she had drunk a mixed pint of wine, spirits and beer. She was sick from the effects of drinking alcohol at least once. She was also seen sniffing or licking vodka from a table at one stage, about which only one person seems to have raised any concern at the time. Post-mortem results show that the SP was approximately three times the legal Drink Drive limit for alcohol. The panel noted that she reportedly began the evening of 14 Dec 21 in high spirits but that her mood changed over the course of the night and it is likely it was influenced by the consumption of alcohol. L/T17/7 K/T16/24 L/T17/8 H/1/1

12. **Conclusion**. The SP showed signs of an unhealthy approach to alcohol, seemingly in common with many of those around her. Of most relevance is that her consumption of alcohol on the evening of 14 Dec 21 almost certainly affected her mood and judgement and the panel concluded that overall it was therefore highly likely that it was a **CONTRIBUTORY** factor in her death.

ANALYSIS

TOR 3 – Which changes are recommended in order to avoid future recurrences?

TOR 4 – Examine the involvement of training establishments, Regiments and Headquarters. What broader organisational change is required to better support Service Personnel and prevent recurrence?

13. This part of the report sets out the analysis of the Inquiry's findings and the recommendations needed to implement change for the future. It addresses the issues from two perspectives: firstly, those measures that contribute towards preventing recurrence of the causal and contributory factors identified in this case; secondly, to cater for those instances in which factors do recur, it sets out the changes required to ensure that a serviceperson in the future is more likely to both ask for and be referred for appropriate help in a timely manner. The analysis is presented thematically, drawing on evidence gained by the Inquiry from all sources and looking at all aspects of the SP's career. It considers whether these incidents were isolated occurrences or part of wider underlying trends.

Permissive environment of inappropriate behaviour

14. **Issue**. The panel noted that in a time period of less than two years after graduating from AFC(H), the SP had been the recipient of unwanted sexual attention from a Warrant Officer and had suffered inappropriate behaviour from her line manager. In addition, she had had two consensual relationships in that period, but both of which were with individuals who were significantly older and more senior in rank to her and whose actions included discreditable moral behaviour. The panel felt this amounted to a concerning series of incidents directed at a very young and junior soldier.

a. **Witness 33**. The panel examined the reasons why the SP did not report the inappropriate actions of Witness 33. Many witnesses reported that the SP did not report the issue because she was afraid of the impact it might have on Witness 33's [redacted] and how he would respond. The SP also urged friends not to report the matter for the same reason. However, the panel noted evidence given by one witness that stated the SP was also afraid of reporting the behaviour of Witness 33 as she feared she would be seen as a serial 'troublemaker', having previously reported the incident involving unwanted sexual behaviour by a Warrant Officer. The panel felt it was particularly concerning that the SP felt she might be negatively impacted by reporting Witness 33, rather than receiving recognition and support for doing the right thing. The panel also noted that whilst friends and colleagues may have been reflecting the SP's wishes by not reporting Witness 33, it is nevertheless concerning that this behaviour was tolerated and prioritised over duty of care considerations towards the SP. K/T25/10 K/T17/18

b. **Wider Evidence**. The Inquiry also received evidence from witnesses who related other incidents of inappropriate sexual behaviour that they had either been subjected to themselves or had witnessed happening to other people. Most of these incidents involved inappropriate sexual language or comments made by male soldiers towards female soldiers. Witness testimony left the panel with the impression that, whilst not all males engaged in such behaviour, it was commonplace amongst a significant minority of soldiers within Larkhill Garrison. One witness described routinely receiving comments from male soldiers whilst out socialising that she described as "*vile*" and "*degrading*". No witnesses stated that they reported such incidents and the opinion of the panel was that this probably reflected the fact that such incidents were tolerated as normalised behaviour by those that experienced them. The panel noted that measures to tackle this kind of behaviour were introduced as part of new policy[3] with effect from Nov 22, as such actions must not be tolerated. K/T4/24 F/19/244 K/T13/12

[3] Defence Instructional Notice – Zero Tolerance to Unacceptable Sexual Behaviour: A Victim / Survivor Focused Approach. Released 18 Jul 22.

c. **Conclusion**. The panel was concerned by the overall evidence regarding inappropriate behaviours. With regards the SP, her relationships and the incidents of unacceptable behaviour to which she was subject involved four personnel from three separate units across Larkhill Garrison. The panel noted that all four personnel were significantly older and more senior in rank than the SP. There was no direct evidence to determine if individuals had abused their rank in these situations, but the panel's opinion was that there was a strong possibility that it could have been a factor and noted that such conduct must not be tolerated. The incidents involving the SP, in addition to other incidents related by other witnesses, were assessed as being indicative of a permissive environment that has enabled unacceptable behaviour to become normalised in some instances across some Larkhill Garrison units. Such an environment may be reflected across the wider Army, but this is not something that could be established within the scope of this Inquiry. K/T4/24 K/T25/39

Recommendation 1. CO 47 RA and RHQ RA Regt Col are to ensure all personnel within their units have received the mandatory Zero Tolerance to Unacceptable Behaviours Awareness Training, by 30 Jun 23.

Recommendation 2. CO 47 RA and RHQ RA Regt Col are to ensure all personnel have completed Behaviours 1 & 2 training, by 30 Jun 23.

Recommendation 3. CO 47 RA and RHQ RA Regt Col are to engage with the APSG Unacceptable Behaviour (UB) team and organise additional UB briefings/training, by 30 Jun 23.

Afternote: the panel would ordinarily have recommended that Climate Assessments be conducted to provide commanders with insights to address inappropriate behaviours, but noted that these had already been completed by 47 Regt RA (Sep 22) and RHQ RA (Mar 23).

Panel Comment: the delivery of briefs and the implementation of policy will not on their own deliver the cultural change needed to alter attitudes and behaviours. Such change is instead a function of leadership. Action should not be restricted to the above recommendations and all commanders must also take any additional necessary steps that they assess are required to bring about effective long-lasting change.

Culture of alcohol misuse

15. **Issue**. The Inquiry analysed the implications of the use of alcohol by the SP and others with whom she served. It was noted that the SP appeared to frequently 'binge drink' alcohol with colleagues and friends, both in barracks and whilst deployed away L/T5/14

on tasks. She also displayed unhealthy behaviours such as frequently posting videos of herself being sick from alcohol on social media and sharing these with friends and colleagues. It appears her behaviour was reflective of a wider culture of alcohol misuse amongst some personnel: L/T5/13

a. **Alcohol Culture**. Anecdotal evidence from witness testimony and the SP's phone records suggests that many other friends and colleagues with whom she served also frequently engaged in 'binge drinking'. Evidence does not suggest this was universal behaviour, as other testimony indicates a range of behaviours including those who drank in moderation or abstained from alcohol entirely, but there appears to be a significant number of people around her who frequently drank in excess. It was also noted that there was widespread engagement in drinking games on the night of the 14 Dec 21, including 'downing' drinks of mixed wine, beer and spirits. The panel considered it unlikely that this incident of personnel playing drinking games was an unusual occurrence. No evidence was received to suggest anyone ever reported any concerns about the SP's alcohol habits or concerns about other individuals to the chain of command. It is the opinion of the panel that this is because the SP's approach to alcohol may not have appeared unusual and may have been accepted as normal behaviour amongst a significant element of the personnel with whom she served. The panel assessed that the evidence suggests that there is a culture of excessive alcohol use amongst some of the population of the units examined. K/T4/12 K/T7/14 L/T4/4 L/T1/9 F/19/236

