ARMY

SERVICE INQUIRY

ARMY PERSONNEL SERVICES GROUP

Service Inquiry into the death of a Service Person who was found in their Single Living Accommodation in Catterick on 5 February 2022

25 July 2023

Section 1 – Executive Summary

Issue

1. On 16 Sep 22, Head Army Personnel Service Group (APSG), in their role as a Single Service Inquiry Co-Ordinator (Army) (SSIC(A)), directed a Service Inquiry (SI) into the circumstances surrounding the death of Highlander (Hldr) [redacted] at Richmondshire Lines, Catterick Garrison on 05 Feb 22. Thereafter, General Officer Commanding 1st (United Kingdom) Division (GOC 1(UK) Div) convened a SI on 26 Sep 22.

2. This is an executive summary of that SI, outlining what happened, what was learned and what actions have taken place as a result of the recommendations. The SI involved hearing oral evidence from twenty-two witnesses, and eighteen witness statements, consisting of family members, medical professionals, members of the unit, friends and other unit members who knew the Service Person (SP).

3. The SI Panel wish to express our deepest condolence to the family for their loss.

What happened?

4. Hldr [redacted] unit had concerns for his [redacted] health shortly after the death of his close friend in Aug 21. He was assessed by [redacted] Garrison Medical Centre (CGMC) in Sep 21 where his presentation was deemed not related to [redacted] health. He at this point was not added to the Vulnerability Risk Management Information System (VRMIS). In Jan 22 his [redacted] health significantly deteriorated with him admitting to his Chain of Command (CoC) to having attempted to take his life three times between Sep and Oct 21. At this point he was added to VRMIS, and a Care Action Plan (CAP) was created. He was subsequently seen at CGMC where an urgent referral was made for him to be seen by the Department of Community Mental Health (DCMH) [redacted]

5. Whilst under the care of DCMH [redacted] Hldr [redacted] had a total of five consultations and was offered the opportunity to be admitted into a place of safety as an inpatient on three occasions. He declined admission on all three occasions. His fifth consultation was on the [redacted] Feb 22 prior to him starting a period of sick leave. He was due to remain in barracks for the duration of his leave. In the early hours of the morning of the 05 Feb 22 Richmondshire Lines Guard room was contacted by a close friend of his who was concerned for Hldr [redacted] welfare. Two members of the guard were tasked to carry out a welfare check of him. Hldr [redacted] was subsequently found in his room unresponsive.

What have we learned?

6. Key causal and aggravating factors – Hldr [redacted] had a well-established history of poor [redacted] health. Whilst in service he had previously [redacted] in 2012 and in 2014. Throughout this period of poor [redacted] health, he was receiving appropriate medical care and support by his CoC. The factors identified during both these attempts, such as him experiencing relationship issues, debt, poor sleep, and consuming excessive quantities of alcohol, were also present during his recent episodes of poor [redacted] health in 2021 and 2022. However, the most recent episode also included additional factors such as the recent death of a very close friend, a lack of career progression and separation issues from his family.

7. As a result of a difficult consultation with the duty doctor in Sep 21 it was reported that Hldr [redacted] likely lost trust with the duty doctor therefore may have been reluctant to seek further medical help. The SI established that throughout his time in the Army it was always the concerns raised by others that would lead to him seeking help for his poor [redacted] health and that his reluctance to seek help may always have been present. The SI established two specific causal factors during the day leading up to Hldr [redacted] death. These were the drinking of excessive quantities of alcohol by him as well as social isolation.

8. The SI identified several missed opportunities that significantly hampered the efforts of others to help him. Of note, is the inadequate Read coding of significant [redacted] health presentations on Hldr [redacted] medical notes throughout his service. The consequence was that it was difficult for subsequent clinicians to identify if he had any previous [redacted] health vulnerabilities or issues. Of additional note was the significant shortfall of Consultant Psychiatrists against the numbers required to fill the authorised posts within all DCMH establishments which had resulted in a longer waiting list for routine appointments than might reasonably have been expected given clinical best practice guidelines.

9. The SI has identified forty-one recommendations. These are grouped into the following areas:

a. **Unit led actions.** Four recommendations are specific to the [redacted] Battalion, The Royal Regiment of Scotland ([redacted] SCOTS), covering the following areas:

(1) Review of the unit alcohol policy to provide a more effective method of monitoring alcohol consumption within the Single Living Accommodation (SLA).

(2) Consider whether there should be a limit to the quantity of alcohol permitted to be stored in the SLA by service persons.

(3) Ensure that all personnel are Moved and Tracked correctly on Joint Personnel Administration (JPA) in accordance with policy JSP 756.

(4) Remind all unit primary support staff that in "Any situation where an adult is at risk of serious harm", they must be referred immediately to Army Welfare Service (AWS) as stated in Vol 3, (Army General Administrative Induction (AGAI) 81.

b. **Policy and Procedures.** Eight recommendations require current policy to be reviewed and amended.

c. **Defence Primary Health Care (DPHC).** There are thirteen recommendations specific to DPHC policies and record keeping. Recommendations include a requirement to address the current significant shortfall of filled Consultant Psychiatrist PIDs[1] within all DCMH establishments as well as to further investigate clinical culture within CGMC.

[1] Joint Personal Administration Position Identifier (JPA PID), is a seven-digit unique number, identifying each post within Defence.

d. **Army HQ, Senior Health Advisor (Army) (SHA(A)).** There are eight recommendations pertaining to SHA(A) procedures and policies. These include two recommendations for a VRMIS system upgrade which would include a system programme change. One recommendation includes the possible requirement to investigate all recent deaths within the unit from the period 2018 - 2022 in order to identify whether the unit had experienced a suicide cluster. Consideration of whether this should be expanded to include other units within [redacted] Garrison must be included.

e. **Field Army Support Medical Deputy Assistant Chief of Staff (DACOS).** There are three recommendations which outline the requirement to investigate further the serious concerns raised over the clinician's performance in this case specifically related to a single interaction in Sep 21 as well as to establish whether or not an opportunity to diagnose poor [redacted] health was missed.

f. **HQ Field Army and HQ Home Command** Both organisations have three recommendations each. These are reminders to all units regarding the timely referral to AWS, adherence to policy and the importance of engaging with their Senior Medical Officer (SMO) to report any issues when they suspect a breakdown has occurred in the Doctor/Patient relationship.

10. These recommendations, their associated progress and evidence of closure criteria being met are tracked in detail through the APSG Lessons Fusion Cell by SO1 Lessons and SO1 Organisational Learning

What progress have we made?

11. The recommendations have already been disclosed to the Senior Point of Authority (SPA), agreed, and endorsed.[2] Eight of the recommendations have now been actioned and closed by the SPA with all remaining recommendations (less one) due to be actioned and closed by the end of Dec 23.[3]

12. This investigation has identified a significant number of issues, many of them specific to Defence's Medical Services (DMS) and the provision of holistic medical support. Command DPHC and Field Army Support Medical (DACOS) have agreed to fully investigate these issues.

Maj I Main LANCS
President of the Service Inquiry

4 March 2024 - Context: The Next of Kin of Hldr [redacted] requested a briefing by the SI President, due to the President leaving the Service this was undertaken by one of the panel members. The brief took place on [redacted] Jan 24 and the Next of Kin provided new evidence in the form of message on Hldr [redacted] phone. Review of the new evidence was assessed as critical therefore the SSIC(A) agreed to an Addendum being added – the Next of Kin and coroner were made aware. There are no amendments to the body of the report – Section 6 is the addendum which explains the new evidence from the family briefing, there are also no amendments to the recommendations of this report.

[2] The SPA is the individual (ideally minimum Band B/OF5 grade/rank) who is held accountable by the Senior Gatekeeper (SG) for implementing the required action.
[3] One recommendation is incorporated as part of a planned system change that is due by 31 Mar 24. This recommendation will be closed then.

25 Jul 23

Service Inquiry into the death of [redacted] Hldr [redacted] on 5 Feb 22.

1. The Service Inquiry Panel formally convened at York on 26 Sep 22 by order of Major General T J Bateman for the purpose of investigating the death of [redacted] Highlander [redacted] who died of Violent or Unnatural Causes in Single Living Accommodation on 05 Feb 22.

2. The following inquiry papers are enclosed:

a. **Section 1** – Executive Summary.

b. **Section 2** – Narrative of Events, Findings and Analysis.

c. **Section 3** – Recommendations and Observations.

d. **Section 4** – Convening Authority Comments.

e. **Section 5** – Reviewing Authority Comments.

f. **Section 6** – Addendum following the Next of Kin brief.

g. **Section 7** – Convening Authority Comments following the Addendum.

h. **Section 8** – Reviewing Authority Comments following the Addendum.

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

j. **Annex B** – Glossary.

3. The SI report was co-authored by Maj [redacted] LANCS and Maj [redacted] RAMC.

President

Maj [redacted] Main LANCS
President of the Service Inquiry
Army Personnel Services Group (APSG)

Members

Panel Member	Panel Member	Panel Member
Maj [redacted] RAMC	Maj [redacted] QARANC	SSgt [redacted] RE

25 July 2023

Section 2 – Narrative of Events, Findings and Analysis

Pre-Event 2009 - 2013

1. **Enlistment into the Army 2009**. The SP (Hldr [redacted] enlisted into the regular Army in Oct 09.[4] His initial training was at the Infantry Training Centre (ITC) [redacted] from [redacted] Oct 09 to the [redacted] Apr 10.[5] The SP joined [redacted] SCOTS on [redacted] May 10. [F6.16]

2. **Deployment 2010**. The SP deployed with his battalion on Op HERRICK 13.[6] [F6.17 F6.18] The SP reported that whilst he was deployed, he experienced some relationship difficulties at home, and that he had witnessed the death of a friend.[7] [F22.1] Both the SP and his spouse reported that he had struggled to adapt following his return home from tour. Upon his return the SP reported increased alcohol consumption which helped him to sleep and deal with frequent episodes of anger and irritability. [F22.1]

3. [redacted] **attempts 2012.** The SP was treated in the Emergency Department at [redacted] hospital on the evening of 8 Jan 12 following several serious attempts to take his own life. [F22.22] These attempts included an [redacted] The SP also informed hospital staff about two recent attempts [redacted][8] Additionally, his spouse reported that on one occasion, leading up to this admission, she had woken with the SP's hands around her neck. However, the SP stated that he had no recollection of this ever happening. [F22.22] The SP, during this period, denied any previous contact with [redacted] health services to his General Practitioner (GP) but did say that he had experienced anger management problems before he had joined the Army.[9] [F22.22]

4. **First admission to an Inpatient Service Provider (ISP) [redacted] Jan 2012.** Following the attempted [redacted] the SP agreed to an informal admission to the [redacted] ward, an ISP located at the [redacted] Hospital in [redacted] Kent. [F22.21] This admission lasted six days. The SP's hospital discharge letter stated that the civilian [redacted] health team had identified that the SP appeared to need counselling for Post-Traumatic Stress Disorder (PTSD) and that any treatment for PTSD would be better set up and facilitated by the Army.[F22.21] [redacted] SCOTS acknowledged that the SP was at risk of further self-harm and therefore added him to the Army Suicide Vulnerability Risk Management (SVRM) Register on the [redacted] Jan 12. [F12.11] The SP was referred to the Department of Community Mental Health (DCMH) [redacted] on the [redacted] Jan 12. [F22.20]

5. **SP's early removal from the SVRM Register.** In 2012, policy stated that any individual attempting [redacted] is to be automatically placed on the SVRM Register for a minimum period of two years. [F7.4] However, the SP was removed from the SVRM by [redacted]

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[4] SP had prior service as a Reservist with [redacted] Jul 08 - Oct 09. [F6.17]
[5] The SP's Initial Medical Assessment dated [redacted] Oct 09 records that he denied any current or past [redacted] health issues and no previous self-harm or attempted suicides were recorded. [F38.3]
[6] Codename for British operations in Afghanistan from Oct 2010 to Apr 2011.
[7] All personnel who deployed on this operation received a one-to-one interview with a member of their units hierarchy upon their return to the UK. This was known as Post Operational Stress Management (POSM). The incident in which the SP claims he witnessed his friend's death was not recorded on the SP's POSM record. [F20.22] The SI Panel confirmed that the [redacted] Battalion, The Royal Regiment of Scotland ([redacted] SCOTS) did lose one soldier as the result of an Improvised Explosive Device (IED) and that this soldier was in the SP's Rifle Company, but no evidence was found which could confirm that the SP witnessed the event. [F25.18 & F25.19]
[8] Spouse found SP [redacted] [F22.23]
[9] Evidence collected by the SI Panel shows that the SP had previously attempted [redacted] when they were [redacted] years old and subsequently received treatment for anger management. [F22.21]

SCOTS Unit Welfare Officer (UWO) fifteen months early and whilst still under the care of DCMH [redacted][10] [F12.11 F11.3] It is the opinion of the SI Panel that the early removal from the SVRM hindered understanding and management of the SP's situation and condition when he was assigned to a new battalion ([redacted] SCOTS). By policy definition, he was still vulnerable and at risk despite being removed prematurely from the SVRM Register, but there was no formal marker to alert his new battalion to this. [11] [12]

6. **SP's CAP not given to new unit or attached to medical notes.** When the SP moved from [redacted] SCOTS to [redacted] SCOTS, the losing unit did not forward the SP's CAP to the gaining unit.[13] Policy stated that the losing unit must forward the CAP to the gaining unit in order to inform the SP's new unit of any past or present issues. The SI Panel are of the opinion that not forwarding the CAP amounted to a missed opportunity to make his new unit aware of the SP's recent poor [redacted] health, vulnerability, and risk. At the time, policy also stated that a copy of the SP's CAP should have been added to his medical records. This did not occur.[14] [F7.4]

7. **Second admission to an ISP [redacted] Jan - [redacted] Feb 2012.** On [redacted] Jan 12, the SP volunteered for his second inpatient admission. He was admitted to the [redacted] Centre, an ISP in Peterborough, following concerns that the SP could not keep himself safe in the community. [F22.32] The SP's parent unit reported that the SP had consumed significant and excessive quantities of alcohol during the weekend leading up to the inpatient admission. On the day prior to admission and whilst alone in his married quarter, the SP caused significant damage to it. It had been reported that there had been similar incidents previously, but the incidents now appeared to be increasing in frequency and severity. [F22.25 F22.32]

8. The SP's admission lasted thirteen days. During the admission the SP was diagnosed with PTSD and moderate depression and was thought to have been harmfully consuming alcohol in order to lessen the impact of the anxiety and insomnia symptoms he had been experiencing. [F22.25] The PTSD was thought to be related to events whilst the SP was serving in Afghanistan. Throughout his admission, the SP was worried about the degree to which his occupation was causing him stress and agitation and that he thought that he may no longer be suitable for the Armed Forces. [F22.25] The military Community Mental Health Nurse (CMHN) recorded the requirement to seek clarification of the SP's time spent in Afghanistan during his initial assessment at DCMH [redacted] However, further clarification of the events or confirmation of the diagnosis were never recorded onto his medical notes. The SI Panel are of the opinion that further clarification of the events in Afghanistan leading up to the diagnosis of PTSD was required. The SI Panel also feel that the diagnosis of PTSD should have been confirmed, further assessed and documented on his medical notes by DCMH [redacted] whilst under their care.

9. **Arrested and charged for Drink Driving [redacted] Feb 12.** Six days following his discharge from the [redacted] Centre in Peterborough, the SP was arrested and charged with drink driving. At this time, he underwent a telephone review with the DCMH [redacted] [F22.28 F11.6]

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[10] The Annex F (SVRM) Policy used by the UWO to remove the SP from the unit SVRM Register did not record the reason for his removal or the name of who authorised it.
[11] Due to [redacted] SCOTS reducing to a single Light Infantry Company "Balaklava Company" in Jun 2013 in accordance with Army 2020 structural changes the SI panel was only able to establish limited evidence of the actions carried out by the unit in support of the SP at this time.
[12] See recommendation section 3u.
[13] The CAP is a chronological version of events that demonstrates how the SP is being actively managed and supported by the CoC during times of vulnerability and risk.
[14] See recommendation section 3v.

10. **First review with DCMH [redacted] following inpatient discharge [redacted] Feb 12.** The SP, accompanied by his spouse, was reviewed by the CMHN on [redacted] Feb 12. The CMHN recorded that the SP denied any current suicidal thoughts. He reported that he continued to have thoughts of hopelessness but felt better able to manage these thoughts. The CMHN also recorded the requirement to discuss the SP's case with the Consultant Psychiatrist with regard to the SP's medication and Joint Medical Employment Standards (JMES) grading.[15] [F22.1] The CMHN continued to treat the SP until his discharge from DCMH [redacted] in Mar 13. The SP, along with his family at the time, left [redacted] SCOTS to join [redacted] SCOTS in Germany in Jul 13. [F6.16 F11.3]

11. **JMES grading not altered.** During this period of poor [redacted] health in 2012, the SP should have been medically downgraded and prevented from undertaking safety critical duties but was not. There is compelling evidence from the Consultant Psychiatrist's discharge letter dated [redacted] Jan 12, which not only identifies a [redacted] health diagnosis, but also records medication prescribed to the SP which would have ultimately required his immediate medical downgrading. [F22.25 F12.14] Despite this he does not appear to have been recommended to have been downgraded by DCMH [redacted] or actually downgraded by the Regiment Medical Officer (RMO). [F22.18] The SI Panel have been unable to identify why the patient was not downgraded during this period. [F36.9]

12. **Alert Codes and Read codes.** The notes entered on the Defence Medical Information Capability Programme (DMICP)[16] were inadequately Read coded during this time. Read codes are a coded thesaurus of clinical terms. They have been used by the National Health Service (NHS) and other healthcare organisations since 1985. Once entered onto a patient's electronic medical notes, they will function as an *electronic tag* and make it much easier for other health care professionals to access the patient's notes and to easily see or search for specific clinical diagnoses. Correctly Read coded diagnoses appear in summary format at the very front of the patient's notes. During the SP's voluntary admissions to [redacted] health care facilities in 2012, some significant [redacted] health diagnoses were made. These diagnoses were inadequately recorded onto the SP's primary healthcare notes thus rendering them very difficult to find. The consequence of not using the appropriate Read codes was that it was difficult for subsequent clinicians to identify if there were any previous [redacted] health vulnerabilities or issues.

13. Evidence gained from his DMICP notes would indicate a lack of adequate Read coding throughout, especially with regard to the SP's [redacted] attempt in Jan 12. Apart from one Read code entry being incorrectly Read coded as a minor problem and located towards the very bottom of the minor problem list, (thus very difficult to find), no [redacted] health Read codes pertaining to the SP's poor [redacted] health in 2012 appeared within the significant problems section of DMICP. The Read coding was inadequate.

14. The SI Panel are of the opinion that had the SP's condition been adequately Read coded in 2012, it would have ensured that all clinicians and medical staff had the ability to build a comprehensive search, thus enabling them to have gained a clearer understanding of the SP's previous [redacted] health history. As it stands, despite having attempted to [redacted] twice and also having been readmitted to an ISP, there is only a single episode entitled '[redacted] health review' Read coded in the minors section of

[15] JMES grading is used to inform commanders and career managers of the employability and deployability of Army personnel. It is often referred to as their 'working grade.'
[16] DMICP is the primary patient management and record database system used throughout Defence – at home, overseas, on operations and exercises, on land and at sea.

the SP's problem list on DMICP. This appears as the 81st minor entry, some 202 lines down the minor problems list.

15. It was only possible to identify that the SP had suffered from poor [redacted] health during 2012 by reading through the significant problems list followed by the 202 lines of minor problems. Only then could anyone reviewing his notes have identified a Read code which alludes to [redacted] health issues. Even then the information is potentially insufficient as it does not portray the true magnitude of the SP's problem. The SI Panel are of the opinion that owing to the inadequate Read coding of significant [redacted] health presentations, the entirety of the SP's medical records would likely need to have been reviewed in order to confirm that there were no additional periods of [redacted] health presentations which were hidden due to not being Read coded at all. A process which can take hours and days without Read codes, as opposed to minutes with them.[17]

Narrative, Findings and Analysis continued 2014 – 2021

16. [redacted] **Attempt** [redacted] **Mar 14.** The SP was treated at the [redacted] Hospital, [redacted] Germany on the evening of [redacted] Mar 14 having once again attempted to take his own life. The SP, whilst consuming alcohol, [redacted][18] [F22.15] The SP discharged himself the following morning and was subsequently seen the same day by a clinician at the Military Medical Centre (MMC) [redacted] During the consultation, the SP explained that leading up to the attempted [redacted] incident, he had just returned home from attending a course to discover that his spouse was leaving him and was taking his [redacted] young children back to the UK. The SP stated that this was completely unexpected and that he believed the reason she was leaving him was because she was fed up with being an Army wife. [F22.15]

17. The SP was assessed as low risk for future self-harm and suicide by clinicians at the MMC in [redacted] Despite this they advised that he be reviewed by the duty CMHN. The SP declined this review. Voluntary admittance into a psychiatric ward was also advised. Again, the SP declined. Clinicians at the MMC Fallingbostel continued to treat the SP in Apr 14. Initially he was treated for emotional upset which was followed by treatment for low mood. Throughout this period, the SP continued to struggle with sleep and was granted lengthy periods of up to twenty-eight days of light duties. [F22.15]

18. **Assistant Unit Welfare Officer (AUWO) Non-reporting of the [redacted] Attempt incident to the SP's parent unit in 2014**. It appears that the [redacted] SCOTS AUWO at the time did not inform his CoC about the SP's second attempted [redacted] Notes recorded on DMICP proved that [redacted] SCOTS AUWO helped to deal with the SP's second [redacted] attempt on [redacted] Mar 14 and liaised with the MMC in Fallingbostel. [F9.11 F22.15] The SI Panel could find no evidence to support that the wider CoC knew that the SP had attempted to take his life on this occasion. The SI Panel feel that had the unit been made aware of this attempt they would likely have added the SP to the SVRM Register. However, this did not happen.

19. If the SP had been added to the SVRM Register, the information regarding the 2014 attempted [redacted] would have been available to the Commanding Officer (CO) and his team during their case conference in Sep 21, during which the CO could not find a

[17] See recommendation section 3a.
[18] Two days prior to this incident the SP was treated by a clinician at the MMC Fallingbostel for emotional upset. SP stated that he was going through a divorce and was struggling to sleep. The SP was bedded down for three days and prescribed medication to assist him with sleeping. [F22.15]

reason to put the SP onto the VRMIS.[19] [20] The SI Panel are keen to point out that when the CO was eventually informed of the SP's attempted [redacted] in 2014, during the VRMIS case conference in Jan 22, he reported that he was 'extremely concerned given this is a presentation he [the SP] has made several times in the past in SCOTS unit memory both in Germany and the UK.' [F22.18 F1.1] The SI Panel consider this a likely missed opportunity by the then [redacted] SCOTS AUWO to record a significant incident of attempted [redacted] which could have helped the SP's future CO make decisions regarding the SP's welfare, especially considering the deterioration which was observed following the SP not being added to VRMIS in Sep 21.

20. **Alert Codes and Read codes.** The SP's [redacted] attempt in 2014 was inadequately Read coded. [F22.15] During this period only three Read codes appear and are incorrectly located in the minor problems section of DMICP.[21] As with the inadequate Read coding in 2012, the inadequate Read coding in 2014 made it difficult for subsequent clinicians to identify any previous [redacted] health problems, vulnerabilities or risk. The SI Panel found no evidence that the clinicians treating the SP in 2014 were aware of the previous attempted [redacted] in 2012.[22] The SI Panel also noted that the SP declined both DCMH input and admission to an inpatient facility, despite the advice of clinicians at the time. [F22.15]

21. **JMES grading not altered.** In line with policy at the time, a single episode of depression should normally attract a Medically Non-Deployable (MND) category for a total of twelve months, particularly if medication is being used.[23] [F26.3 F36.9] Policy also stated that all significant episodes of self-harm should have been reviewed by DCMH. This review should have included a consideration of the SP's JMES grading and whether or not his recurrent [redacted] and poor [redacted] health was compatible with military service. [F12.12] This was the SP's second documented [redacted] whilst in service as well as one documented attempt prior to service. The SP was not downgraded and was still considered to be Medically Fully Deployable (MFD) during this period of time. The SI Panel are of the opinion that the SP should have been medically downgraded and considered for a Medical Discharge from service, by the Military Medical Services, in line with policy. It appears that the medical chain as a whole missed the opportunity to apply this policy. However, owing to the passage of time the SI Panel have been unable to ascertain the specific reasons behind this omission. By not downgrading the SP, the SI Panel is further of the opinion that future clinicians were disadvantaged in their ability to identify previous psychiatric history. [24]

22. **Regimental Support Team (RST) [redacted] 2019-2021.** In 2019, the SP was assigned as part of the RST to assist in recruitment.[25] His spouse described at this point that having the SP at home in [redacted] for so long was *"the best thing ever."*[26] She also mentioned however that the SP was stressed as he had so many hurdles to deal with, including separating from his first wife, and issues surrounding his pending divorce.[27]

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[19] VRMIS provides a platform for the recording and management of individuals identified at risk and replaced the paper-based system (SVRM).

[20] The SI Panel were able to establish the SP's admittance onto the SVRM register following his first attempted [redacted] in 2012 via Army Pers-Health and are of the opinion that the CoC could have done this in 2021. [F12.11]

[21] The Read codes recorded in the minor problems section were [redacted], low mood and emotional upset.

[22] During the time that the SP was treated for poo[redacted] health in 2014, there is no reference in any of the clinical notes that refers to the [redacted] in 2012.

[23] [redacted] [F22.18]

[24] See recommendation section 3n.

[25] Based in [redacted] The SI Panel were able to establish that the SP was assigned for family reasons. The exact reason could not be ascertained. [F36.23]

[26] By this point his second wife.

[27] [redacted] [F20.5]

Throughout this period, the SP's [redacted] health became a concern to his new partner, so much so that she insisted that the SP see a doctor in [redacted][28] [F27.13] The SP's DMICP records show that whilst in [redacted] and apart from his ongoing Muscular Skeletal injury (MSK) rehabilitation appointments and subsequent JMES grading review, the SP was only ever seen once by a clinician for treatment pertaining to a minor medical condition, rather than for anything related to his [redacted] health. [F22.3]

23. **Poor [redacted] whilst with the RST.** The SP's spouse claims that the clinician who saw the SP at [redacted] for treatment pertaining to a minor medical condition was dismissive towards him at the time and said that he needed to grow up. It is worthy of note that the doctor who saw the SP whilst at [redacted] was the same doctor who would eventually be involved in the *"difficult"* consultation in Sep 21 at CGMC.[29] Whilst in [redacted] this doctor did not record any discussion regarding the SP's [redacted] health onto DMICP. The spouse stated that after seeing the clinician, the SP was angry and stated that he was done with asking for help and that he would deal with his issues on his own. She stated that this led to the SP drinking more, and this would often end with the SP then trying to end his life and her always having to stop him. [F27.13] The SI Panel are of the opinion that the SP was suffering with poor [redacted] health whilst attached to the RST but this appears never to have been raised outside of the SP's family and it is unlikely that the Officer Commanding (OC) RST, the [redacted] SCOTS CoC or the doctor in [redacted] were ever made aware of any [redacted] health issues during his time in [redacted]

24. **Deployment 2020.** The SP deployed with his unit on Op TORAL 10.[30] [F38.7] The SP's spouse recalls that he had trouble adjusting back to normality upon his return from Afghanistan. He excessively consumed alcohol during the first few weeks back in the UK before eventually settling back into family life. [F27.13] Prior to the SP returning from tour in Oct 20 he was caught along with other members of the unit sending cigarettes home via the British Forces Post Office mailing system. He was convicted of smuggling at Court Martial in May 21. [F11.7] [redacted] [F27.13]

25. **The lack of career progression by the SP.** During a period of five years and seven months between May 14 and Dec 19, the SP was Medically Fully Deployable for only nine and a half months.[31] [F22.18] The SP experienced both upper and lower limb injuries during this time, which restricted his deployability on operations and is likely to have hindered his ability to promote. Medical notes and witness accounts suggest a negative impact on the SP's self-esteem due to a lack of career progression. [T34.3 F22.18] A close friend reported that every time the SP was put forward for a Potential Junior Non-Commissioned Officers (PJNCO) Cadre, he would suffer an injury and be unable to attend the course.[32] The SP became annoyed when he saw people that he joined the Army with promote through the ranks whilst he was left behind. [T23.6]

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[28] The SI Panel found no evidence that the SP was seen for any [redacted] health condition whilst at home in [redacted]

[29] In her statement to the coroner the SP's sister stated *"I know from my conversation with him [the SP] that the doctor [at [redacted] had told him in not so many words to stop wasting his time, that he basically had a good life that he should be grateful for. We [the SP's family] told him that the doctor was wrong and that how he was feeling needed to be addressed quickly. He eventually went back to [redacted] and went to see a doctor there. He called me just before he went in and said that he was dreading going in there and telling this doctor how he was feeling, that he was burnt out and struggling to sleep. It ended up being the same doctor [who he saw at [redacted] with the same response… When he came out he told me he wasn't going to ask for help anymore because the doctor keeps dismissing him as some attention seeker."* [F1.19]

[30] Op TORAL was the codename for the British presence within Afghanistan post 2014 as part of NATO's Resolute Support Mission.

[31] He was unable to deploy owing to poor medical fitness for four years and nine months in total.

[32] For an Infantry soldier the first step in a combat career is promotion to Lance Corporal. To do this, a soldier must pass a PJNCO Cadre.