b. **Unit Alcohol Policy**. The panel examined the implementation of alcohol policies by 14 Regt RA, under whose policy RHQ RA falls, and 47 Regt RA and found that they were all compliant with AGAI 63[4] alcohol policy when assessed against the main requirements for a comprehensive Unit Alcohol Management Plan; the conduct of annual All Ranks Alcohol Awareness Briefs and holding the required numbers of trained Unit Alcohol Advisors (UAAs) and Alcohol Advice Practitioners (AAPs). They also produced evidence of discussing the Unit Alcohol Management Plan on Unit Health Committee meetings at least twice annually and publishing unit alcohol states on Part One Orders. The panel noted that AGAI 63 is intended to be a baseline policy and that the UAAs are trained with a variety of capabilities that can be exploited at unit level. The panel concluded that the evidence indicated additional measures are required to counter alcohol misuse that go beyond the minimum current baseline policy. In addition, the effectiveness of overall current Army policy also needs to be examined to ensure that it encourages units to deliver additional measures beyond those currently mandated in policy. G/16/1-9 D/15/1-5 G/21/1 C/2/1-30

[4] Army General Administrative Instructions, Volume 2, Chapter 63, Alcohol Misuse.

Recommendation 4. RHQ RA and CO 47 RA are to engage with the Academic Department of Military Mental Health and request an Operational Mental Health Needs Evaluation (OMHNE) survey, to allow commanders to understand and assess the current culture and identify areas for development, by 30 Sep 23.

Afternote: An OMHNE is recommended as it will allow an in-depth examination of the alcohol culture within units.

Recommendation 5. RHQ RA and CO 47 RA are to exploit additional training and learning opportunities to deliver cultural change to alcohol use where required within their units and review and update their Unit Alcohol Management Plans, by 31 Jul 23.

Recommendation 6. Army Pers Health Branch are to review AGAI 63 (Alcohol Misuse) to ensure that all tools supporting behavioural change are accessible and highly usable, by 30 Sep 23.

Afternote: The LWC (ITR Owner/TRA) is in the process of conducting a major review of the current Substance Misuse ITR with the intent of to separating the syllabus into two specific Training Objectives: Substance Misuse and Alcohol Awareness.

c. **Alcohol Controls**. Whilst units were assessed to be compliant with AGAI 63 alcohol policy in most areas, the panel noted that during Ex THORNEY ADVENTURE, conducted by RHQ RA in Jul 21, there were no alcohol controls in place on the evening of 12 Jul 21, during which the SP was subject to the incident of unwelcome sexual attention by a Warrant Officer. In particular, no bar hours were enforced and no individual was designated to oversee the closure and vacation of the bar. The unit appeared aware of its duty of care responsibilities and this this lack of appropriate controls was a non-conformity with existing Army policy guidance. The panel's opinion is that alcohol consumption is likely to have contributed to the incident that occurred. In addition, the lack of controls could have led to a dangerous situation given that the personnel on the package were conducting water-based activities the following day and some are likely to have still been under the influence of alcohol. The panel therefore considered this an **OTHER FACTOR**.

K/T19/10

K/T15/9
K/T5/26

Recommendation 7. The Regimental Colonel RHQ RA as DDH is to ensure that all DDH roles and responsibilities are conducted in accordance with policy for all future activities, in particular in relation to the control and consumption of alcohol whilst deployed on unit activities out of barracks. This is to be achieved through the production of an SOI to cover these types of activity. Immediate implementation.

Mental Health Awareness

16. **Issue**. One of the most noticeable elements of this case is the fact that concerns were not raised about the SP to the chain of command or to any welfare services by friends or colleagues. The panel considered it important to examine what role mental health awareness skills and training played in the events that unfolded:

a. **Mitigating Circumstances**. In order to understand whether poor awareness of mental health matters led to the SP not being referred for help, the panel considered any evidence that suggested reasons other than poor awareness may have led to issues not being reported. Evidence indicated that the SP confided in a wide range of people about different problems that she faced, most notably her flatmates, close female friends and some of her wider work colleagues. The panel felt that by confiding different elements of her situation to many people there was no holistic or coherent understanding, which prevented the totality and significance of her stress and unhappiness being recognised and acted upon. Other testimony suggests that some personnel were aware she was under significant stress but did not report it as they took comfort in the fact she had a close relationship to her family and regularly sought support from them. In addition, the panel noted that her flatmates were in a different unit to the SP and were of the opinion that this may have acted as a barrier to referring the SP for support. There is no direct evidence to support this latter factor, but the panel's opinion was that a junior soldier would probably be less likely to approach a different unit's chain of command in order to report an issue about another soldier.

K/T11/18
K/T13/7
K/T11/34
L/T5/7

b. **Warning Signs**. Despite the presence of some mitigating reasons why the severity of the SP's problems was not recognised, other evidence suggests clear warning signs were present in the weeks before her death. Not only did the SP directly tell many people about the stress she was under, some witnesses also observed that she was increasingly tired and irritable from around Nov 21 onwards and often linked this with the effect of Witness 33's actions on her. Witnesses noticed too that she increasingly seemed to turn to alcohol in the last few weeks of her life and this alcohol consumption was sometimes linked with unusual or erratic behaviour. In addition, several witnesses observed her state of stress, as evidenced by shaking and crying, following her voluntary removal from the CET task on 7 Dec 21. Her ex-boyfriend, Witness 5, had also been aware from early 2021 onwards that she was having intrusive dreams about the death of her uncle and this later became known to a friend, Witness 16, in early Dec 21. It appears that the severe panic attack that she suffered on 9 Dec 21 was also known to several people and she had intimated about suicidal thoughts to one witness following this and spoke of the 'night terrors' from which she was suffering. Despite the

K/T11/15
L/T5/13
K/T7/15
K/T25/16
L/T16/2

warning signals, most witnesses stated that they were extremely shocked and surprised when they found out about the death of the SP, which itself is a strong indicator that they lacked the awareness to recognise the severity of her condition. K/T9/35

c. **Mental Health Training**. The Inquiry examined what mental health training had been delivered by 47 Regt RA and RHQ RA during the period leading up to the SP's death. The panel noted the Army-wide roll out of the Optimising Performance through Stress Management and Resilience Training (OPSMART) mental health programme until Oct 21, at which point it transitioned to training delivered under ACSO 3218. It was noted that the delivery of OPSMART was affected by COVID-19 restrictions which introduced delays into the programme. Records seen by the Inquiry show that 47 Regt RA conducted Mental Health awareness training for some personnel in Sep 20. Evidence suggests only three personnel of those interviewed as part of the Inquiry had completed OPSMART mental health awareness briefs and therefore it appears likely that only a small number of her friends in her accommodation had received recent training in mental health awareness. Records show that the SP herself had completed Mental Resilience Training during her training at AFC(H) but had not completed any during her subsequent service. E/1/1 G/22/4

d. **Conclusion**. The panel concluded that mental wellbeing warning signs were clearly present in the weeks before her death but that these were missed, most likely due to insufficient awareness of mental health matters amongst the personnel to whom she was known. The panel was also concerned that some witnesses stated during testimony that they felt there was still a stigma attached to seeking help for mental health problems in the Army. Whilst this evidence is anecdotal, it highlights a potential aspect of mental health awareness that needs to be addressed as part of the overall problem. The panel acknowledged that positive changes to the provision of mental health training in the Army were already taking place prior to the death of the SP via the introduction of ACSO 3218, albeit that the delivery of this training was hampered by the COVID-19 pandemic. ACSO 3218 applies to the whole Army but Recommendation 8 below is designed to provide assurance that this new mental health training is completed in a timely manner by those units where training deficiencies were identified by this Inquiry. K/T1/5

Recommendation 8. RHQ RA and CO 47 RA are to implement and exploit the training delivered as part of ACSO 3218 (Army Stress Management and Resilience Training) to its full effect. Units are to deliver the full suite of courses to their units: Mental Fitness Brief, Mental Fitness Workshops, Mental Fitness Course, Conversations Skills Course and Conversations Skills Brief, by 31 Oct 23.

Afternote: The panel noted that significant progress has already been made on the delivery of ACSO 3218 at unit level. Besides unit-led training, it is noted that ACSO 3218 also delivers through-career training as part of promotion courses up to Warrant Officer rank.

e. **Suicide Prevention Training**. In this incident, the SP specifically intimated to another witness about having suicidal thoughts and was herself trying to deal with Witness 33 [redacted] In addition, the Inquiry is aware that a total of five deaths by Violent / Unnatural Causes, including confirmed suicides, occurred in Larkhill Garrison over the four-year period 2019-2022. The panel concluded that teaching individuals on how to approach personnel who they suspect may be at risk of suicide should be specifically included in training. It was noted that Army Pers Health has already taken active steps to promote such training and that the current recommended training is Zero Suicide Alliance Training. K/T25/22

Recommendation 9. COs of Larkhill based Unit's (1RHA, 14RA, 19RA, 26RA, 32RA and 47RA) are to deliver suicide awareness training using either the Zero Suicide Alliance Training or forthcoming ITR package to all personnel, by 31 Oct 23.

Afternote: Zero Suicide Alliance Training, although not currently mandated, is endorsed training and the Defence Suicide Prevention Working Group have previously issued direction that it will become a mandatory ITR.

Awareness of welfare support services

17. **Issue**. There is no evidence to indicate that the SP approached the Unit Welfare Department or other sources of support for any of the range of issues she faced during her time in RHQ RA. The limit of her requests for support during this time was occasionally asking the chain of command if she could be released early at weekends to return home to deal with what she described as 'family issues'. It is notable that the SP confided in her family and a range of friends about many of her problems. It is also the opinion of the panel that some of her actions in the last few days of her life suggest that she was trying to seek help from some of her friends. To that end, it seems that to some degree she recognised that she needed help and support. These facts make it more notable that she did not seek support from any welfare support services at this stage. The panel felt it relevant to examine the profile of the welfare support services available to consider if a lack of awareness could have influenced her inaction in this respect: G/26/1-4 K/T8/30 L/T15/5 F/19/127

a. **Unit Welfare booking-in process**. RHQ RA is supported by 14 Regt RA Unit Welfare Department. The Unit Welfare K/T23/3

Department supports 14 Regt RA, RHQ RA, other ADCON units and all personnel on courses at the Royal School of Artillery. The department delivers a welfare services brief to all personnel who are on courses and it is likely that the SP would have received a brief during her Initial Trade Training course at 14 Regt RA. She would have fallen under the remit of 14 Regt RA Unit Welfare again when posted into RHQ RA. The SP would have been required to undertake an arrivals process on taking up her post at RHQ RA and this would include 'booking into' the welfare department. Evidence suggests at the time the SP arrived at RHQ RA the physical check-in with the welfare department had been replaced by a virtual process due to COVID-19 restrictions, though it cannot be definitively established whether or not the SP completed this check-in as records for this period of COVID restrictions could not be produced. The Unit Welfare Department continued with the virtual check-in process afterwards due to it being considered more efficient. The Unit Welfare Officer stated during testimony that he felt that this removed a valuable opportunity to form an initial rapport with individuals when they first arrived. D/13/1 K/T23/5

Recommendation 10. CO 14 RA is to ensure the welfare department ceases virtual check-in process for new arrivals and reverts to physical check-ins for all personnel, by 31 Mar 23.

b. **Profile of 14 Regiment RA Unit Welfare Department.** The unit welfare department supports a large cohort of circa 700-900 personnel across seven units. The welfare building is located outside of the main camp which makes it less prominent to single soldiers. Anecdotal evidence given during testimony also suggests some CET personnel had the misconception that the Unit Welfare Department was there mainly for married personnel, rather than for single soldiers. The department had a workforce of three personnel at the time of the SP's death, though evidence given to the Inquiry suggests that the workforce strength has also varied significantly over the years. Workforce strength had also been affected by illness at times. The department used to conduct 'drop-in clinics' in camp for single soldiers in the past, though this had ceased, in part due to lack of available workforce. Whilst the Inquiry did not hear any evidence to directly link the SP's decision not to contact welfare to the low profile of the department, the panel felt it could have had an effect in this and future cases and make it less likely for a serviceperson to seek help. K/T23/3 K/T1/7 K/T23/4 K/T23/7

c. **Other welfare support services**. Besides the unit welfare department, evidence indicates the SP also did not contact any of the other available support services about her problems, such as the Padre or medical chain. Most notably, the SP did not utilise the 'Speak Out' bullying helpline to report the actions of Witness 33, though it cannot be established to whether or not

the SP was aware of the helpline. Service personnel are also able to self-refer themselves to the Army Welfare Service, though anecdotal testimony heard by the Inquiry suggests this is not widely known. Testimony given by the Unit Welfare Officer stated that he had already identified further opportunities to promote the wider support services available to all personnel.

Recommendation 11. CO 14 RA is to ensure the Unit Welfare Department take all necessary steps to raise its own profile and that of other sources of support amongst all units supported by 14RA, ensuring all actions are captured during CO's monthly Unit Welfare Management Committee meetings, by 30 Sep 23.

Management of the SP's bereavement by suicide

18. **Issue**. The Inquiry examined how the SP was managed after she suffered bereavement by [redacted] in Aug 20 following the death of her uncle, given that this was deemed to be a factor in her own death:

a. **VRM Register**. AGAI 110 states bereavement by suicide is a risk factor that should be taken into account when assessing an individual's own vulnerability to suicide or self-harm. The SP lost her uncle [redacted] in Aug 20. The SP was on leave at the time and requested additional time off through her chain of command to grieve with her family and to attend the funeral. Her Troop Commander stated that the SP did not ask for any additional support at the time and cited her strong and stable family background as one of the principal reasons why she was not placed on the VRM register as a result of the incident. AGAI 110 states that suicide and self-harm behaviours are 'rarely the result of a single factor or incident' and given the positive way in which it appeared the SP coped at the time of the incident, the panel concluded that it was a proportionate decision not to place her on the unit's VRM register at that time. K/T21/3 G/13/2

b. **Bereavement Support**. Whilst the SP appeared to cope well following her bereavement [redacted] it is widely recognised that this is a risk factor that can affect individuals at a much later stage after the event. Bereavement support services have always been available to service personnel and specialist postvention support has subsequently been created since Jun 22 to specifically support those dealing with bereavement by suicide. It is not clear whether the SP was aware of the available bereavement support services, but the fact that she was not referred to the Unit Welfare Department removed one opportunity to make her aware of these services at the time of the incident. It cannot be stated what effect it would have had if she had definitely known about available bereavement support services, but the panel felt that most

service personnel would be more likely to seek help if they were already aware that specialist support was available.