26. The SP's Soldiers Joint Appraisal Report (SJAR) in 2015 recommended the SP for promotion. [F1.11] However, witnesses describe the SP being happy in his role within [redacted] SCOTS but showing little motivation to promote. [T23.4] One colleague stated that trying to motivate the SP to attend a PJNCO Cadre was quite hard. [T23.10] The SP's Platoon Commander (Pl Comd) expressed his surprise at how the SP was too comfortable with not promoting and how happy he seemed with having no responsibility. The Pl Comd highlighted that the SP lacked the drive to push himself. [T34.9] The SP's spouse commented that she was always pushing him to attend the PJNCO Cadre, but that he did not want to do it. The SP never promoted during his twelve years in the Army. The SI Panel are of the opinion that whilst injuries likely affected his ability to promote, the evidence suggests that the SP also lacked the drive and motivation to attend his PJNCO Cadre.[33]

27. **Infantry Versatile Engagement Expansion (IVEE) 2021.** As part of the IVEE programme, the SP was offered and accepted to convert his Versatile Engagement (VENG) from a 'Short' twelve year contract to a 'Full' twenty-four year contract meaning that the SP could serve up until 2033.[34] The SP's annual appraisal SJAR for 2020 recommended the SP for conversion to VENG Full.[F1.16] The SP's Company Commander, his immediate Officer Commanding (OC), recalled that when the SP had converted his contract to VENG Full he would now need to fulfil the role as a Rifleman within a Rifle Company. It was now clear to the OC that the SP was not very comfortable with this concept and reluctant to do so. However, the OC had difficulties finding an alternative job for the SP. [35] [T34.10]

28. The SP was offered IVEE on the assumption that he would be able and willing to progress from the junior ranks. The SI Panel feel that although strongly recommended for promotion during periods of his career, the SP was never fit for long enough to be able to successfully prepare for, attend or eventually pass a PJNCO Cadre. There is no evidence to support that extending the SP's contract would have changed this. Additionally, prior to the offer of VENG Full being made, evidence shows that the SP's willingness to progress through the ranks had waned. The SI Panel feel that the decision to offer VENG Full to the SP was not in the best interest of either the SP or the Infantry.[36]

29. **Temporarily Employed Elsewhere (TEE).**[37] The SP was not 'moved and tracked' on JPA[38] by his unit whilst assigned to the RST in [redacted] The administrative responsibility for the SP throughout his time with the RST remained with the parent unit in [redacted] North Yorkshire. He should have been 'moved and tracked' from [redacted] to [redacted] in line with policy.[39] [F38.13 F38.14] This was an incidental finding and whilst the SI Panel accept that lack of movement and tracking oversight is not thought to have directly impacted on the SP's [redacted] health and wellbeing, it is worthy of note as it potentially contributed to a lack of direct and routine oversight of his health and wellbeing.[40]

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[33] See recommendation section 3b and 3c.
[34] As it stood, prior to being offered this extension, the SP would normally have had to leave the Army at the twelve year point due to not reaching the rank of corporal within twelve years.
[35] The decision was taken by the OC to move the SP back into the Company stores which the SP was happy with. [T34.10]
[36] See recommendation section 3ee.
[37] TEE is often referred to as 'Black Economy' and allows army personnel to be temporarily assigned away from their units for a period of duty without an assignment order. [F38.1]
[38] JPA is an electronic-based personnel administration system.
[39] Failure to correctly arrive personnel places unnecessary risk on the accuracy of personal data. Throughout the SP's time at RST JPA showed his location as [redacted] North Yorkshire. [F38.7]
[40] See recommendation section 3z, 3ff.

Narrative, Findings and Analysis continued 2021

30. **Returning to the unit.** Prior to the SP's last deployment on Op TORAL his spouse recalled that the SP did not want to go back to [redacted] as he hated camp. She recalled the SP stating that he would much rather stay at home than be sat in his room, drinking whilst becoming depressed. She stated that he always knew that he would have to go back which affected his mood and made him anxious. [F27.13]

31. The Padre recalled the SP feeling as though living amongst younger Highlanders in the lines made him feel like they were from different worlds. After serving twelve years in the Army most of the SP's initial cohort were now Non-Commissioned Officers (NCOs) or Senior Non-Commissioned Officers (SNCOs) and had moved on. [T23.1] In Aug 21 and prior to returning to [redacted] the SP received the good news that his spouse had fallen pregnant again. His spouse recalled that the SP was excited as well as fearful.[41] [F27.13]

32. **Death of a close friend Aug 21.** A close friend of the SP was found deceased in his Single Living Accommodation (SLA) in barracks in Aug 21, [redacted].[42] The SP's spouse recalled on hearing this news that *"...it was a life changing moment for the family and things were never the same again."* Prior to him returning to camp to help with the funeral preparations, she describes the SP as being depressed as well as distant, and reports that he was no longer talking and was drinking heavily. She recalled that during the rehearsal preparation the SP felt drained. [F27.13] During this time the SP made a request to his OC to be removed from attending the PJNCO Cadre as he claimed that he, *"Didn't think his head was in it."* [43] [T34.10]

33. It was during the rehearsals for the funeral that the SP was first identified as a possible concern by his CoC. The Padre recalled being asked to befriend him by the UWO.[44] [T23.1] This was also the first time that the Padre met with the SP during which he remembers having no concerns, as he recalled times when the SP would laugh and joke as well as times when he would be quite positive, albeit mixed with periods of sadness. [T23.1] The SP's PI Comd recalled receiving a short eulogy for the deceased from the SP, the contents of which concerned the PI Comd enough to ensure that he subsequently forwarded it to the OC. [T34.9 F19.20] The eulogy highlighted to them both just how much the death of his friend had clearly affected the SP and that he was now someone upon whom they would need to keep an eye.[45] [T34.9] Trauma Risk Management (TRIM) was offered by the CoC but was declined by the SP.[46] [F24.23 F8.15] The SP's immediate CoC were of the view during the period shortly following the deceased's death, they recognised that the SP as someone grieving for the loss of his best friend. The PI Comd recalled being advised by the OC to keep a very close eye on the SP. [T34.9]

34. **Friend's funeral [redacted] Sep 21.** Of all the pallbearers, it was the SP that the Company Sergeant Major (CSM) recalled struggling the most during the funeral. The other pallbearers seemed to take it all in their stride, but he remembered the SP being visibly

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[41] The nature of the fear remains undetermined.
[42] The deceased [redacted] from the same unit as the SP, and a very close friend of his. Assistant Coroner [redacted] concluded that this SP's death was as a result of [redacted] on [redacted] May 22.
[43] As planned and prior to the death of his close friend the SP was due to return from RST at the end of Aug 21, start of Sep 21 to attend a PJNCO Cadre.
[44] The Padre recalled establishing a *"bit of a rapport"* with the SP during this time and so felt qualified to identify that the SP was really struggling on the day of the funeral. [T23.1]
[45] The PC recalled that *"I never thought that it was potentially a threat"* or that the issues were *"far more deep-rooted and going to develop into something else."* [T34.9]
[46] TRIM is an initiative that aims to capitalize on the social cohesion available within units by training personnel in the early recognition of symptoms associated with post-traumatic stress.

upset and finding it difficult to carry the coffin.[47] [T23.7] The SP's OC recalled being surprised at the funeral by how close the deceased's family were to the SP. It was at this point the OC realised that this was not just a friend from the military, but a genuinely close friend of the SP's. The OC also recalled that it was at this point that the CSM commented that the SP may be having a relationship with one of the deceased's sisters.[48] [T34.10]

35. The SP's spouse recalled that on the day of the funeral her husband had been very quiet with her and did not speak much. She recalled that as soon as he walked through the door of their home after the funeral, they argued.[49] [F27.13] The argument led to the SP returning to barracks in Yorkshire during the weekend of [redacted] Sep 21, earlier than was anticipated by the unit.[50] The SI Panel are of the opinion that the SP did not want to come back to barracks in Yorkshire and that the thought of returning there negatively affected his already low mood and caused him significant anxiety. Moreover, the SI Panel are also of the opinion that the death of the SP's close friend would have further worsened his poor [redacted] health.

36. **Marital problems.** It was during the weekend of [redacted] Sep 21 whilst socialising together, the SP confided in the AUWO that he was having problems at home and that he and his spouse were not getting on. [T23.6] The CSM stated during interview on [redacted] Sep 21 that the SP's spouse had *"...blocked the SP from her life and chucked him out the house."* [T23.7] The SP's spouse stated that *"...the day he walked out through the door is when her life turned upside down and he left us."* She recalled that whilst back in camp her husband became very nasty and hostile towards her.[51] [F27.13] The SI Panel are of the opinion that the SP and his spouse were likely having relationship issues at this point and would likely have impacted on his already poor [redacted] health.

37. **The growing concerns regarding the SP's [redacted] Health.** It was upon the SP's return to barracks in Yorkshire after the funeral that the CoC started to have growing concerns for his [redacted] health. The OC witnessed first-hand the SP shaking and appearing anxious prior to physical training. He recalled that the SP *"...did not look well and looked, like, pasty, as if he hadn't slept."* He stated that the SP told him that *"...he had thrown up in the shower because he was so anxious about things, and he wasn't feeling well at all."* The OC made the decision that the SP should now be medically assessed, and a Vulnerability Risk Management (VRM) case conference would be convened.[52] [T34.10]

38. At this stage, the OC recalled being concerned that the SP was upset but not concerned that the SP would hurt himself. [T34.10] The PI Comd recalled being in regular contact with the SP at this point and remembered the recurring theme during these contacts was how broken he was "...*I was unaware of the depth of the issues that he*

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[47] [redacted] [T34.10]

[48] There were numerous witness accounts that would indicate that the SP was in a relationship with the deceased friend's sister. The duration and extent of this relationship remains unclear. [F27.13 T34.9 T34.10 T23.6]

[49] The spouse had found out during the funeral that her husband had been drinking with one of the deceased's sisters who the spouse didn't get along with and had suspected her husband had known intimately some years previously. [F27.13]

[50] The SP had been granted one weeks leave after the funeral to return home and spend time with his family.

[51] The spouse claimed at this point she would normally block the SP on her phone as she knew he would end up saying something that he would later regret saying. [F27.13]

[52] VRM is a measured, individual assessment by the CoC with assistance of pastoral, medical and welfare support and is designed to identify those with vulnerability to suicide or self-harm behaviours and provide structure to subsequent management and support. VRM is therefore a G1 Management Tool, at the heart of which is the most basic leadership tenet of 'knowing your people.'

had." [53] [T34.9] The CoC were becoming more aware that the SP's situation was not improving and that there were several other factors of a social and domestic nature that were impacting on the SP's life.

39. The CoC recalled how physically unwell the SP looked. The OC recalled *"I have a very limited experience dealing with* [redacted] *health and I saw a soldier that was clearly struggling with something, but I didn't know what…I was worried because we'd just had a suicide that it may be something along that sort of line,* [redacted] *health."* [T34.10]

40. The OC continued *"…he [the SP] struck me as being a bit anxious. I use that term because we had another soldier at the time who ended up getting discharged…And his [the other soldier] was absolutely anxiety, it was not depression or self-harm, …he was having panic attacks…therefore, at the time I remember thinking [with regard to the SP], you know, anxiety and that sort of stuff was clearly in the back of my mind and, therefore, the way he [the SP] was presenting himself, upset, appeared to be very anxious, very similar actually in terms of like shakiness and all that…"* [T34.10]

41. **Reporting Sick Sep 21.** The CoC sent the SP to [redacted] Garrison Medical Centre (CGMC) on the morning of [redacted] Sep 21, because they were concerned about his [redacted] health. The duty doctor [54] who would eventually see the SP was critical of the CoC's opinion that the SP was suffering from poor [redacted] health. [55] The duty doctor felt that the SP's issues were purely welfare and not [redacted] health related. However, when reviewing individual witness accounts at the time, it is the opinion of the SI Panel that the CoC were justified in being concerned about the SP's [redacted] health.

42. Throughout the period leading up to the funeral and the SP's first presentation at the CGMC, there are an abundance of observations justifying the concern by the CoC for the SP's [redacted] health.

a. By his own admission to the OC, the SP was "*struggling"* and *"not in a good place."* The OC observed "*…seeing him walk forward to me...shaking and like he couldn't control the shake in his hand and saying he hadn't slept and all that…I thought…there's something going on here, it's quite serious."* [T34.10]

b. The PI Comd observed: *"I saw a man who generally could be quite a cheerful, happy chap, but clearly, he was so broken up by this that there was almost a lack of joy in his life that was taken from him." "He was always, he kind of slumped his shoulders, head dipped, walking around…I hardly saw him smile…you could physically see that there was times that he was shaking, he was anxious and, like I said, his demeanour…you know he was hunched over, he wasn't smiling and we were starting to get concerned that…the depth of the issues…was developing into something a bit more."…he spoke to me briefly…he was struggling for money…I'm 95 per cent sure he was saying that he was struggling with sleeping."* [56] [T34.9]

c. The CSM observed: "*…there was a lot that was sort of starting to bring him down,* [redacted] *he still hadn't attended an NCO's cadre at his age; the*

[53] Debt concerns as well as the SP's inability to get a decent amount of sleep was starting to have a further impact on the SP's [redacted] health. The SP's debt issue first became apparent when the SP opened up to the CSM and the PC that he was struggling and wouldn't be able to get up the road and see his family. [T34.9 T23.7]

[54] The duty doctor was a Lieutenant Colonel RMO from another unit with [redacted] Garrison.

[55] The OC stated during interview, that it almost felt like he was being reprimanded by the duty doctor who, according to the OC said, *"…you shouldn't be sending soldiers to me like this, there's nothing we can do with this, this is not a medical problem."*

[56] A friend of the SP who also lived in SLA stated that the SP was having issues with sleep over this period. He recalled. *"He was going a good couple of days without sleep."* [T23,10]

death of his close friend; and then, if this was the day just after the funeral, she had essentially blocked him from…her life…and chucked him out the house. So, when he had made all that evident to us, that's when we started getting concerned that, with what's just happened with [SP's deceased friend] with similar sort of instances, that we should now be focusing on him." [T23.7]

43. **Sick Parade.** When the SP arrived at CGMC he was initially seen by a Combat Medical Technician (CMT). [F22.15] The CMT recalled that she and other CMTs working within CGMC had received very little direction on how to deal with [redacted] health patients. [F9.15 F9.16] She stated that CMTs were to refer [redacted] health patients towards the duty doctor, having first exhausted all other routes, such as the UWO and Padre.[57] The CMT recalled having spoken with the SP that he was struggling to deal with the death of his close friend and several different domestic issues. The CMT recalled *"it was quickly highlighted that there wasn't much I could do for [the SP] other than refer him to the doctor as the next line of help."* The CMT stated *"I can just recall that he was clearly a man needing help. He was really quiet and timid and not too enthusiastic about sharing much detail."* [58] [F27.17]

44. On engaging with the duty doctor the CMT recalled that the doctor was dismissive and initially refused to see the patient.[59] The CMT distinctly recalled having to ask the same doctor three times, within the space of one hour, before the doctor reluctantly then agreed to see the SP. [F9.15 F9.16 F9.18] The duty doctor refutes this and stated that the DMICP time stamp evidence suggests that the CMT only had a five-minute window of opportunity to request that he see the SP.[60] However, the SI Panel established a likely window of opportunity of no less than eight minutes and no greater than fourteen minutes in which the CMT could have requested that the duty doctor see the SP.[61] The SP was added by the CMT to the duty doctor patient list, and he was subsequently then seen by the duty doctor that afternoon. [F30.3] It is the opinion of the SI Panel that the CMT was justified in their concern regarding the SP's [redacted] health to the degree that she felt the duty doctor's opinion was required.

45. **CMT mental health training and guidance.** The CMT who initially assessed the SP at the sick parade in Sep 21 raised concerns about the general lack of formal mental health training received by CMTs. At the time of the SP's presentation, the Medic's Primary Health Care Treatment Protocol (MPHCTP), third Edition, did not include mental health guidance. Mental Health Conditions were subsequently included in the revised fourth edition. [F33.5 F33.2] The revised MPHCTP now offers CMTs the guidance that they may need to seek, with formal mental health training being provided on CMT 1 courses from Jun 23.[62] [F33.6, F33.7] The SI Panel feel that the issues surrounding CMT mental

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[57] Medic's Primary Health Care Treatment Protocol, third Edition which is one of a set of publications used by CMTs in the delivery of Primary Medical Care at the time did not include mental health guidance. Mental Health Conditions was subsequently included in the revised edition 4 dated 04 Jan 23. [F33.5 F33.2]

[58] The CMT also stated "*I could tell that he was reluctant to even be in the situation of having to talk to me but clearly wanted help. I remember using my own perspective at this point on how I would be feeling if my best friend had just* [redacted] *alongside a relationship breakdown and that was enough for me to know he was struggling.*" [F27.17]

[59] The CMT recalled that the duty doctor on declining to see the SP said that the medic should instruct the SP to go back to his unit welfare, even though it was the unit welfare who had first encouraged the SP to report sick. [F9.15]

[60] The DMICP system can be used to log the timings of specific points in the SP's consultation. 'Arrival', 'Sent for' and 'left' are all time stamped onto the system. However, the SI Panel are aware that these time stamps may not be a true reflection of the actual timings.