Recommendation 12. All COs of Larkhill based Unit's (1RHA, 14RA, 19RA, 26RA, 32RA and 47RA) are to ensure that bereavement support services, including postvention bereavement support, is widely advertised to all personnel within their units, by 30 Jun 23.

Afternote: Army Pers Health has conducted an information campaign to raise awareness to unit chains of command about the availability of postvention support. It was noted by the Inquiry that all major Larkhill-based units have been visited by and subsequently received bereavement support for individuals through the current AMPARO contract.

c. **Transfer of welfare information between units.** In Feb 21, six months after suffering loss bereavement [redacted] the SP was posted to RHQ RA. No evidence was presented to the Inquiry to indicate that knowledge of her bereavement [redacted] was passed to her new unit. For those service personnel who do not meet the threshold for VRM reporting, various tools exist to facilitate transfer of relevant welfare information on posting, including use of the Welfare Flag on the Joint Personnel Administration (JPA) system. In this instance neither the Welfare Flag nor other methods were used, presumably because the SP's bereavement [redacted] was not considered to be an ongoing issue. Whilst the Welfare Flag or other methods could have been used, the opinion of the panel was that the decision not to report was proportionate in this instance. AGAI 110 lists a total of 29 risk factors and the opinion of the panel was that it would be impractical to utilise this tool for all instances as it is likely that a significant proportion of service personnel would be subject to at least one risk factor at any one point in time. It was the opinion of the panel that such widespread reporting could actually hamper identifying those at most risk. Instead, the panel's opinion was that the greatest safeguard is in creating an environment in which those who experience problems are equipped with the awareness, knowledge and empowerment to seek help. E/8/1

Impact of limited Regimental Duty experience

19. **Issue.** During the SP's military career, she had served only 16 months outside of training, of which only 6 months had been spent at Regimental Duty. The panel examined whether her lack of Regimental Duty experience had any impact on events:

a. **Effect of limited experience.** The SP spent six months at Regimental Duty, of which it is assessed that she spent approximately half of that time on COVID-19 leave or annual leave. She then commenced her posting in RHQ RA in Feb 21

which itself was also significantly affected by COVID-19 restrictions and the requirement to work from home. The panel's opinion is that the SP's limited experience of Regimental Duty could have affected her reaction to some of the causal and contributory factors to which she was exposed. The panel's belief is that she may have acted differently if she had served longer within a typical Regiment so as to find her feet amongst peers, discover the support available to soldiers and learn how to access it. She would not have gained this same typical experience serving in RHQ RA. It is notable that when her problems occurred she did not seek help for any of them through the conventional support channels that would have been available within RHQ RA. Had the SP had greater Regimental Duty experience, the panel's opinion was that she would have been likely to have had a better understanding of the extent of the Army's duty of care and the range of the support available to individuals who experience problems. She may therefore have been more willing to seek support. Periods spent at home on COVID-19 leave and working from home may also have weakened the trust and bond she would otherwise have formed with her chain of command. K/T9/6 K/T18/49

b. **Effect of RHQ structure**. The panel noted that the CET is a very small team, often including very junior soldiers who are operating in a headquarters made up of relatively senior individuals. Junior soldiers are expected to operate with a higher degree of autonomy than may routinely be expected at Regimental Duty and do not have the network of pastoral support usually provided by operating in a conventional Troop and Battery construct. For this reason, the panel concluded that junior soldiers would benefit from a minimum level of Regimental Duty experience prior to being selected for a CET posting. Current RA policy states that soldiers are to have a minimum of 3 years' experience prior to being selected for an Extra-Regimental Employment assignment, such as a CET posting, though this policy appears to be driven by the needs to balance a serviceperson's career, rather than duty of care reasons. It is notable that this minimum period was not enforced in the case of the SP's selection for the CET. D/4/1 D/3/1 C/1/2

Recommendation 13. Hd A&S is to ensure all cap badges review their Extra Regimental Employment policies and are to ensure an appropriate minimum level of Regimental Duty experience is implemented, taking into account the findings of the SI, by 30 Sep 23.

Army Foundation College (Harrogate)

20. **Issue**. A feature of this Inquiry is that the SP had a relationship with an individual, Witness 5, who had been her instructor at AFC (H). This fact led to the Inquiry undertaking a limited and proportionate examination to look specifically into the

safeguarding provisions and culture at AFC(H) regarding relationships between instructors and trainees. The available evidence suggests that the relationship began soon after the SP's graduation, but it seems apparent that the fact that the SP and instructor had become known to each other in a professional capacity at AFC(H) in the first instance, contributed in some way to the relationship subsequently commencing. The panel therefore felt it necessary to examine whether this relationship had occurred because of, or in spite of, the safeguarding culture at the college: K/T17/4

a. The Inquiry interviewed the AFC(H) safeguarding lead and the Designated Safeguarding Officer to consider the overall regime in place at the college. Testimony suggested that safeguarding responsibilities are taken very seriously with strict policies in place to prevent inappropriate relationships between staff and trainees. These policies are impressed on all staff, including instructors. Policy is formulated from a number of sources, including measures under the Department for Education's Keeping Children Safe in Education[5]. The college is also subject to OFSTED inspection. Instructors are briefed on the safeguarding standards expected of them during arrival interviews and then during the Workplace Induction Programme which includes a two-hour safeguarding module and which has to be completed within three months of arrival. Subsequent CPD training is also used to reinforce safeguarding provisions. The response to any reported incidents also reinforces the seriousness with which safeguarding is taken with any transgressions that do occur being dealt with by immediate suspension and full investigation of the reported incident. L/T18 L/T19 L/T18/4 L/T19/5 L/T18/5

b. Safeguarding training also covers trainees. Trainees are briefed on the standards expected of themselves and the standards which they can in turn expect from instructors. All trainees are also briefed on how to report transgressions and a range of options are available for them to do so. There are also physical controls in place that aid prevention of inappropriate interactions between staff and trainees, including a system of duty staff and CCTV monitoring key areas.

c. **Conclusion**. Whilst it was considered appropriate to only conduct a limited investigation into the safeguarding culture, the panel were satisfied that any Instructor at AFC(H) could reasonably be expected to know the safeguarding standards expected of them and the inappropriateness of any relationship between an instructor and trainee. They would also clearly understand the emphasis that AFC(H) placed on safeguarding and would understand the severity with which any inappropriate relationship would be dealt. The panel concluded that it was unlikely in this instance that a weakness in the safeguarding

[5] Keeping Children Safe in Education 2022, Statutory Guidance for Schools and Colleges, dated 1 Sep 22.

culture contributed to the relationship between Witness 5 and the SP arising.