[61] This likely window of opportunity was discussed with the CMT, who is insistent that they immediately went to see the duty doctor whereupon he refused to see the SP and instead sent her away to gain more information which she did before returning to update the duty doctor. The CMT recalled that during each separate occasion that she raised her concerns regarding the SP's welfare with the duty doctor, she was met with deflective questions from him and that it was not until the third time of seeing the duty doctor that he agreed to see the SP.

[62] A pilot Mental Health Module for CMTs took place in early Jun 23 at the Defence Medical Academy (DMA) Whittington. [F33.6]

health training and guidance, which existed at the time of the SP's initial presentation in Sep 21, have subsequently been addressed.

46. **A difficult consultation.** Following the initial assessment by the CMT, the duty doctor eventually agreed to see the SP. The duty doctor recalled that the consultation with the SP *"was not the easiest"* and stated when asking questions that he felt that the SP became *"quite defensive."* [T23.8] The doctor's overall impression of the SP at that point was that he looked *"particularly bewildered and confused,"* and that the doctor *"honestly thought that the SP did not understand how he'd ended up where he was."* The UWO who had referred the SP to CGMC received a phone call from the duty doctor shortly after the consultation with the SP. [T23.9] The UWO recalled that the duty doctor's opinion at the time was that the SP was unable to answer any of his questions and that he found it *"quite incredulous"* that the SP couldn't even give basic answers to simple questions. The UWO is of the opinion that the medical consultation had *"soured"* and believed that this was because the duty doctor couldn't get the right answers to his questions, therefore, *"maybe assumed that the SP wasn't telling the truth."* [T23.9]

47. The OC recalled seeing the SP shortly after his medical consultation, and that the SP appeared clearly to be very upset, and as though he had been crying. The OC also recalled that the SP was shaking, and that he was angry about how he had just been treated during his interactions with the duty doctor. [T34.10] The SP reported that his consultation had been *"horrific"*, and that 'it was an *"absolutely horrendous experience"* stating that the duty doctor *"had just had a go at him"*, had essentially challenged the SP on why he was not dealing with things in his life and had told him there was nothing wrong with him. Shortly after speaking with the SP, the OC recalled receiving a phone call from the duty doctor who described the consultation with the SP as being confrontational.[63] [64] [T34.10]

48. The OC stated during interview, that it almost felt like he was being reprimanded by the duty doctor who, according to the OC said, *"...you shouldn't be sending soldiers to me like this, there's nothing we can do with this, this is not a medical problem."* [65] [T34.10] The OC also recalled that the duty doctor described the SP as a soldier of *"below average intelligence"* who was struggling to deal with the issues in his life and that *"there was nothing medically wrong with him and not to waste his time."* [66] The PI Comd stated during interview that he had previously agreed to meet up with the SP immediately after the medical appointment. He recalled seeing the SP walking from CGMC and that he was visibly *"...shaking, irate, frustrated and wound up."* [T34.9]

49. The PI Comd recalled that the SP felt that the duty doctor had *"bullied him"* which left the SP now feeling *"uncomfortable"* and that he *"no longer had confidence in the medical chain."* The SP at this point was adamant that he never wanted to see any doctor again.[67] [T34.9] The SI Panel are concerned that the atmosphere within the doctor's

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[63] The duty doctor during interview could not recall speaking either with the UWO or the OC regarding the SP. [T23.8]

[64] The duty doctor during interview could not recall using the word confrontational but does recall that it was at times, being a difficult consultation. [F23.8] The OC thought that the doctor had called him because he knew that the doctor, maybe had overstepped the mark or that the consultation hadn't gone well, and that the doctor was maybe trying to cover themselves. [T34.10]

[65] The OC recalled the duty doctor stated that *"I had to push him hard to see if he could handle his problems."* The duty doctor during interview stated that the OC's comment was a genuine misunderstanding on the part of the OC. [T34.10]

[66] The OC's recollection is written in the Learning Account (LA) and was also recalled during interview, stating that the clinician said that the SP was "of below-average intelligence" and *"nothing wrong with him."* The duty doctor utterly refuted the OC's claim and stated that if he had said something it would have been on the lines of "*This gentleman is emotionally immature*," and *"There was currently nothing medically wrong with the SP insofar as he did not have a [redacted] health diagnosis."* [F8.8]

[67] The PC recalled that the SP was aware that he was unwell hence why he had agreed to attend the medical centre to hopefully get help. [T34.9]

consultation room at this point would likely not have been conducive to an effective consultation between the duty doctor and the SP.

50. **Loss of Trust.** The General Medical Council (GMC) publication 'Duties of a Doctor' advocates that patients must be able to trust doctors with their lives and health. [F17.7] To justify that trust, a doctor must show respect for human life and make sure their practice meets the standards expected of a doctor. The SI Panel are of the opinion that there is an abundance of accounts from numerous members of the SP's CoC and from the duty doctor which suggests that during the consultation the patient doctor relationship had broken down and subsequently the trust that the patient had with the duty doctor was lost. [T34.10 T34.9 T23.9 T23.7 T23.6 T23.8] The SI Panel are also of the opinion that the duty doctor's practice may also have fallen short of the standards outlined by the GMC, which may have had an impact on the SP's [redacted] health. The SP had openly declared to his friends and CoC that he had lost trust in the medical chain. The SI Panel note that the duty doctor accepts it was a difficult consultation but did refute some of the claims made by the CoC. It is important to note that the COC at no point raised their concerns about this consultation to the medical chain at the time.[68] The SI Panel feel that this issue is beyond the scope of the inquiry and recommends that this event be fully investigated by a more appropriate authority.[69]

51. **Lack of communication between the CoC and the duty doctor.** The duty doctor recalled being *"disappointed but not surprised"* that there had been no contact from the unit to give him any prior context or warning that the SP was coming to CGMC, and as such the SP had in the duty doctor's view "*attended cold.*" [70] [T23.8] When asked to explain the implications of attending cold, the duty doctor stated that he would be unprepared and that he was denied the opportunity to search the records for any previous similar presentations before calling the patient into his office. The CoC did not inform anyone within the medical chain of the SP's proposed attendance at CGMC. It is the opinion of the SI Panel that an opportunity for the duty doctor to be briefed by the CoC with regard to their growing concerns over the SP's [redacted] health, prior to the SP presenting at the medical centre, was missed, and subsequently disadvantaged the duty doctor.

52. **Lack of communication between the duty doctor and the CoC.** Following the consultation between the duty doctor and the SP, the duty doctor did not deem it necessary to review the SP's previous medical records. The duty doctor justified this by referring to the fact that neither the SP nor the CoC had communicated anything significant enough to warrant a review of the SP's notes. The duty doctor felt that he had identified the nature of the presentation and that [redacted] health was not a feature and so felt that *"This is the correct way ahead"* as these are "*domestic problems that aren't amenable to being cured by* [redacted] *health input.*" The duty doctor stated, "*I did not go back in to look further into DMICP, and to be honest, even if I had and had seen his prior history, it probably would not have changed what I'd done, to be honest.*" [T23.8]

53. It is the opinion of the SI Panel that the duty doctor would have had enough time, if he had wished, to contact the CoC and elicit their concerns regarding the SP, the nature of the SP's presentation and any other information deemed relevant prior to the consultation. The SI Panel also note that the duty doctor had been informed by the CMT on three occasions that the SP had presented with what the CMT believed were [redacted]

[68] The SI Panel established that it was only following on from the SPs death that the medical chain became aware of the full detail of the 'difficult consultation' in Sept 21.
[69] See recommendation section 3d, 3j.
[70] The duty doctor recalled being disappointed that considering with hindsight how concerned the CoC were about the SP that no one from the CoC had reached out to forewarn the duty doctor of the context of the SP's presentation. [T23.8]

health issues. The duty doctor could have acted on the CMT's information and called the CoC to further clarify the situation. It is the opinion of the SI Panel that this represents another opportunity missed for the CoC's concerns and perceptions regarding the SP's [redacted] health in the weeks, days, and hours leading up to his presentation, to be communicated to the duty doctor. Especially when considering that the CGMC Practice Manager recalled that 'In my experience this was not a busy duty doctors' clinic.' [71] [F9.14]

54. **Further effects of a lack of appropriate Read coding.** Even if the duty doctor had reviewed the SP's previous DMICP notes, it is the opinion of the SI Panel that he would have been disadvantaged by the already established lack of adequate Read codes pertaining to the SP's significant past psychiatric history, including his previous attempts to take his own life in 2012 & 2014.

55. **Medical Diagnosis.** The duty doctor recorded the SP's presenting complaint as an 'Adjustment Reaction' on the patient's notes and also sought the advice of a DCMH clinician. [F22.15] During Interview, the duty doctor reiterated his opinion that this case was welfare related but not medical. [T23.8] The duty doctor recalled that he was not concerned for the SP's [redacted] health but more for his emotional health.[72] [T23.8 F22.15] When asked during interview for a definition of the difference between emotional health and [redacted] health the duty doctor stated that emotional health was his definition and not a formal definition. The duty doctor described [redacted] health as *"a specific clinical diagnostic problem, be that depression, be it PTSD, be it anxiety disorder or adjustment reaction, i.e., that which very definitely requires medical input and it is appropriate to medicalise, as opposed to somebody being upset/unhappy because of domestic circumstances."* [73] [T23.8]

56. **Engagement with DCMH** [redacted] Following the consultation with the SP, the duty doctor called DCMH [redacted] later that afternoon for reassurance. [F22.15] The duty doctor recalled engaging with DCMH [redacted] because the SP was "*so unusual.*" [74] [T23.8] The duty doctor also recalled having concerns for the SP due to the nature of his personality and the answers he gave when questioned. The duty doctor also suspected that this case was potentially going to become more complicated and therefore wanted to see what the DCMH opinion was. The DCMH Mental Health Practitioner (MHP) did not remember the call with the duty doctor so could only refer to his notes on DMICP. [T34.5] The MHP suggested a period of watchful waiting to the duty doctor, which according to the MHP meant that the SP should have been seen again by a doctor within two weeks. [F22.15 T34.5] The duty doctor did not plan a follow up consultation with the SP as he felt this was not indicated. [T23.8]

57. **Watchful Waiting.** There appears to have been a difference between the duty doctor and the DCMH MHP's understanding of the concept of watchful waiting. The duty doctor confirmed that his own use and understanding of the term *'watchful waiting'* was *"...not a medical term"* but purely one used by him. The duty doctor reports that he used this term because he felt that the SP's presentation was not in any way related to [redacted] health. He referred the SP back to the unit with the understanding that *"...the problem is going to be taken care of at unit level, in which case the SP will never reappear for this*

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[71] Only eight patients were seen during the duty doctor clinic. [F9.14]

[72] The duty doctor stated during interview that if he didn't want to formalise something as '[redacted] *health"* in the medical meaning of the word, then he would use *"emotional health"* when he didn't know why soldiers had reported to the medical centre who were in emotional difficulty because of their domestic circumstances or work circumstances. [T23.8]

[73] See recommendation section 3k, 3aa.

[74] The duty doctor found the SP to be unusual due to the lack of initiative shown by him to take care of his own problems. The clinician felt very much that he was almost institutionalised and had fallen into the pattern of being told what to do every single day and that in fact, either he did not have the capacity, or he was so unused to exercising the capacity to make decisions for himself without being told. [T23.8]

issue in the medical centre again and it will just remain on the notes but nothing more will happen".[T23.8] However, the MHP's understanding of *'watchful waiting' was* stated as. *"Watchful waiting is also referred to as active monitoring".* [T34.5] The MHP felt that whilst reviewing the duty doctors DMICP entry for the consultation *"...that the problems seemed to be [centred] around miscarriage and relationship break-up, and I've signposted to the appropriate agencies and suggested watchful waiting",* [T34.5] the MHP defined watchful waiting as, "...*which means that he should have then been seen in another two weeks..." [by the duty doctor].*

58. The duty doctor having taken the initiative to call DCMH and seek advice, was then advised by the MHP to implement a plan of watchful waiting, which should have included (according to the MHP's understanding), an actual follow up appointment in two weeks. However, the duty doctor's understanding, meant that no active follow up was planned and subsequently there was no plan or intention to review the SP again at this stage. The duty doctor recalled that *"All I'm doing is I'm watching and waiting to see if he returns. What I'm not doing is I'm not at that stage, unless anybody's raising concerns back to me, I'm not going to be following up on him".*[75] [T23.8] The SI Panel are of the opinion that because of the different use and understanding of 'watchful waiting' by the two medical professionals, an opportunity to medically re-assess or follow up the SP was missed. The MHP thought that he was advising the duty doctor to follow the patient up within two weeks when in fact the duty doctor interpretated this advice as '*not to follow the patient up'*. [T23.8] When considering that the evidence suggested that the consultation was difficult, it is the further opinion of the SI Panel that conducting a follow up consultation within two weeks would likely have been in the best interests of both the SP and the duty doctor.

59. **Medical Diagnosis.** The SI Panel consider that the CoC observed a range of signs and symptoms which could indicate that the SP was suffering from poor [redacted] health in the weeks, days and hours leading up to his presentation at CGMC on [redacted] Sep 21. The duty doctor felt that the SP's presentation was not in any way related to [redacted] health.[76] [77] [T23.8] This notwithstanding, the Read code added to the consultation on DMICP by the duty doctor referred to 'Adjustment Reaction' which is a [redacted] health diagnosis according to both the ICD-10 and DSM-V.[78] Furthermore, it is notable that despite the duty doctor's stated opinion that the SP's presentation was more to do with the SP's emotional health than any diagnosable [redacted] health issue, he nevertheless sought advice from the on-call clinician at DCMH [redacted] The SI Panel are of the opinion by seeking assurance from a MHP this somewhat undermined the duty doctor's assertion that he believed the SP's problems were limited to welfare / emotional health. [T23.8]

60. The SI Panel have identified a difference of opinion with regard to what the SP's spouse, the CoC and the SP himself described as elements of poor [redacted] health, with that of the opinion of the duty doctor. The SI Panel are of the view that the duty doctor's stated opinion that the SP's presentation was more to do with the SP's emotional health than any diagnosable [redacted] health issue appears to have adversely affected the decisions made by the CO at the VRM case conference held later that day and that subsequently the SP was not added to VRMIS and continued to suffer with progressively

[75] The duty doctor believed having spoken with the SP's OC that sufficient safety netting was in place. [T23.8]
[76] President of SI Panel *"[was this presentation] Medical or Welfare?"* Duty Doctor: *"Yes, still Welfare."* [T23.8]
[77] President of SI Panel: *"And yet there was a need to seek advice [from DCMH]?"* Duty Doctor: *"Yes. Yes, because he was so unusual. and like I say, Welfare, and I still stick by it, Welfare was the most appropriate at that point. However, I did have concerns for him that I would not normally expect to have had because of the nature of his personality and his answers."* [T23.8]
[78] The International Classification of Diseases (ICD-10, 1st Oct 15) is the 10th edition of a global categorization system for physical and mental illnesses published by the World Health Organization (WHO) is used by clinician to record a patient's medical diagnosis (now 11th edition, 1st Jan 22). [F39.1 F40] The Diagnostic and Statistical Manual of Mental Disorders, often known as the DSM can be used by Psychiatric services to record a patient's medical health diagnosis.

poor [redacted] health over the coming months. This may not have been the case had he been properly integrated onto the VRMIS system as a result of the initial VRM conference.

61. **CMT Concerns.** The CMT who had initially assessed the SP prior to him seeing the duty doctor had concerns with regard to the duty doctor's attitude towards the SP and also the documentation on DMICP. She recalled reading the consultation in the SP's medical notes and concluding that it was *"...borderline insulting..."* [79] [F9.15] The CMT recalled raising her concerns with [redacted] SCOTS RMO regarding the whole interaction and consultation. The CMT also at this point had concerns that the duty doctor had edited the notes he had entered on DMICP with regard to the consultation with the SP. [F9.15 F9.18]

62. The SI Panel can confirm that the duty doctor's notes had indeed been edited by the duty doctor post consultation. The SI Panel are of the opinion that later the additions made to the notes by the duty doctor simply confirmed his opinion of the case (Plan) in light of his subsequent engagements with the SP's CoC and DCMH. The duty doctor edited his notes on the same day as the consultation, [redacted] Sep 21, and the SI Panel can confirm that there was no further editing of the DMICP notes by anyone after this date. The SI Panel are of the opinion that regarding the editing of the consultation notes on DMICP, no impropriety had occurred. [F30.8]

63. **CGMC Culture.** The SI Panel note that the CMT had raised these concerns with her CoC at the time. However, the investigation surrounding these concerns appears to have never been dealt with and subsequently the SI Panel are of the opinion that the CMT's concerns may not have been taken seriously by CGMC CoC or dealt with in a timely manner in accordance with JSP 950 1-2-13. [F21.8] The SI Panel are of the opinion that this may also have contributed to the CMT's perception that the culture within CGMC was often challenging and therefore warrants further investigation.[80]

64. During the SI a number of CMTs communicated that they did not feel supported by the CGMC doctors, particularly when those doctors were fulfilling the role of duty doctor. *"...many doctors were unnecessarily hard to approach due to the fear of feeling disruptive to their work, even if they were in the duty doctor role." "Depending on the doctor covering duty on the day, this would be the deciding factor to how stressful a medics duty would be." "...at the time surrounding [the SP's] presentation and up until after his death, there was an increase of [redacted] health issues within the garrison and many doctors would prove to be highly unapproachable at the time." "It would take multiple conversations with doctors convincing them to see [redacted] health patients". This left CMT's feeling unsupported by clinicians causing them to suffer with anxiety and stress and potentially leading to a culture of negativity."* [81] [F9.15]

65. The SI Panel are of the opinion that CMTs should never be made to feel reluctant to seek advice from appropriate clinicians. Doctors should always be approachable. Doctors should consider seeing, signpost or offering advice with regards to patients with whom CMTs have concerns. However, during the SI a number of CMTs highlighted the

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[79] The RMO recalled *"I think that the initial concerns from [Named CMT] may have been that the entry from [Named Doctor] on DMICP in September was unpleasant, and unkind, and reflected the concerns raised by the [redacted] SCOTS CoC at that time that [The SP] may not have been taken seriously when he presented in distress."* [T34.7]

[80] See recommendation section 3w, 3x.

[81] The SI Panel are keen to point out that not all doctors working with CGMC during this period, were seen as unapproachable by the CMTs.

difficulties in getting patients seen by duty doctors and also described, at times an unsupportive culture.[82]

66. **Duty doctor's conversation with the SP's OC.** The OC recalled being taken aback by what the duty doctor had said to him *"...with the Colonel having said there was nothing wrong with him and this happened shortly before we then went into the VRM conference, it did change things. I suppose I felt slightly reassured that, you know, he the one thing he did say was that there was nothing - because there was nothing wrong with the soldier, you know, he's just upset at the moment, I thought, right, fine, you know, he's not - he's not suicidal, this isn't a major issue."* [F34.10] The SI Panel are of the opinion that the conversation between the duty doctor and the OC was probably more of a one-sided conversation that resulted in the OC receiving a 'talking to' rather than a 'talking with' the duty doctor[83]. The SI Panel feels that this discussion had an adverse effect on the OC prior to the VRM case conference taking place. As the OC was questioning at this point *"Maybe we've misread this...based on there being no mention of any medical issues in the past...as well as the [named duty doctor] saying there's nothing wrong with this soldier, it painted it in a very different context."* [T34.10]

67. **Suicidal Ideation.** Prior to the VRM risk case conference on [redacted] Sep 21, the SP informed the AUWO that he had recently had suicidal ideations. The AUWO recalled asking the SP whether he had thought about killing himself? The SP replied, *"I've thought about it...I've not thought how I'm going to do it, but I have thought, you know, everybody would be better off without me."* [T23.6] The suicidal ideation was never raised at the initial VRM risk case conference by the AUWO in Sep 21. On the evening of [redacted] Jan 22 the SP did admit to his PI Comd that during the period between Sep/Oct 21, he had physically attempted to take his own life on three separate occasions. No evidence could be found to substantiate this claim.

68. The SI Panel are of the opinion that the AUWO should have informed the VRM case conference panel of this ideation to allow them to make an informed consideration before deciding whether or not to declare him as vulnerable and add him to VRMIS. This information would have also greatly assisted the duty doctor when assessing the SP. The SI Panel are also of the opinion that the SP having suicidal ideation despite being 'passive' may not have given rise to the SP being added to VRMIS, but it would have needed to be fully investigated by the unit. [F7.5] The SI Panel are of the opinion that had the CoC had the opportunity to investigate the suicidal ideation, the SP's significant past [redacted] health history between 2012 - 2014, might have also been revealed earlier, as opposed to following his death. The SI Panel are of the opinion that because the AUWO did not inform the CoC of the ideation, an opportunity for anyone within the unit's Primary Level of Support to correctly safeguard the SP, was missed.

69. **[redacted] SCOTS VRM case conference [redacted] Sep 21.** Following the OC's recommendation, [redacted] SCOTS held a VRM case conference in respect of the SP. [F25.6] The OC recalled trying to organise a medical appointment for the SP prior to the VRM conference taking place. He stated that *"...we wanted to have some advice from the medical chain before we got to the case conference...to have somebody have a look at him who...knew the soldier and would review them"*, and *"so he could sit in the case conference and actually give us some advice on how we should be dealing with him."* [84] [T34.10] The OC recalled that after

[82] See recommendation section 3l.

[83] The OC reported he received a phone call from the duty doctor shortly after the consultation *"...I felt I was almost getting a reprimand from him [the duty doctor] as well as because he told me off and said you shouldn't be sending soldiers to me like this..."* [T34.10]

[84] [redacted]. Apart from the CMT the SP was only seen by the duty doctor. [T34.7]

speaking with the duty doctor and the UWO that he now had doubts about whether it was necessary to hold a VRM case conference or whether the SP needed to be placed onto VRMIS[85]. The OC recalled that he attended the VRM case conference, less convinced that the SP needed to be on VRMIS than he was before the SP had attended his medical appointment.[86] [T34.10]

70. The VRM case conference was also attended by the AUWO and the CSM.[87] [T23.7 T23.6] [redacted], the unit had requested additional support via higher headquarters', as such the unit was provided with a General Duties Medical Officer (GDMO) who acted as medical cover throughout the duration of the [redacted] absence.[88] [89] The GDMO stated during interview, that she thought that during VRM case conferences, *"[redacted] SCOTS relied strongly on medical opinion more than any other risk factors."* [90] [T34.8] CO [redacted] SCOTS stated during interview that when making his decision, whether to add the SP to the VRM register on this occasion, he was leaning more towards the medical factors and opinion rather than other factors.[91] [T34.6]

71. The decision to put someone onto VRMIS rests with the unit CO and is based on their assessment of the risk and whether the underlying factors affecting the individual are sufficiently serious to require the full application of the policy to ensure the unit's support. [F7.5] The outcome from the VRM case conference was not to add the SP to VRMIS. The CO endorsed the recommendation proposed by both the OC and UWO to attach the SP to the Unit Welfare Office for the duration of the Company's deployment on Op ORBITAL.[92] [93] The Adjutant (Adjt) recalled that *"It was decided that he would be given a long weekend off, so he could travel to [redacted] and try to repair his relationship with his wife, thereafter on returning he would be assigned to work in the Unit Welfare Office."* [F34.4] The SP took the decision not to travel up to [redacted] to see his family but chose to remain in barracks.[94]

72. There was a significant passage of time between the VRM case conference taking place and the recording of individual witness transcripts. As such witnesses who gave evidence under oath, at times, struggled to remember precisely what was discussed during the conference. No minutes were taken for the meeting by the unit and as the decision was made not to add the SP to VRMIS, no CAP was produced. The SI Panel are of the opinion that if minutes had been taken during the VRM case conference it would have proved useful in establishing who attended, what was discussed, what decisions were made, by whom and why. The SI Panel are also of the opinion that had

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[85] The VRM case conference initially takes place when an SP has been identified as potentially vulnerable and the CO chairs the meeting and considers whether or not the SP is to be entered onto the VRMIS.

[86] The OC recalled that he was very much swayed by the fact that the duty doctor, even if he had pushed the SP a bit hard or maybe been a bit hard on him, that the duty doctor was clear there was nothing medically wrong with the SP. [T34.10]

[87] The AUWO recalled that normally he wasn't involved in case conferences for SPs, but in this case due to his closeness to the SP he was asked to attend. [T23.6] The CSM recalled being invited to the case conference as the OC had just arrived and he had been in the post a year so could act as continuity in respect to the SP. [T23.7]

[88] A GDMO is a junior doctor who has not yet commenced speciality training.

[89] The GDMO on [redacted] Sep 21 started work with [redacted] SCOTS as their point of contact/acting [redacted] until Feb 22. [T34.8]

[90] Risk factors are those factors that potentially increase the possibility of suicidal behaviours and can be individual, relational, community and social factors.

[91] The CO was referring to the duty doctor's comments that there was absolutely nothing wrong with him. Another factor was that the SP expressly stated he would never consider self-harm because of his children.

[92] Op ORBITAL is the code name for British military operations to train and support the armed forces of Ukraine.

[93] CO recalled thinking that *"the answer was to put him somewhere where he's with a friend doing useful, gainful activity that will keep his fingers busy with people that know him and care for him."* [T34.6]

[94] The PC recalled that he *"didn't discuss this situation with him but I remember sitting there thinking, why has he done this?"* He had the opportunity to go up on a long weekend, resolve whatever he needed to and to see his family. [T34.9] Looking back now the PC suspects that there may well have been other underlying issue that effected the SP's decision not to travel home. The AUWO recalled that the SP had told him that he had called his wife to say that he was coming home and that she didn't want him to come up the road. [T23.6] The CSM gave him money so the SP could afford to go home that weekend. [T23.7]

the VRM case conference been documented, the decision not to add the SP to VRMIS would likely have been clearly stated.[95]

73. **The inexperience of the CoC.** The VRM case conference that was convened in respect of the SP was attended by many members of the CoC who were new to their respective roles. The CO, like the OC had only recently arrived at the Regiment.[96] The Adjt had himself, only been in the appointment since May 21. [T23.2] The CO recalled *"...myself, the [Regimental Sergeant Major] RSM, the Adjutant, three of the Company Commanders...all changed over during that summer period."* The CO recalled *"...we lacked that institutional knowledge during this early phase..."* [T34.6]

74. The CO tried to mitigate this lack of continuity by asking both the AUWO and CSM to attend the VRM case conference. The SI Panel are of the opinion that having additional people attend the case conference, such as the AUWO and the CSM, represented a positive move by the unit, as both of these individuals knew the SP very well and would have been able to offer the CO some form of added reassurance regarding the SP's character. The SI Panel are also of the opinion that the decision by the CO not to put the SP onto VRMIS was also possibly influenced by the lack of his team's experience at this point. [97]

75. During the period of the first VRM case conference, the UWO was the most experienced person with regard to the VRMIS process. He had been in post since Oct 20. The UWO also knew the SP very well as he was the SP's CSM in [redacted] Germany in 2014. The CO recalled that the UWO offered continuity during VRM case conferences due to his *"...long history in [redacted] SCOTS."* [T34.6 T23.9] The SI Panel are of the opinion that due to the summer changes experienced by the unit, the experience of some personnel of VRM case conferences may at this point have been minimal, but that adequate measures were put in place by the unit to counter the possible lack of 'institutional knowledge.' [T34.6]

76. **Previous self-harm.** The UWO could not recall if the subject of previous self-harm was raised at the VRM case conference. [T23.9] The GDMO recalled that no one from the unit during the VRM case conference asked her about the SP's previous [redacted] health history. The GDMO reviewed the SP's DMICP notes.[98] [T34.8] The SI Panel are of the opinion that the GDMO had been disadvantaged by the already established lack of adequate Read codes pertaining to the SP's significant past psychiatric history, including previous attempts to take his own life in 2012 & 2014. The SI Panel are also of the opinion that this gave rise to a missed opportunity by the VRM case conference to capture the SP's significant past psychiatric history. Had the unit known this information it would likely have affected the opinion of the VRM case conference panel and subsequently the CO's decision.

77. **SP Not added to VRMIS.** The CO recalled that once everyone has had their chance to speak during the VRM case conference the decision lies with him. *"...I made a very clear decision that I was not going to put him on the VRM at that stage, that there were other things we could do for him and so we went down that route instead...I just didn't see him as being as serious as he perhaps was...it didn't strike me at that stage as*

[95] See recommendation section 3e, 3f.
[96] Both the CO and the OC took up their appointments in [redacted] SCOTS in Jun 21.
[97] The CO recalled *"I've got the doctor with his experience, as [Named Officer] sort of correctly sort of said, a Colonel, Lieutenant Colonel; on the other hand, I've got a brand-new Company Commander who doesn't yet know his people and is anxious about this one individual. So, there was a - in terms of credibility, I gave the doctor more credibility."* [T34.6]
[98] The GDMO recalled having subsequently reviewed the SP's notes after his death that "...his [redacted] health history and his previous [redacted] is not in his significant past medical history. It's much further down in his minor past medical history." [T34.8]

being serious." [T34.6] The CO recalled that in his opinion the threshold for adding to VRMIS had not been met *"...it just didn't trigger, for whatever reason it didn't trigger my tripwire for it, the threshold..."* [T34.6] It is the opinion of the SI Panel that the SP had likely displayed enough risk factors at a significant enough magnitude to warrant being admitted onto VRMIS as a vulnerable adult. The SI Panel also feels that the lack of institutional knowledge secondary to the relative short time in post of most of the command team likely played a part and resulted in the decision not to add the SP to VRMIS, and thus giving rise to a missed opportunity to provide an enhanced level of awareness and associated support.

78. **Duty Doctor's influence on the unit CoC**. Before the consultation with the duty doctor on the [redacted] Sep 21, the OC believed the SP was vulnerable. However, after speaking with the duty doctor and the UWO, he now had doubts whether holding a VRM case conference was even necessary. The OC at this point was new in the role and recalled the difficulties with identifying the right course of action to take *"...having never been trained in medicine...and suddenly you're faced with a soldier who is...clearly presenting with something."* The OC admitted *"...feeling absolutely out of my depth handling VRM cases...I very much was swayed by the fact that the doctor - even if I thought he'd pushed him a bit hard...he was absolutely clear there was nothing medically wrong with this soldier".*[99] [T34.10]

79. The SI Panel are of the opinion that the CoC likely relied too heavily on the medical opinion and do not appear to have identified or considered the non-medical risk factors [100] which were present at the time, when coming to their decision on whether or not to place the SP onto VRMIS. It is the opinion of the SI Panel that despite the OC's doubts with regard to both the duty doctor's opinion that *"this is welfare not medicine"* [T23.8] and the SP's report that the consultation was *"Horrific"*, not one member of the CoC, who shared these concerns tried to gain further clarity from any member of the medical chain as to why the SP was in such an emotional state following his departure from the consultation.[101] [102]

80. **RMO [redacted] SCOTS' absence.** RMO [redacted] SCOTS [redacted] The RMO recalled "So *that's probably the biggest infantry battalion in [Named Garrison] left without a doctor for that entire period."* He also recalled upon his return to work [redacted] from the unit had been felt *"...I think people were quite stressed to not have a medical officer..."* [T34.7] The Adjt recalled *"Continuity in the med chain is the one thing that we need, and we do not have, and it hurts us, not just in managing vulnerable people but a whole other host of other aspects.* [T23.2] The SI Panel acknowledge that the [redacted] absence of the RMO and impact of this on 'continuity in the med chain' was challenging and likely affected the operational integrity of the Regiment. However, with regard to the SP, the SI Panel have found no evidence which suggests that the RMO absence directly impacted on his case.