Organisational structure of RHQ RA

21. **Issue**. The inquiry examined the impact that the organisational structure of RHQ RA had on events in this case. RHQ RA is a staff headquarters and as such its structure does not readily compare to a Field Army unit HQ. It is notable that it therefore lacks much of the organic workforce around which many Army policies and processes are devised and the panel assessed the potential implications of this: D/3/1

a. **Chain of Command**. The CET is a small team of junior soldiers embedded within the much bigger senior staff headquarters of RHQ RA. The SP's immediate chain of command was limited to the Officer-in-Command (OIC) SNCO and the SO2 Engagement who is 'double hatted' as the OC. This is a contrast to a normal Troop/Battery organisation which would give a serviceperson multiple points of contact to whom they could turn for assistance if needed. The panel's opinion was that the senior make-up of the headquarters could be an imposing barrier to a very junior soldier and make it less likely that they would seek help from other individuals if they felt they could not approach their designated chain of command. There is some evidence that indicates the SP would not have been willing to discuss welfare matters with the OIC SNCO due to comments he had previously made about her and that had been relayed to her by another individual. This would have further narrowed the points of contact to whom she could have turned in this instance. K/T9/4 K/T7/5 K/T8/14 F/19/128

Recommendation 14. Hd A&S is to ensure that all RHQs with embedded recruitment teams review their structures, in light of the SI findings, to ensure junior soldiers have access to a sufficiently broad command structure, by 30 Sep 23.

Afternote: As secondary duties, RHQ RA has already nominated the RA Battery Sergeant Major (BSM) to act as the CET Squadron Sergeant Major (SSM) and the SO3 Officer Recruiting as the CET Troop Commander.

b. **Support Arrangements**. As RHQ RA lacks much of the organic workforce that typical Field Army units possess, it is dependent on other units to provide many G1-G8 support services, drawing principally on the support of 14 Regt RA. These arrangements are captured in a Memorandum of Understanding (MoU) but the Inquiry highlighted that confusion remains over the division of responsibilities, particularly in the area of G1 administration. The discipline incident on Ex THORNEY ADVENTURE in Jul 21 was dealt with by the RHQ K/T20/5 K/T20/5

RA chain of command whereas CO 14 Regt RA stated that he expected all discipline matters to be dealt with by his RHQ. The confusion over this process may have contributed to the manner in which this incident was handled at the time. Testimony given to the Inquiry also demonstrated that some personnel were confused over the provision of welfare support arrangements to RHQ RA and 14 Regt RA UWO stated that he had not been aware of the MoU until preparing to give evidence to the Inquiry. As there is no evidence that this confusion over support arrangements directly affected the SP, the panel deemed this to be an **OTHER FACTOR**. It was considered highly likely that other Arms & Services RHQs are likely to have similar challenges in their own support arrangements. J/2/2 J/2/2 K/T14/5 K/T23/27 K/T20/6

Recommendation 15. Hd A&S is to conduct a Command Review by directing all RHQs to review their G1-G8 administrative support arrangements and ensure robust processes are in place and that the role of any supporting organisations are clearly defined and understood, by 30 Sep 23.

c. **Recruitment Team Selection Process**. The Inquiry noted that that due to its structure, RHQ RA lacks the organic resources to support significant numbers of personnel with complex welfare support issues. The Inquiry also noted strong anecdotal evidence that CET posts are attractive to those with complex welfare or other G1 issues as the posts offer stability and are non-deployable. This situation has the potential to attract a number of personnel with welfare needs that would be disproportionate to what RHQ RA could be expected to support. Current CET selection processes do not allow G1 considerations to be taken into account. Whilst the panel strongly felt that G1 needs should not ordinarily preclude personnel from CET postings, the numbers of such personnel should remain within what RHQ RA can reasonably be expected to support. In extremis, the selection process should allow refusal of an individual's selection if it is beyond what RHQ RA can reasonably support and if it is therefore in the best interests of the individual as well. This factor did not affect the SP in this case and is therefore deemed an **OTHER FACTOR**. K/T20/7 K/T20/5

Recommendation 16. Hd A&S is to ensure that all Engagement Team selection processes include reasonable measures to allow RHQ's, if necessary, to refuse individuals on G1 grounds if it is disproportionate to their ability to support and therefore in the best interests of the individual, by 30 Sep 23.

Afternote: The RA Corps Engagement Team Selection and Induction Policy (dated Sep 22) has been updated and incorporates G1 specific matters during both the selection and subsequent arrivals process.

Accommodation management in Larkhill Garrison

22. **Issue**. Investigations by the Inquiry highlighted potential issues over the way SLA is managed by units in Larkhill Garrison. The SP was posted from 47 Regt RA to RHQ RA in Feb 21 when she started work in the CET. At the time she applied to retain her room in 47 Regt RA SLA and this was approved by the losing and gaining chains of command. In Jul 21, the SP was then instructed to move rooms into the CET SLA by RHQ RA, seemingly for administrative reasons. Instead, the SP took over a room in the CET SLA as instructed but still retained her 47 Regt RA SLA where she continued to reside unknown to both chains of command. Both RHQ RA and 47 Regt RA were unaware that she was still living in the 47 Regt RA SLA and the true situation was not known to either chain of command until after her death in Dec 21. This maladministration did not directly affect this case, but it could have had significant implications in accounting for personnel in the event of a fire or other problem. The panel therefore assessed this to be an **OTHER FACTOR**. The panel noted that, with several units stationed in Larkhill Garrison, it appears to be common practice for personnel to be assigned between units within the Garrison.

E/8/1

G/8/1

J/1/1-5

J/4/2

Recommendation 17. All COs of Larkhill based Unit's (1RHA, 14RA, 19RA, 26RA, 32RA and 47RA) are to review their unit accommodation Standing Orders/Instructions to ensure they include provisions to accurately account for personnel in accommodation blocks, by 30 Jun 23.

Recommendation 18. Army Pers Dir are to review AGAI 53 to ensure that it contains direction that ensures units accurately account for personnel in SLA, by 30 Sep 23.

SECTION 5 – RECOMMENDATIONS

TOR 3 – Which changes are recommended in order to avoid future recurrences?

TOR 4 – Examine the involvement of training establishments, Regiments and Headquarters. What broader organisational change is required to better support Service Personnel and prevent recurrence?

1. Recommendation 1: CO 47 RA and RHQ RA Regt Col are to ensure all personnel within their units have received the mandatory Zero Tolerance to Unacceptable Behaviours Awareness Training, by 30 Jun 23.

2. Recommendation 2: CO 47 RA and RHQ RA Regt Col are to ensure all personnel have completed Behaviours 1 & 2 training, by 30 Jun 23.

3. Recommendation 3: CO 47 RA and RHQ RA Regt Col are to engage with the APSG Unacceptable Behaviour (UB) team and organise additional UB briefings/training, by 30 Jun 23.

4. Recommendation 4: RHQ RA and CO 47 RA are to engage with the Academic Department of Military Mental Health and request an Operational Mental Health Needs Evaluation (OMHNE) survey, to allow commanders to understand and assess the current culture and identify areas for development, by 30 Sep 23.

5 Recommendation 5: RHQ RA and CO 47 RA are to exploit additional training and learning opportunities to deliver cultural change to alcohol use where required within their units and review and update their Unit Alcohol Management Plans, by 31 Jul 23.

6. Recommendation 6: Army Pers Health Branch are to review AGAI 63 (Alcohol Misuse) to ensure that all tools supporting behavioural change are accessible and highly usable, by 30 Sep 23.

7. Recommendation 7: The Regimental Colonel RHQ RA as DDH is to ensure that all DDH roles and responsibilities are conducted in accordance with policy for all future activities, in particular in relation to the control and consumption of alcohol whilst deployed on unit activities out of barracks. This is to be achieved through the production of an SOI to cover these types of activity. Immediate implementation.

8. Recommendation 8: RHQ RA and CO 47 RA are to implement and exploit the training delivered as part of ACSO 3218 (Army Stress Management and Resilience Training) to its full effect. Units are to deliver the full suite of courses to their units: Mental Fitness Brief, Mental Fitness Workshops, Mental Fitness Course, Conversations Skills Course and Conversations Skills Brief, by 31 Oct 23.

9. Recommendation 9: COs of Larkhill based Unit's (1RHA, 14RA, 19RA, 26RA, 32RA and 47RA) are to deliver suicide awareness training using either the Zero Suicide Alliance Training or forthcoming ITR package to all personnel, by 31 Oct 23.

10. Recommendation 10: CO 14 RA is to ensure the welfare department ceases virtual check-in process for new arrivals and reverts to physical check-ins for all personnel, by 31 Mar 23.

11. Recommendation 11: CO 14 RA is to ensure the Unit Welfare Department take all necessary steps to raise its own profile and that of other sources of support amongst all units supported by 14RA, ensuring all actions are captured during CO's monthly Unit Welfare Management Committee meetings, by 30 Sep 23.

12. Recommendation 12: All COs of Larkhill based Unit's (1RHA, 14RA, 19RA, 26RA, 32RA and 47RA) are to ensure that bereavement support services, including postvention bereavement support, is widely advertised to all personnel within their units, by 30 Jun 23.

13. Recommendation 13: Hd A&S is to ensure all cap badges review their Extra Regimental Employment policies and are to ensure an appropriate minimum level of Regimental Duty experience is implemented, taking into account the findings of the SI, by 30 Sep 23.

14. Recommendation 14: Hd A&S is to ensure that all RHQs with embedded recruitment teams review their structures, in light of the SI findings, to ensure junior soldiers have access to a sufficiently broad command structure, by 30 Sep 23.

15 Recommendation 15: Hd A&S is to conduct a Command Review by directing all RHQs to review their G1-G8 administrative support arrangements and ensure robust processes are in place and that the role of any supporting organisations are clearly defined and understood, by 30 Sep 23.

16. Recommendation 16: Hd A&S is to ensure that all Engagement Team selection processes include reasonable measures to allow RHQ's, if necessary, to refuse individuals on G1 grounds if it is disproportionate to their ability to support and therefore in the best interests of the individual, by 30 Sep 23.

17. Recommendation 17: All COs of Larkhill based Unit's (1RHA, 14RA, 19RA, 26RA, 32RA and 47RA) are to review their unit accommodation Standing Orders/Instructions to ensure they include provisions to accurately account for personnel in accommodation blocks, by 30 Jun 23.

18. Recommendation 18. Army Pers Dir are to review AGAI 53 to ensure that it contains direction that ensures units accurately account for personnel in SLA, by 30 Sep 23.

SECTION 6 – CONVENING AUTHORITY COMMENTS

1. **Convening Headquarters:** HQ London District

2. **Commander:**

   a. Major General Sir Christopher Ghika KCVO CBE, General Officer Commanding London District and Major General Commanding the Household Division.

3. **Timelines:**

   a. I am content that the staffing of the Inquiry report has been completed thoroughly and in an expeditious manner.

4. **Affected Persons:**

   a. I note that there are six affected persons identified during the course of the Inquiry.

5. **Findings of the Inquiry:**

   a. I have reviewed fully the Service Inquiry report into the circumstances relating to the death of Gunner [redacted] and I am content that the Terms of Reference (TOR) provided have been met.

   b. Whilst I am content with the findings provided within the report, I am surprised to find that no action had been taken forward with regards to Witness 20. Whilst I accept that Witness 20 was not in Gnr [redacted] immediate chain of command, nor had been in the same unit at the time, the way Witness 20 had conducted himself whilst in a position of authority through the rank he held, suggests to me that it is at odds with the Army's values and standards.

6. **Recommendations of the Inquiry**

   a. I have considered the recommendations made by the panel and I am content with what has been proposed.

   b. I further recommend that where potential failings are identified, the appropriate process must be followed ensuring all facts and the merits of the case are fully considered. Where a breach of the Service Test has been initially identified, a fair and thorough investigation should be carried out to determine if there is a requirement for further action to be taken.

7. As the Convening Authority for this Service Inquiry (SI), I am grateful to the President and their Panel for the thoroughness of their Report in meeting their Terms of Reference (TOR).

8. On behalf of the Army may I offer my condolences to Gunner [redacted] family.

Major General Sir Christopher Ghika KCVO CBE 06 Jul 23

SECTION 7 – REVIEWING AUTHORITY COMMENTS

1. I have reviewed the Service Inquiry report into the untimely and tragic death of Gnr [redacted] on 15 December 2021. My observations are below.

Context

2. Gnr [redacted] joined the Army in Mar 19 and undertook Junior Entry Basic Training at Army Foundation College (Harrogate), completing the 49-week 'long course'[6] and graduating in Feb 20 into the Royal Artillery (RA). She was subsequently posted to 14 Regt RA in Larkhill in Aug 20 to undertake a 4-week Initial Trade Training course as an Uncrewed Aerial Systems operator. On completion of her training, she was posted within Larkhill to 47 Regt RA, from where she subsequently volunteered and was selected to serve as part of the Corps Engagement Team (CET) in RHQ RA. She took up her appointment in the CET in Feb 21 and was still serving there at the time of her death. Gnr [redacted] finished her last day of work prior to Christmas leave on 14 Dec 21. She was due to join her family for Christmas but had decided to remain in Larkhill for a few days beforehand. On the evening of 14 Dec 21, she attended a party in the accommodation block where she was living at the time. Gnr [redacted] was reported to have been in a happy mood for most of the evening. Later in the evening she was joined at the party by a married SNCO with whom she was conducting a secret relationship. After he left around midnight, others observed a marked decline in her spirits for reasons that have not been fully identified. At a later stage that night, she was seen crying in a kitchenette area within the accommodation block and told others she was upset over matters relating to her uncle's death by suicide, which had occurred the previous year. She was last seen in the early hours of the 15 Dec 21 in her room at which point a flatmate noticed that she was visibly upset. She stated this was due to family problems and that she would explain the problems in the morning. She was last active on WhatsApp at 02.21hrs and her body was discovered in her room the following afternoon by concerned friends. All the available evidence suggests that [redacted] though this will be confirmed or otherwise by the Coroner.