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[99] The OC also recalled that *"...there was also a part of me that said, you know, this is a Colonel in the medical crew who knows what he's doing and he's telling me there is nothing [redacted] wrong with this soldier, he's just upset and struggling to deal with the issues in his life."* [T34.10]

[100] There are a number of risk factors that are deemed non-medical which appear in AGAI 110 and were noted as present with regards to the SP. [F7.5]

[101] On the process of making a complaint the OC stated: *"This was something that we – [sic] weren't happy with and was discussed at the case conference...I don't know how you make a complaint...if it's a doctor who shouts at a soldier and we think that's horrendously inappropriate...what do we do? Who do I flag that up to? I...did feel...he'd been pushed into an uncomfortable place by [named duty doctor]."* [T34.10]

[102] See recommendation section 3s, 3t.

81. **No formal referral was made to AWS by the unit.** The SP was attached to the Unit Welfare Office from 29 Sep 21 until the 17 Jan 22.[103] The CO recalled *"I thought the answer was to put him somewhere where he's with a friend doing useful, gainful activity that will keep his fingers busy with people that know him and care for him."* [T34.6] The SP was seen weekly by the Padre, with each session lasting between one to two hours. The Padre would then update the UWO. The UWO relied heavily on the Padre, owing to the latter's previous experience working as a member of AWS for ten years prior to being ordained. It was during this period that the SP had a number of issues and could have directly benefitted from a referral to AWS. However, owing to the Padre's past experience, no referral was made. [F23.9] The SI Panel are of the opinion that the Padre may well at this point been seen by the CoC as fulfilling the AWS function, as such the unit did not see the need to make a formal referral to AWS.

82. Whilst the AUWO recalled referring the SP to AWS *"...for his finances, marital problems and stuff like that"* [T23.6] , AWS confirmed to the SI Panel that no referral was ever made by [redacted] SCOTS for the SP. [F8.21] The SI Panel are of the opinion that the UWO relied too heavily on the Padre's previous AWS experience despite this now being outside of the Padre's current scope of practice and professional responsibility. An opportunity was missed to refer the SP to an appropriate welfare agency that was more current and competent in welfare matters than the Padre.[104] The SI Panel note that despite the UWO comments that he was lucky to have the Padre and his experience of welfare issues, not one single referral to an appropriate welfare agency was ever made by either the SP or by the unit on his behalf.[105]

83. The PI Comd recalled that in late Oct or early Nov 21, he thought that the SP was still broken. [T34.9] The SP was still not sleeping properly, and there were still physical signs of anxiety being displayed. The PI Comd was concerned that the SP was *"...still very evidently grieving"* and felt *"...that this was turning into a man who did have some form of depression."* The PI Comd recalled engaging with the UWO who stated that he would investigate the PI Comd's concerns.[106] [T34.9] A close friend during interview recalled over this same period that the SP was drinking far more than usual. [T23.10]

84. Another friend recalled that he felt the reason the SP was excessively consuming alcohol was because he was severely depressed and that the drinking was a coping mechanism. [T23.5 T23.10] DMICP records show that the SP claimed he was averaging over 18 bottles of beer per night during Aug – Dec 21. [F22.18] It is the opinion of the SI Panel that the only welfare support or medical treatment the SP received during his time spent within the Unit Welfare Office, was in the form of pastoral care once a week by the Padre, and signposting for debt management by the Regimental Administrative Officer (RAO). It would appear that none of the other issues initially identified by the CoC or raised by the duty doctor in Sep 21, were ever formally actioned or resolved by the CoC or the Unit Welfare Office.

85. Whilst attached to the Unit Welfare Office, the SP informed the AUWO that he was experiencing some financial difficulties.[107] The AUWO recalled that it was when the SP was in front of the RAO, that he admitted that he was *"struggling to live"* on only *"a hundred pound a month."* [T23.6] The RAO during the interview stated that there was a lot

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[103] [redacted] Company [redacted] SCOTS deployment on Op ORBITAL on [redacted] Oct 21 and was extended until [redacted] Dec 21. Because of this, the SP remained under the care of the UWO until his Company returned from Christmas leave on [redacted] Jan 22.

[104] The Padre had not been employed in the capacity of an AWS SNCO since Jan 2010.

[105] See recommendation section 3o, 3y, 3bb, 3cc.

[106] No evidence was found that would support that the UWO engaged with the SP in respect to the PC's concern.

[107] [redacted] [T23.6]

of self-induced pain in respect to the SP's finances. *"He'd just been court-martialled, received a large fine."* [108] *"His relationship was going through, unfortunately, a breakdown phase" and that "...his partner was the one in charge of the finances."* [T23.3] The AUWO recalled that the SP was living off his credit card. He recalled that when he asked the SP why he was constantly using his credit card? the SP replied *"Well, I'm needing that to live on."* As such the SP was paying off his credit card bill every month which left him very little. [T23.6]

86. What could not be established by the SI Panel was the amount of debt that the SP was in at this time. The Company Quartermaster Sergeant (CQMS) recalled that the SP's biggest concern was that once he had paid his Child Support Agency to his ex-wife, plus the money that he gave to his spouse, he was leaving himself short. The CQMS also stated. *"Plus he had outgoings like car, [car] insurance, phone and I think it was just getting on top of him a bit too much."* [109] [T23.4] After seeing the RAO, the AUWO and CQMS both sat with the SP and together they made a plan to try and make the SP's finances more manageable after three months. The CQMS recalled that *"...we worked it out and, by the end of that process, he seemed pretty happy, like, look, this is doable, it's not going to be heartache."* [T23.4] The unit at this point believed that the SP's debt was manageable.

87. The UWO's impression, during the SP's placement within the welfare department, was that apart from the SP raising some concerns surrounding debt, his other issues appeared to have improved. The UWO also felt that he had become less of a risk. The CO recalled *"I was able to see him when I would visit...the Welfare Centre and then at that [SIC] Halloween party I had a good chat to him on that occasion, and as did my wife, and he struck me as a really amiable, nice, easy to talk to character."* [T34.6]

88. However, the AUWO stated that during this period and leading up to Christmas he didn't think that the SP was improving. He recalled. *"He was - I believe he was deteriorating. But when you spoke to [the SP], and you know...he would sit there and tell you to your face, 'I'm all right.'* [T23.6] By simply looking at the SP the AUWO could tell that he was tired and lethargic but wasn't sure why? He recalled the SP saying *"...I'm not sleeping at night. I'm not getting to sleep till like five, six o'clock in the morning...I was like, well, you need to tell your MO..."* [110] [T23.6]

89. The AUWO as a friend did not want to dive into the SP's marital problems. However, he claimed that the SP's marital relationship wasn't improving. He was friends with both the SP and his spouse on Facebook and recalled that he would see messages that she would post saying that all she wanted was for her husband to come home to be there for his son. However, the AUWO recalled that the SP contradicted this by claiming that the relationship was over and that his spouse no longer wanted to be with him. [T23.6]

90. The SI Panel feel that contrary to the UWO's opinion, the evidence suggests that the SP's condition had deteriorated since moving to the Unit Welfare Office. There are conflicting views between the UWO and that of the AUWO and PI Comd with regards to the progress made by the SP whilst under their care. The SI Panel are of the opinion that the UWO did not take the concerns of the PI Comd seriously enough and that the SP's excessive drinking as a form of coping, as well as his inability to sleep properly were issues that were known to the CoC, and which could have been acted upon. The SI

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[108] SP's final payment for his court martial fine was on [redacted] Sep 21 which was prior to him speaking with the RAO.

[109] CQMS recalled that he thought that the SP's spouse was also looking for more money because it was the lead-up to Christmas. [T23.4]

[110] The SI Panel can confirm that the SP did not act upon this advice and that no appointment to see an MO was made.

Panel are also of the opinion that by not adding the SP to VRMIS in Sep 21, an opportunity to help manage these issues was missed. Had he been added to VRMIS by the CoC, there would have been three separate opportunities during the Commander's Monthly Case Review (CMCR) to formally assess the SP to ascertain if any progress had been made by the SP during the period, he was assigned to the Unit Welfare Office.[111]

Narrative, Findings and Analysis continued 2021 – 2022

91. **Op ORBITAL.** The PI Comd stated that it was always the unit's intention to try and take him on Op ORBITAL as a driver. He recalled *"…it would help reduce the [SP's] financial burden…as well as putting him into a new environment…where he's got a focus."* [T34.9] The CSM recalled after the VRM conference in Sep 21 and prior to the Company's deployment on Op ORBITAL it was decided *"…it was better to leave him behind…to try and rebuild his relationship and still continue at home."* [T23.7] Upon his return to barracks following the funeral of his friend in Sep 21, the SP did not then return home to [redacted] again until Christmas leave in Dec 21. The SI Panel were unable to establish why the SP had not previously returned home prior to Christmas, but it is possible that financial constraints may well have played a significant part in the SP's decision and ability to travel home between this period.[112]

92. **Travelling home to** [redacted] The PI Comd stated that the SP's biggest concern was that he would not be able to go home and see his family. He recalled *"He always said that the pride and joy of his life was his little boy and that was the one thing he was always adamant to go up and go see…and was really the driving force behind him getting up the road…and he was concerned that because he'd had these debts…he was then struggling and having to make sacrifices elsewhere to try and see his son and his stepson up the road in* [redacted] [T34.9] A friend of the SP stated that it was common for the private soldiers not to travel home every weekend as they simply could not afford to.[113] He recalled *"You're skint by the first weekend…you haven't got any petrol money to get up any other weekends anyway."* [T23.5] The AUWO recalled *"I even lent him money to go home at Christmas to make sure that he had money for the kids to buy them at least a couple of presents."* [T23.6]

93. **SP's relationship**. The SP's spouse described difficulties with her and the SP's relationship. She recalled *"I fought for my relationship with [the SP], but there was just something that wasn't right. He was so dismissive of everything I asked, [including] even for him to come home [to] sort this [out]. He wouldn't."* She stated that her husband *"…was just not wanting to listen to anything it was like something was holding him back."* [F27.13] The PI Comd recalled that the SP would *"always talk about being with his wife and being with his family."* His impression of the SP's relationship with his spouse was that it had been *"…up and down and there was turbulent points in his relationship with his wife, but they always seemed to get through it."* [T34.9] During a planned visit made by the SI Panel to the family home, the SI Panel recalled the spouse saying something very similar to the PI Comd's comment. The PI Comd mentioned that he knew that the SP was also regularly speaking with his deceased friend's sister at the time but did not realise the extent of their relationship until after the SP's death.[114] [T34.9] Evidence indicates that the

[111] As a minimum, all soldiers on the unit VRM Register must be regularly assessed at the CMCR in accordance with Chapter 3 of AGAI 57 - Army Health Committees.
[112] The SI Panel estimated that following deductions the SP would have had between £100-£200 disposable income per month. The AUWO estimated that the cost of travel and spending money once at home would likely have totalled "…north of two hundred quid. I'd Imagine." [T23.6]
[113] Due to travel cost and distance [redacted] SCOTS soldiers tended to travel home once a month which was normally on the first weekend of the month, having been paid.
[114] The PI Comd recalled being told by one of his soldiers that the SP was having a relationship with his deceased friend's sister. [T34.9]

relationship between the SP and his spouse prior to the Christmas leave period was an amicable one.[115] [T34.3]

94. **Christmas leave period 2021.** When the SP commenced Christmas leave, the AUWO recalled having only one concern at this point and that was the SP's marriage. [F6.15] He recalled *"The only concerns I really had…to be honest, was…him going home and the reconciliation not happening…"* [T23.6] Within the first week of the SP being at home in [redacted] the AUWO texted him to see how he was doing. The AUWO could not recall if he called the SP in his capacity as a friend or because of his role as the AUWO. It was at this point that the AUWO found out that the SP was no longer living at his home address, as he had been ejected from the family home by his spouse. This was also the time that the AUWO first found out that the SP was having a relationship with someone else.[116] Both the PI Comd and the CQMS had tried to contact the SP on several separate occasions during the lead up to Christmas day. The CQMS recalled that the PI Comd had messaged him on Christmas Eve saying *"…he was struggling to get in contact with [the SP]"*. The CQMS tried to contact the SP via several text messages, the CQMS recalled *"I also tried to phone him a couple of times and couldn't get through."* [T23.4]

95. The AUWO called the SP on several different occasions during the Christmas stand down period. He recalled. *"I never physically seen him [but] he seemed happier. He was going round visiting the kids, picking the kids up, taking them out, stuff like that."* [T23.6] The AUWO believed that this was a good time for the SP and that he was in a *"better place."* The AUWO then recalled "*It then deteriorated a little bit coming towards the end of Christmas leave…It was only later on that I found [out] that he was sleeping in his car."* The AUWO on being told this invited the SP to stay with him and his family in [redacted] should the SP have any issues.[117] [T23.6] The SP acknowledged the AUWO's kind offer but did not take him up on it. The SP's spouse recalled that contrary to her husband stating that *he slept in his car over the Christmas period, "…he never…he was staying with [the deceased friend's] sister to which he never admitted, for me to only [find] out on [the] day he died [that] it was true."* [F27.13]

96. **Road Traffic Accident (RTA) [redacted] Jan 22.** The SP was involved in an RTA whilst on Christmas leave. Following the RTA, the SP became concerned that his driving licence had expired, and that he may therefore have voided his insurance, which could potentially have caused significantly more debt. The AUWO recalled that the SP called him concerned that *"…his car insurance would be void."* [T23.6] The AUWO having gone onto the DVLA website was able to reassure the SP that he was still insured. Due to the RTA, the SP remained at home with his family for the final week of leave prior to returning to work. [F22.27]

97. The AUWO's concern for the SP increased following the RTA. [T23.6] The PI Comd felt that the RTA made the SP more anxious. [T34.9] Upon his return to barracks the SP saw a doctor and reported that '…they [SP and spouse] didn't argue, he felt things got better, but [the marriage] still feels on the rocks.' [F22.27] The SI Panel are of the opinion that the SP returned to barracks more anxious and had not managed to resolve the difficulties in his relationship.

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[115] The Padre recalled the SP *"…made a phone call to his wife…, and you know, they spoke very amicably, and they got a video for his little boy looking at me dressed as Santa, and it was a very amicable phone call".* [T34.3]

[116] The AUWO recalled thinking *"…you're going home to try and sort out your marriage, and you're…staying with somebody else [another woman] - which in turn didn't work out either."* [T23.6]

[117] The AUWO recalled that during all of the encounters that he had with the SP over the Christmas period, *"…not once did he show or give me any indication that there was problems that he couldn't deal with."* [T23.6]

98. **SP's relationship with the deceased friend's sister.** There is conflicting evidence from the witnesses interviewed as to whether or not the SP was sleeping in his car or staying with his deceased friend's sister throughout the period of Christmas leave. The SP's spouse recalled that her husband never stayed in the car stating he was staying with the deceased friend's sister. [F27.13] Evidence would indicate that after the RTA the SP returned to the family home for the remaining period of his leave which is estimated to be between the [redacted] Jan 22. The extent of the SP's relationship with his deceased friend's sister remains unclear. However, it is the opinion of the SI Panel that this relationship might have contributed to the difficulties the SP was having in his marriage which may have also impacted on the SP's [redacted] health.