3. It is noteworthy that Gnr [redacted] death came 'out of the blue' to her chain of command, none of whom were aware of any significant problems at the time. It has also been established that Gnr [redacted] was not in contact with any welfare services at the time of her death and did not have any diagnosed mental health issues, her only contact with the medical chain having been for routine matters.

Service Inquiry

4. On 30 May 22, GOC (LONDIST) directed a Service Inquiry convene to investigate the circumstances surrounding the death by Violent / Unnatural Causes of Gnr [redacted] in her Single Living Accommodation on 15 December 2021. The Service Inquiry (SI) Panel formally convened at Andover on 07 Jun 22.

5. The Panel has identified two causal and three contributory factors in the tragic death of Gnr [redacted] and has duly considered the effect of her relatively short experience of military life (both as a result of COVID-19 restrictions and in terms of time served). They have sensibly focussed their recommendations on making similar causal and contributory factors less likely in the future, on making it more likely that Service People in similar

[6] For Royal Armoured Corps/Household Cavalry, Royal Artillery and some Royal Logistic Corps roles.

circumstances can recognise their needs and seek support, and on making it more likely in future that colleagues and friends will notice and warning signs and act in support.
As the Reviewing Authority for this Service Inquiry (SI), I am grateful to the President and their Panel for the thoroughness of their Report in meeting their Terms of Reference (TOR).

RECOMMENDATIONS OF THE SERVICE INQUIRY

Findings of the Inquiry.

6. I endorse the Convening Authority's analysis of the findings of the Inquiry. I concur that it presented a picture of a young woman who outwardly was successful, thriving and in control. It is tragic that the extent of the effects upon Gnr [redacted] of the problems she was encountering only became clear after her death.

Shortcomings. The Inquiry has identified shortcomings across the following areas:

b. Inappropriate behaviour; in particular, inappropriate sexual attention

c. A culture of excessive alcohol use

d. Mental Health awareness and acting on warning signs

e. Awareness of welfare support services

f. Impediments to the provision of support caused by military organisational structures

Recommendations.

7. The recommendations are designed to prevent recurrence in the following areas and are to be communicated more widely by the Organisational Learning Team such that broader Army and Defence audiences may benefit from the Panel's findings and prevent recurrence:

a. **Inappropriate behaviour.** In addition to the normal mandated training, sensible additional measures have been imposed locally upon 47 Regt RA and the RA Regimental Colonel to ensure that training is repeated, the right specialist advice and guidance is sought from the APSG Unacceptable Behaviours Team, and to place greater emphasis on the requirement for leadership in this area. I note that Larkhill based units were quick to undertake Climate Assessments and emphasise that the Army's mandated training, undertaken annually by all service personnel, is fit for purpose.

b. **Alcohol use.** While Larkhill based units appeared compliant with the Army's alcohol policies, I endorse the additional provisions we have recommended to review those policies, conduct an Operational Mental Health Needs Evaluation, seek additional training and learning opportunities to identify and evaluate potential cultural problems, and improve control measures while away on duty.

c. **Mental Health and acting on warning signs.** There is excellent training available. Cultural change within the organisation over the past few years is

significant and is steadily making mental health and suicide prevention training more attractive to personnel. Nevertheless, I fully endorse the need to do more locally and quickly. I welcome the planned through life training interventions, and the mandating of annual suicide prevention training across the Army.

d. **Awareness of welfare support services**. The combined effects of COVID-19 and of Gnr [redacted] lack of experience have prompted the Army to immediately improve the provision of welfare support, vulnerability management processes and the provision of bereavement support.

e. **Impediments to the provision of support caused by military organisational structures.** Much must be done in these areas. We will:

(1) Ensure all cap badges review their Extra Regimental Employment policies and are to ensure an appropriate minimum level of Regimental Duty experience is implemented, taking into account the findings of the SI;

(2) Ensure that all RHQs with embedded recruitment teams review their structures, in light of the SI findings, to ensure junior soldiers have access to a sufficiently broad command structure;

(3) Conduct a Command Review by directing all RHQs to review their G1-G8 administrative support arrangements and ensure robust processes are in place and that the role of any supporting organisations are clearly defined and understood; and

(4) Ensure that all Engagement Team selection processes include reasonable measures to allow RHQ's, if necessary, to refuse individuals on G1 grounds if it is disproportionate to their ability to support and therefore in the best interests of the individual.

Management of the recommendations

8. **Ownership.** Each recommendation has been allocated an accountable sponsor with the authority to effect the required changes. While this achieves the necessary improvements locally, we also have a responsibility to enable broader audiences to take pre-emptive action. The Organisational Learning Team is to exploit these findings by communicating them widely. Particular attention is to be given to broadly advertising recommendations 9, 12 and 17 pertaining to Zero Suicide Alliance Training, Bereavement Support Services, and Accommodation Policies via exploitation products such as CO's Newsletters. The 18 recommendations are allocated as follows:

a. Army Personnel Directorate: 1

b. Army Personnel Health Branch: 1

c. Head Arms and Services: 4

d. RA Regimental Colonel: 7

e. All Larkhill based Unit Commanding Officers: 3

f. Commanding Officer 14 Regt RA: 2

g. Commanding Officer 47 Regt RA: 6

9. **Progress to closure.** All recommendations have been endorsed and accepted allowing them to be addressed and implemented. One was to have been completed by 31 Mar 23. Five will be completed by 30 June 2023, one by 31 July 2023 with a further ten being completed by 30 September 2023 and the final one by 31 October 2023. At the time of writing, 8 have been completed with the remainder on track to be finalised by the designated completion date.

10. **Record keeping.** These recommendations, their associated progress to completion and supporting evidence is recorded on the Defence Lessons Identified Management System (DLIMS). Progress is monitored and assured by the APSG Lessons Team.

SUMMARY

11. I am satisfied that the death of Gnr [redacted] has been comprehensively investigated, the findings appropriately analysed and reported on thoroughly. The Inquiry recommendations have been endorsed and have been appropriately tasked for implementation.

12. I acknowledge the Convening Authority's remarks regarding the fact that no sanctions resulted from the administrative investigation into the actions of Witness 20. I have examined this matter and note that legal advice was sought on the case at the time. I am satisfied that it was appropriately investigated and that whilst the actions of Witness 20 cannot be condoned, it was legally appropriate that Major Administrative Action was discontinued.

13. Gnr [redacted] Next of Kin will now be offered a copy of the Service Inquiry report and a briefing by the Service Inquiry President to explain the findings and answer any questions that they may have.

14. On behalf of the Army, I offer my sincere condolences to the family, friends, and colleagues of Gnr [redacted] I hope that the Inquiry has provided information which will enable them to reach some peace and closure.

07 Aug 23

EJR Chamberlain
Brigadier
Head Army Personnel Services Group and
Single Service Inquiries Coordinator (Army)

Annex A to
[redacted] Gnr [redacted] SI
Dated 9 Jun 23

CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL C J GHIKA CBE

GENERAL OFFICER COMMANDING LONDON DISTRICT (LONDIST)

1. A Service Inquiry (SI) is to be convened, in accordance with Section 343 of the Armed Forces Act 2006 (AFA 06), to investigate the circumstances surrounding the death of [redacted] Gunner [redacted] who was found deceased, by way of violent/unnatural causes (VUC) in her Single Living Accommodation on 15 December 2021.