99. **Possible conflict of interest.** The AUWO knew the SP as both a personal friend and within his capacity as the AUWO.[118] Evidence suggests that at times, this complex relationship resulted in a conflict of interest which led to the non-passage of important information between the AUWO and the CoC. This likely resulted in missed opportunities for the CoC to act in the interests of the SP. The SP and AUWO had contact on a daily basis during the SP's tenure in the Unit Welfare Office. As such the AUWO nurtured both his friendship with the SP as well as their working relationship as a member of the unit welfare staff.

100. The AUWO knew of the SP's suicidal ideation at the time of the first VRM case conference in Sep 21, but never raised this with the CoC at the time. [T23.6] This is significant because the CO later suggested that if he had been aware of any suicidal ideation at the time, he would have added the SP to VRMIS.[T34.6] The SI Panel have already identified that not adding the SP to VRMIS at this point was a significant missed opportunity to formally track the decline in the SP's condition as observed by both the AUWO and PI Comd.

101. Prior to Christmas leave the AUWO recalled that he did not think that the SP was improving and that in fact he was deteriorating. The AUWO did not report this to the CoC. [T23.6] This omission likely resulted in a further missed opportunity. If the AUWO had informed the CoC about this decline, the CoC would likely have considered putting the SP onto VRMIS and thus ensuring protections and regular reviews. The SI Panel note that the PI Comd also noticed this deterioration at the time. The SP went onto Christmas leave with the CoC wrongly assuming that all was well, when in fact it was not. The AUWO claimed he did report this to the UWO, although no evidence has been found to support this claim or to suggest that this information went any further.

102. When during Christmas leave, on learning that the SP had been ejected from the family home, the AUWO admitted that he had acted in his capacity as the SP's friend rather than as AUWO. He recalled. *"...I was like...[profanity], man. but that was my friend head on, not the Welfare Officer. I wasn't at work - although technically, you know, I'm still a Welfare Officer, but I wasn't at work. I was speaking to him as a friend."* [T23.6] Again, the AUWO does not appear to have informed the CoC of this significant event at the time and another opportunity for an informed CoC intervention was lost. This account also highlights the lack of understanding on the part of the AUWO of his enduring role as a member of the welfare staff and the impartiality required in order to maintain both the function and safety net that is the unit welfare system.

103. There are several further incidents which highlight a potential conflict of interest stemming from the fact that the AUWO and the SP were friends. The AUWO lent the SP

[118] This is not uncommon within infantry regiments which recruit geographically and where many people know each other and their families from outside as well as inside the Army and where individuals can stay in the same organisation for many years.

money and invited him to stay with his family over Christmas. Whilst inviting the SP into his family home reflects the commendable action of a good friend, given his role as AUWO, the SI Panel feel that he should have informed the CoC of these developments. However, he did not. It is the opinion of the SI Panel that some of the judgements made by the AUWO when supporting the SP were centred around his friendship and not within his official capacity as AUWO. A conflict of interest appears to have occurred whereby the AUWO has opted to act in one role or another but not both and as such several missed opportunities for the CoC to be made aware of the situation and consider intervention, were lost. The SI Panel are of the opinion that despite there being a conflict of interest, at no point did the AUWO act with anything other than the SP's best interests in mind.[119]

104. **Difficulty sleeping.** Upon his return to the unit from Christmas leave, the CoC became aware that the SP was experiencing difficulties sleeping. The OC remembered that it was later that week after the SP's return to work that the SP had informed him that he was having trouble sleeping. The OC recalled that the SP had said *"...he was using [redacted] to try and help [him] sleep."* [120] [T34.10] Despite the sleeping issues, the OC at this point felt that the SP was not vulnerable. He recalled at the time *"...he was struggling to sleep, and he looked a bit anxious and unwell."* [121] The OC recalled *"...our initial reaction was...we're going to get you a medical appointment and see if we can do anything about it."* [T34.10] A medical appointment at CGMC was made by the unit for the SP on the [redacted] Jan 22. [F22.18]

105. **CGMC medical appointment [redacted] Jan 22.** During his appointment with the doctor, the SP reported that he had been struggling to sleep for the last two months and that he felt that it was getting worse. [F22.18] The only time the SP slept was when he had consumed alcohol but acknowledged that this was not a good solution. The doctor recorded that the SP felt down, depressed, and hopeless but considered that this was due to the lack of sleep rather than any other issues. At its worst, the SP reported that his inability to sleep made him wish at times he was dead. However, the doctor recorded that the SP had no plan to take his own life.[122] [F22.18] The doctor had advised that the SP start a sleep diary and placed the SP on light duties for two weeks. The SP was prescribed medication to assist with his sleep. A review in one week was also planned. The OC recalled that the SP came back from his appointment "*...In really good form*". [T34.10] The OC remembered chatting with the SP who now appeared satisfied that he had been given medication to help him sleep.

106. **Incident of significant concern [redacted] Jan 22.** Two days after his appointment with the doctor, a further decline in the SP's [redacted] health was observed. During the early hours of the morning, the Padre noticed that he had received a text message from the SP. The Padre *"...was concerned by its wording...the word in it implying that...he's giving up."* [F23.1] The Padre was concerned to the point that he felt it necessary to immediately inform the CoC via the AUWO. On receipt of this information from the Padre, and upon his advice, the AUWO contacted the unit duty staff, who conducted an immediate visit to the SP before messaging the AUWO who then attended the SP's SLA. The AUWO attended because of his own concern at hearing that the duty Sergeant (Sgt) had seen evidence of a potential [redacted] attempt. The concern appears to have been centred upon

[119] See recommendation section 3g.
[120] SP was taking over the counter tablets to aid him sleeping.
[121] The OC recalled *"I knew he didn't sleep. He stayed up watching movies and stuff like that and he often came across as being...often...quite pale."* [T34.10]
[122] The doctor determined that the main presenting issue was that of insomnia which was leading to the secondary symptoms, of low mood and passive ideation. His aim was to treat the insomnia first and then reassess to determine if the low mood and ideation had resolved. [T22. 18]

the discovery of a [redacted] Following the visit by the duty staff, [redacted] was removed from the room and the SP was escorted to the guardroom where he remained under the supervision of the guardroom staff until early morning. [F5.4 F9.1 F9.2]

107. **Medical Appointment at CGMC [redacted] Jan 22.** Following the discovery [redacted], the CSM made an appointment for the SP with CGMC. The doctor requested to see the SP in person that day. The SP attended CGMC on the afternoon of [redacted] Jan 22. He was initially assessed by a GDMO before being seen by the doctor. The doctor felt that the SP's presentation suggested that he was a moderate to severe risk of suicide. He therefore immediately discussed the case with the on call CMHN at DCMH [redacted] The on call CMHN suggested that the doctor make a same day urgent referral. [F22.18 F22.27]

108. **Urgent referral to DCMH [redacted] [redacted] Jan 22.** Within the referral document the doctor stated the SP as being *"...33-year-old infantry soldier with several years of feeling low in mood (unable to remember when he last felt normal)."* [F22.27] The doctor also identified a previous attempt in Sep/Oct 21 [redacted] The SP also reported often having thoughts about killing himself and about not wanting to be here but that he could not work himself up to take his own life. It was during this consultation that the doctor prescribed the SP onto medication as well as stating their intention to medically downgrade him.[123] The referral to DCMH [redacted] was promptly accepted and the SP was allocated an urgent face to face appointment the next day. [F22.18 F22.27]

109. **PI Comd's visit with the SP [redacted] Jan 22.** The PI Comd visited the SP during the evening following the medical assessment. The PI Comd recalled that the SP *had "...admitted to having attempted to take his life three times between September and October [2021]."* [T34.9] This was the first recorded admission to the CoC of significant attempts at [redacted] by the SP following the period when the duty doctor had informed the CoC that the SP had welfare problems, but not [redacted] health problems, and that the CO had decided against adding the SP to VRMIS in Sep 21. The PI Comd immediately reported this admission to both the Adjt and OC. This disclosure strengthens and supports the SI Panel's opinion that during the period of the SP's Sep 21 consultation with the duty doctor, the CoC were concerned that he was likely suffering from poor [redacted] health.

110. **VRM risk conference [redacted] Jan 22.** Following the significant incident of concern ([redacted]), a VRM risk conference was convened. The CO concluded that the SP was vulnerable and as such added him to VRMIS. The OC was nominated as the CAP lead and stated his intention to directly discuss the SP with DCMH [redacted][124] [125] It was during this conference that the CO was first made aware of the SP's previous poor [redacted] health in both the UK and Germany. [F22.18 F1.1] The RMO briefed the CoC on the medical plan in place which included an urgent appointment with DCMH [redacted] that day and an RMO follow up and potential downgrading.

111. **CoC discusses SP with DCMH [redacted] [redacted] Jan 22.** Prior to the SP's urgent appointment with DCMH [redacted] the OC had arranged to discuss the SP's condition directly with them. The nature of the discussion centred on the OC's concerns that

[123] There is often a delay between identifying the need to downgrade and the ability to do so. Grading reviews take approximately 30 minutes and are carried out in separate clinics and often have significant waiting time owing to high demand.
[124] The CAP lead is responsible for the day-to-day management and engagement with the individual and those supporting the individual on the VRM Register.
[125] The OC discussed the SP with the CMHN who was scheduled to urgently assess the SP on the [redacted] Jan 22. [F1.20]

keeping the SP safe around the clock whilst still located within SLA was almost impossible.[126] He also communicated the recent discovery [redacted] in the SP's room and his opinion that the SP *"…was on the cusp of making a real attempt at suicide."* [T34.10] The OC also expressed his hopes that as part of DCMH's care provision, the SP would be housed in an appropriate place of safety. *"I felt reassured that they were likely to admit him."* [F1.20]

112. **The SP's ideas, concerns, and expectations [redacted] Jan 22.** During this period, in which the SP suffered a decline in [redacted] health, he took the opportunity to discuss his ideas, concerns and expectations with members of both the CoC and of the medical chain. *"He thought he was a hopeless case."* [F22.1] He found himself frustrated at not being able to enjoy the things in life he usually found enjoyable. Likewise, he used to be very sociable but found himself *"…counting down the minutes for someone to leave his room."* He no longer *"…wants to be here…"* but describes lacking the motivation to kill himself. He stated he lacked *"…focus and meaning."* He informed the Padre that he was *"… beyond fixing."* [F8.8 T34.3] He felt *"…he was a problem and a hinderance…"* to his CoC by *"…causing them more problems."* He wanted the *"…ground to swallow…"* him. [F22.18] He felt *"…it would be easier for other people and himself if he wasn't here."* He also felt *"…usually resilient but not at present."* He stated that he *"…just wants to feel normal again, wants some meaning [and] feels drained."* He thought as though he was destroying his life and *"… doesn't want to feel like this anymore."* [F22.18]

113. **DCMH [redacted] review with the SP [redacted] Jan 22.** The SP attended DCMH [redacted] and underwent a full initial psychiatric assessment. The CMHN conducting the assessment documented that the SP presented with symptoms in keeping with a diagnosis of depression. He reported experiencing these symptoms for approximately one year. The CMHN assessed his risk of self-harm as moderate. The CMHN also suggested that he was admitted informally to an in-patient ward in order to remain safe. However, the SP refused to be admitted. During this assessment, the SP alluded to his past psychiatric history, but the CMHN incorrectly recorded 'No previous history of deliberate self-harm' onto the consultation notes.[127] [F22.8]

114. **Follow up on all significant information disclosed by the SP.** During the DCMH [redacted] review with the SP on [redacted] Jan 22 the CMHN recorded that the SP had sought help from DCMH [redacted] after his first marriage had broken down. [F22.8] She also recorded that the SP informed her that he was admitted at this time, but no further details about this admission were ascertained during the initial consultation. The SI Panel are of the opinion that this information was significant in gaining a clearer understanding of the SP's previous [redacted] health history and would have at some point needed to have been investigated further. Had the SP accepted the voluntary admission to an Inpatient Service Provider (ISP), it is the opinion of the SI Panel, that his complete psychiatric history would have been identified significantly earlier than it was.[128] It is also important to note that the psychiatrist's initial assessment, due to take place on the [redacted] Mar 22 in the community, would likely have occurred on the first day of the voluntary admission. At the end of the assessment, the SP was safety netted and sign posted to the crisis team, members of his

[126] This concern was enduring throughout the period of time in which the SP was under the care of DCMH [redacted]
[127] The CMHN recorded onto her initial report "No previous history of DSH" after being informed by the SP that he tried to [redacted] himself in Sep 21 (after the death of his friend by suicide and start of his marriage breakdown). The CMHN also knew at this point that the SP had had a poor experience at ISP Peterborough many years ago.
[128] This was also the opinion of a number of the DCMH clinicians and one of the reasons they would have preferred him to have been admitted.

CoC and friends.[129] The CMHN intended to review the SP face to face immediately following the weekend.[130] [F22.7 F22.8]

115. **SP not admitted to a psychiatric ward.** As previously established, the OC had expressed his hope that as part of DCMH's care provision, the SP would be housed in an appropriate place of safety. However, with the SP declining to be informally admitted to a psychiatric ward, the CMHN had no powers with which to admit him against his will. The CMHN stated "*Although I didn't believe he would meet the criteria to be detained under the Mental Health Act…If he would be agreeable to go in hospital voluntarily then this, in my opinion was the best option.*" [T23.11] At the time the CMHN felt that admission would have benefited the SP as it would have provided him some respite as well as the opportunity for further assessment and treatment whilst in a place of safety. It is the opinion of the SI Panel that the SP did not cross the threshold to be sectioned under the Mental Health Act and that the SP's decision not to be admitted was his alone to make.[131] [F22.8 F1.19 F28.1]

116. When highlighting the benefits of admission to the SP, the CMHN recalled that the SP spoke about his previous negative experiences of being an inpatient on a psychiatric ward many years ago.[132] The SP stated. "*…The experience wasn't beneficial and didn't help.*" [F25.2] The CMHN also stated that COVID 19 was a further barrier to the SP agreeing to admission, as he would have to regularly test and remain isolated. The CMHN recalled. "*…he smoked and wouldn't be able to smoke…he felt his mood would deteriorate in hospital as he would be further isolated and not in his own comforts.*" [T23.11] She also recalled the SP saying that he did not want to kill himself and felt that he was able to keep himself safe in the community. [F22.8] The SP would be offered the opportunity of being admitted as an inpatient on a further two occasions whilst under the care of DCMH [redacted] He declined on both occasions. [F22.13 F22.11]

117. When the AUWO asked the SP why he would not go into hospital he recalled his response: "*…No. All they'll do is sit there and they'll just [profanity] sit and prod and poke you. I'm not doing it.*" [F23.6] The AUWO also stated that both he and the CQMS made more of an effort to be in regular contact with the SP, especially after the SP had declined the admission. [F23.6] The SI Panel are of the opinion that the SP would never have agreed to a voluntary admission into a psychiatric facility and that the only scenario which would have seen him admitted, would have been if his [redacted] health had deteriorated to the point that he could have then been forcibly admitted, under the Mental Health Act. The SI Panel are also of the view that the recorded two additional offers of admission by DCMH [redacted] were based on the view that admission was always the better option, and not because of any perception by staff that the SP's condition had deteriorated. The SI Panel also note that admission was the desired outcome for the CoC and would have helped the unit to better manage the risk associated with the SP's condition.