2. An SI is to assemble in Andover on 6 June 2022. The SI is the Panel's priority task and takes precedence over any other duties.

3. The SI Panel comprises:

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

   b. Member: Maj [redacted] RMP

   c. Member: [redacted] Sgt [redacted] .

4. The legal advisor to the SI is: [redacted]

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

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

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

8. The Panel may hear evidence from any such other witnesses or subject matter experts as it deems appropriate and may dispense with the attendance of any witness if it concludes that the witness evidence will not assist the SI. The President should note that

a witness statement taken by the RMP/SIB may not be admitted as evidence to the SI, unless the express consent of the witness providing the statement has been obtained.

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

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

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

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

GENERAL ADMINISTRATION

13. LONDIST is to provide the following:

a. A professional Verbatim Court Recorder to be present to record evidence at Hearings as required. This must be requested via HQ APSG.

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

c. Stationery as required by the Panel.

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

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

f. Access to clerical support as required.

g. IT including Laptop, as appropriate and as required, for the Panel members.

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

Original signed

C J GHIKA CBE
Major General
General Officer Commanding LONDIST Date: 30 May 2022

SERVICE INQUIRY TERMS OF REFERENCE
[redacted] GUNNER [redacted]

1. The Panel is to investigate the circumstances surrounding the death of [redacted] Gunner [redacted] Royal Artillery, who died of Violent / Unnatural Causes in her Single Living Accommodation on 15 December 2021.

Terms Of Reference

2. The Service Inquiry (SI) is to address the following Terms of Reference:

a. ToR 1 – What happened? Establish the facts surrounding [redacted] Gunner [redacted] death, incorporating those relevant from Gunner [redacted] full career history including their time at Army Foundation College (Harrogate).

b. ToR 2 – Examine the events prior to [redacted] Gunner [redacted] death including the day of her death. Identify contributing, causal or other factors.

c. ToR 3 – Which changes are recommended in order to avoid future recurrences?

d. ToR 4 – Examine the involvement of training establishments, Regiments and Headquarters. What broader organisational change is required to better support Service Personnel and prevent recurrence?

Output

3. Within the Service Inquiry report the Panel is to include an executive summary of the case, addressing each of the ToR listed above. The Panel should:

a. Set out the facts established by the evidence, on the balance of probabilities.

b. Make appropriate recommendations for the unit(s), the Army and Defence.

c. Set out any additional facts relevant to the matter under inquiry, disclosed from the evidence given to the Panel and any other evidence which the President decides should form part of the record.

d. Include transcripts of oral evidence, copies of witness evidence given to the Panel and any other evidence which the President decides should form part of the record.

e. Note that the President may amend the ToR if required in consultation with the Convening Authority and Reviewing Authority.

4. HQ APSG is to submit the Service Inquiry report to the Convening Authority on completion of the Service Inquiry.

Annex B to
[redacted] Gnr [redacted] Sl
Dated 9 Jun 23

GLOSSARY

Acronym/Abbreviation	Definition
AAP	Alcohol Advice Practitioner
Admin	Administration
ABN	Army Briefing Note
ACSO	Army Command Standing Order
AE PID	Authorised Elsewhere PID
AFC (H)	Army Foundation College (Harrogate)
AGAI	Army General Administrative Instruction
APSG	Army Personnel Services Group
ARITC	Army Recruitment Initial Training Command
ASLS	Army (Recruitment Initial Training Command) Staff Leadership School
ATR	Army Training Regiment
AWS	Army Welfare Service
BAS	Bereavement and Aftercare Service
BC	Battery Commander
Bdr	Bombardier
BQMS	Battery Quarter Master Sergeant
BSM	Battery Sergeant Major
Bty	Battery
CA	Convening Authority
CET	Corps Engagement Team
CNO	Casualty Notification Officer
CoC	Chain of Command
CO	Commanding Officer
Col	Colonel
Comd	Commander
Cpl	Corporal
Cse	Course
CVO	Casualty Visiting Officer
DFO	Duty Field Officer
DMICP	Defence Medical Information Capability Programme
ERE	Extra Regimental Employment
Fd	Field
Gnr	Gunner
GOC	General Officer Commanding
Hd A&S	Head of Arms and Services
HQ	Headquarters
INCREP	Incident Report
IOC	Interim Operating Capability
IT	Information Technology
ITT	Initial Trade Training
JCCC	Joint Casualty & Compassionate Centre

JNCO	Junior Non-Commissioned Officer
JPA	Joint Personnel Administration
JSP	Joint Service Publication
LA	Learning Account
LAR	Learning Account Review
LBdr	Lance Bombardier
LEGAD	Legal Advisor
Lt Col	Lieutenant Colonel
LONDIST	London District
LWC	Land Warfare Centre
Maj	Major
MOD	Ministry of Defence
MoU	Memorandum of Understanding
NOD	Non-Operational Death
NOTICAS	Notification Of Casualty (Report)
OC	Officer Commanding
OIC	Officer In Command
Ofsted	Office for Standards in Education
PAP	Potentially Affected Person
PIR	Post Inquest Report
PNC	Police National Computer
PT	Physical Training
QM	Quartermaster
RA	Royal Artillery
RA BSM	Royal Artillery Battery Sergeant Major
RA CET	Royal Artillery Corps Engagement Team
RASM	Royal Artillery Sergeant Major
Regt	Regiment
RCMO	Regimental Career Management Officer
RFO	Regimental Field Officer
RHQ RA	Regimental Headquarters Royal Artillery
RMO	Regimental Medical Officer
RMP	Royal Military Police
ROO	Regimental Orderly Officer
ROS	Regimental Orderly Sergeant
RRB	Recruit Record Book
RSM	Regimental Sergeant Major
SCD	Supervisory Care Directive
Sgt	Sergeant
SH	Self Harm
SI	Service Inquiry
SIB	Special Investigation Branch
SLA	Single Living Accommodation
SME	Subject Matter Expert
SNCO	Senior Non-Commissioned Officer
SO2	Staff Officer Grade 2 (Major)
SP	Service Person or Personnel
Sp	Support
Sqn	Squadron
SSgt	Staff Sergeant

SuT	Soldier Under Training
SVRM	Suicide Vulnerability Risk Management
Tp	Troop
TOR	Terms Of Reference
TRiM	Trauma Risk Management
Trg Wg	Training Wing
Trg WO	Training Warrant Officer
TRiM	Trauma Risk Management
UAA	Unit Alcohol Advisor
UAS	Uncrewed Aerial Systems
UHC	Unit Health Committee
UWO	Unit Welfare Officer
UWSNCO	Unit Welfare Senior Non-Commissioned Officer
UWWO	Unit Welfare Warrant Officer
VLO	Victim Liaison Officer
VRMIS	Vulnerable Risk Management Information System
VUC	Violent or Unnatural Causes
VCR	Verbatim Court Recorder
WFH	Working From Home
WIP	Workplace Induction Programme
WO1	Warrant Officer Class One
WO2	Warrant Officer Class Two