118. **Further effects of a lack of appropriate Read coding.** Like others who had cared for the SP during 2021 and 2022, the clinicians at DCMH [redacted] were somewhat disadvantaged by the already established lack of adequate Read codes pertaining to the SP's significant past psychiatric history, including previous attempts to take his own life in 2012 and 2014. Whilst not all of this information was required during the initial risk

[129] Safety netted and signposted is a process of what to do and where to go in the event that his [redacted] health declined over the weekend.
[130] See recommendation section 3m.
[131] The SP was able to receive the information from the CMHN, weigh up the pros and cons of staying in hospital and then make his decision not to be admitted and communicate his decision to the CMHN. [F22.8]
[132] Kent and then Peterborough in 2012. [F22.21 F22.22 F22.23 F22.25]

assessment process, it is the SI Panel's view that this information would likely have been helpful to DCMH [redacted] for the purpose of determining the SP's future risk and management.

119. **Lack of engagement with the SP's family.** The SI Panel found no evidence that either the CoC or DCMH [redacted] had attempted to engage directly with the SP's family at any point during the SP's contact with DCMH [redacted][133] DPHC's independent review into the death of the SP also concluded a lack of engagement between DCMH and the SP's family. They reported 'In this case the [SP's] wife could have been consulted, notwithstanding the strained marital relationship. Such communication with his wife could have helped corroborate history as well as inform assessment, reviews, and treatment.' [F11.3] The SI Panel agree with the independent review's point and believe that engagement with the SP's family could have afforded both the CoC and DCMH more management options and may have even allowed his spouse to encourage voluntary admission to an ISP.

120. **Continued excessive and harmful use of alcohol during DCMH care.** The SP reported during his initial DCMH [redacted] review on [redacted] Jan 22, that although he had previously consumed alcohol he had not done so since [redacted] Dec 21. [F22.8] However, there is an abundance of evidence to suggest that the SP was consuming alcohol throughout Jan 22 and during the period immediately leading up to his death. The SP informed the doctor, during a consultation on [redacted] Jan 22, that he tried not to drink alcohol during the week but was still consuming alcohol on weekends.[134] [F22.18]

121. The SP reported to the doctor that reviewed him on [redacted] Jan 22 that the only time he slept was when he had consumed alcohol. [F22.18] The PI Comd recalled "*...there's a few times that...I walked into his room, and he was drinking.*" [T34.9] The CQMS recalled "I *knew he was drinking which I discouraged...*" [T23.4] A friend who lived in the same accommodation recalled. *"...a couple of weeks before he died...there was maybe about seven crates of Budweiser just stacked up [in the SP's cupboard].*" [T23.10] In her statement to the Coroner, the SP's sister recalled. '*He was drinking there alone [in his room] while listening to music. This became a regular thing for him in the days before he died. I told him/begged him to stop but he used it as a coping mechanism and a way to sleep.*' [135] [F1.19]

122. A close friend informed the SI Panel that before and during the SP's time under the care of DCMH [redacted] during a typical drinking session the SP would drink until he passed out with the exception of running out of alcohol and being unable to locate someone sober enough to go and purchase more. [F23.5] The SI Panel consider that the SP gave inconsistent accounts to clinicians in regard to his alcohol intake, and that whilst the SP claimed to be largely abstinent from alcohol, he was in fact drinking to an excessive and potentially harmful level throughout the period of his care with DCMH [redacted][136]

123. **DCMH [redacted] review with the SP [redacted] Jan 22.** The SP attended his review with the CMHN as planned on Mon [redacted] Jan 22. The CMHN recorded no significant changes since the previous Friday. The SP reported contact with his friends over the weekend but felt guilty that people were going out of their way to help him. The CMHN focused on the

[133] Despite this there is evidence which suggests that the SP was communicating limited information to his spouse and sister. The SP informed the CMHN that he had told his spouse of his appointments but had not given all of the detail as he didn't want to worry her. [F22.12] Likewise, the SP informed his sister that he was "*...being put on 'suicide watch'.*" [F1.19]

[134] SP informed the doctor that at weekends he would drink one bottle of wine and eighteen beers. [F22.18]

[135] See recommendation section 3i, 3r.

[136] See recommendation section 3h.

SP's poor sleep and advised on a sleep hygiene strategy, as sleep was still a significant problem. The CMHN recorded that the risk of substance misuse, including alcohol, was low. [F22.12] The SP reported that that although he was happy to let people know that he was okay and grateful that close friends were checking up on him, having random people checking for the sake of it was not helpful. [F22.12] Both the CMHN and SP agreed that the CMHN would discuss this with his unit. The OC would later confirm that this discussion took place, and a 'light touch' approach was implemented by the unit.[137]

124. **Multi-Disciplinary Team meeting (MDT) meeting [redacted] Jan 22.** The CMHN presented the SP's case to her colleagues at the MDT meeting in order to optimise the SP's care.[138] During the meeting, the Consultant Psychiatrist stated her intention to carry out a same day paper review of the SP's case in order to provide recommendations and assist with the SP's short-term management. It was decided during the MDT that the CMHN would update the Padre and the unit. The CMHN also engaged in a telephone call with the RMO which allowed for a more comprehensive discussion about numerous aspects of the SP's case. It was also disclosed during this meeting that the SP had been offered two DCMH appointments per week but had declined this as it was perceived by the SP to be too intrusive.[139] [F22.14] Therefore, the existing one session per week consultation plan remained in place.

125. **Recording of MDT meetings.** The SP's case was presented and discussed on two occasions at the DCMH [redacted] weekly MDT meeting[140]. The outcomes of the MDT meetings were recorded on the Risk Management Update (RMU) document. Whilst this document accurately recorded the outcomes of the MDT and the plan going forward, the SI Panel are of the opinion that the discussion leading up to these outcomes and plan, was poorly recorded.

126. In the case of the SP, the RMU document appears to be the same document cut and pasted from one meeting to the next, with only minor amendments made towards the end of the document.[141] This is significant when considering that two separate clinicians purportedly authored almost identical documents one week apart with only minor changes to distinguish one from the other. On the basis of these documents alone, it is difficult to fully understand what was discussed at the two MDT meetings and how decisions were reached. It is also difficult to ascertain if any individual clinician's opinions were voiced, or if there were any concerns or advice from other clinicians not directly involved with the SP's care but who nevertheless may have been able to add value to it.

127. There is a Standard Operating Procedure (SOP) which has been produced by DPHC, which directs practitioners on how to correctly record MDT meetings.[142] The SI Panel noted during interview that not one of the clinicians who attended the MDT meeting was able to account for what was discussed during the meeting, which would have

[137] It was agreed between the OC and the CMHN that checks would be carried out in the evening, but not too late and again in the morning. [F1.19]
[138] An MDT meeting is a weekly meeting that takes place between the health care professionals of DCMH [redacted] in order to discuss individual patient cases.
[139] On average the SP was reviewed by a CMHN every 3 days. Initially the SP agreed to once a week consultation and then subsequently did agree to twice weekly sessions. [F22.14]
[140] The first MDT was held on the [redacted] Jan 22 and the second on the [redacted] Feb 22. [F22.14 F22.9]
[141] When word counting the 'RMU' document for the MDT meeting held on the [redacted] Feb 22. When excluding both the information which was cut and pasted from the previous MDT document (Sections 1 and 2), assuming that the 'update following patient review' section was generated from the previous SP review paperwork and not generated as part of the MDT discussion. The SI Panel concluded that the approximate original content of the document produced at the MDT (section 3 and 4) constituted approximately only 12% of the word count of the entire document.
[142] 2021DPHCSOP-03- 03-004 MULTI-DISCIPLINARY TEAM PROCEDURES FOR DCMHs. Dated May 21. [F33.4]

proven useful to the SI. As such the SI Panel are of the opinion that the recording of future MDTs must be recorded in line with DPHC SOP.[143]

128. **Face to Face MDT meetings.** Prior to Covid 19, MDT meetings were routinely conducted face to face by DCMH [redacted] staff. Hybrid working, driven by the pandemic, and wider availability of technology has increased the occurrence of MDT meetings taking place over Skype. The reason it is understood that DCMH has not reverted to face to face meetings because of key personnel, including Consultant Psychiatrists, being employed remotely. The Clinical lead at DCMH [redacted] stated *"...in my opinion I would rather have a psychiatrist who's on site, who's got an open door that you can just go to have a consultation [with]...at any point."* [T23.12]

129. The SI Panel agreed with the Clinical lead and are of the opinion that DCMH [redacted] has allowed weekly remote MDT meetings via Skype to become normal practice due to the remote working of key personnel. The SI Panel are of the opinion that wherever possible the core constituents of an MDT meeting should aim to meet face to face, with only those who would otherwise be unable to attend the meetings in person, adopting a hybrid approach. It is the opinion of the SI Panel in the case of the SP, that the MDT meeting, although remote did not appear to have impacted negatively on his care.[144]

130. **Consultant Psychiatrist same day paper review.** The main focus of the Consultant Psychiatrist's same day paper review was to provide some advice with regard to the patient's short-term management, specifically their occupational grade and medication. During the MDT, the Consultant Psychiatrist had offered to provide her recommendations the same day. This was owing to the fact that she would otherwise be out of office for another six days but also because she felt that the SP could benefit from a prompt change in medication. [F9.20] During the MDT the Consultant Psychiatrist did not recall being asked by any of the attendees to perform a full review of the SP's DCMH [redacted] notes. She also did not recall any of the attendees discussing that the SP required an urgent Consultant Psychiatrist review. She was also not asked by any of the attendees during the meeting to see the SP on that day. The Consultant Psychiatrist worked within a local understanding at the time, that any DCMH clinician could, if required, request an urgent Consultant Psychiatrist review at any time. [T23.14]

131. The Consultant Psychiatrist recorded on her DMICP entry on that day that she reviewed both the RMO's referral to DCMH and the CMHN's initial assessment, recorded during the SP's first visit to DCMH [redacted] [F22.29] The Consultant Psychiatrist felt that these documents were key as they contained recent assessments of the SP. When reviewing the SP's DMICP record, in order to provide recommendations, the Consultant Psychiatrist would typically look at consultation entries, clinical documents, the PULHHEEMS tab [145], the medication tab, the diary tab, the task tab and the problem section. The Consultant Psychiatrist recorded that the Read code 'low mood' was listed in the problem-all section and as being active on [redacted] Jan 22. She also noted that there was no information in the problem-all section of the doctor's referral dated [redacted] Jan 22. There was also no summarised past psychiatric history prior to 2022. It was the typical practice of the Consultant Psychiatrist to look to see if the patient in question had previously been formally downgraded on account of their [redacted] health. This would have been reflected in the S grade of the PULHHEEMS section of the SP's DMICP notes.

[143] See recommendation section 3p.
[144] See recommendation section 3dd.
[145] The PULHHEEMS system of medical classification is a tri-Service system, described in JSP 950, and takes its name from the first letters of the division under which the medical examination is carried out.

According to the SP's notes he had never been downgraded on account of his [redacted] health. [T22.18 T23.14]

132. The Consultant Psychiatrist understood at the time that the CMHN who had conducted the SP's initial DCMH assessment on [redacted] Jan 22, did not at this point have a complete understanding of the SP's past psychiatric history, as outlined by the SP during that initial assessment.[146] However, for the purpose of providing recommendations to assist with the SP's short-term management, the Consultant Psychiatrist did not deem it necessary to seek out any distant psychiatric history at this point. The Consultant Psychiatrist intended to seek to gain a full understanding of the SP's psychiatric history when performing a Consultant Psychiatrist initial assessment at a later date. Having reviewed the information, the Consultant Psychiatrist then documented her understanding of the SP's recent [redacted] state, risk history since Sep 21, existing prescribed medication, alcohol history and his personal circumstances. The Consultant Psychiatrist felt that this was the required information in order for her to complete her task at that point in time. [T23.14]

133. **Consultant Psychiatrist recommendations.** As a result of the same day paper review, the Consultant Psychiatrist recommended that the SP should be downgraded to Medically Non-Deployable (MND), unfit for weapon handling and safety critical tasks, unfit for night and shift work and that he also required outpatient psychiatric treatment. She advised the CMHN to discuss with the SP whether his needs would be best met by being sick at home. [F22.29] The Consultant Psychiatrist also identified the need for her advice to be reviewed and so communicated this recommendation to the CMHN who agreed to contact the relevant MO.[147] She also recommended short term medication advice with the intention of alleviating the SP's distress at the earliest opportunity. She provided specific advice with regard to initiation, dose and frequency of [redacted] [F22.9] She also felt that the MO would be the best person to review this advice and would ultimately decide whether or not to prescribe this medication. She communicated this recommendation to the CMHN who in turn agreed to contact the relevant Medical Officer (MO). She also added limited dispensing advice as there was a history of the SP presenting with [redacted] thoughts. The Consultant Psychiatrist's final recommendation was for a routine Consultant Psychiatrist's initial assessment in order for her to be clear on a diagnosis and review of medication. She added that should a cancellation arise; the SP would be suitable to be offered this appointment.[148] [F11.16]

134. **Consultant Psychiatrist's same day paper review.** Having scrutinised the circumstances leading up to and including the completion of the same day paper review on [redacted] Jan 22, the SI Panel are of the opinion that the Consultant Psychiatrist responsible for the review liaised effectively with the requesting clinician, identified the areas she needed to explore, reviewed the appropriate documentation and DMICP records and presented her findings in an appropriate time and manner to the requesting clinician. She also suggested MO involvement and advised on following up on the SP's care. [F22.29 F11.16] The SI Panel are of the opinion that her recommendations and management advice were appropriate. The SI Panel feel that like other clinicians accessing the DMICP system, the Consultant Psychiatrist's ability to attain a full understanding of the SP's

[146] The SP informed the CMHN that he had sought help from DCMH [redacted] after his first marriage breakdown and had later informed the CMHN that he had been admitted into an ISP for his own safety.
[147] The Consultant Psychiatrist felt that the MO was the gate keeper for formal downgrading decisions and therefore would be the appropriate person to review her advice. [F9.20]
[148] The SP was placed on a waiting list for routine appointment for the [redacted] Mar 22 which was seven weeks from the completion of the Consultant Psychiatrist's paper review.

[redacted] health circumstances was undermined by the inadequate Read coding of the SP's past psychiatric history.

135. **A lack of Consultant Psychiatrists at DCMH [redacted]** The SI Panel are of the opinion that the lack of Consultant Psychiatrists directly impacted on the level of support provided by DCMH [redacted] DCMH [redacted] was and still is established for three full time Consultant Psychiatrists. [F36.4 F36.6] At the time of the SP's death, they only had two civilian Consultant Psychiatrists. One was absent owing to annual leave immediately followed by study leave and the other psychiatrist was working remotely in the [redacted], part time for two days per week, on Tuesdays and Wednesdays. [F38.16] The third psychiatrist was hard gapped.[149] Whilst the SP was under the care of DCMH [redacted] only the psychiatrist working part-time remotely from the [redacted] was available to contribute to his care. A CMHN caring for the SP stated. *"...if we need someone [a patient] assessed by a psychiatrist, if they're remote it can be difficult...but also, we've got a really long waiting list because for so long we've not had our full capacity [of psychiatrists]."* [T34.1] The CMHN also described that owing to how the lack of available psychiatrists and the associated long waiting list for routine appointments was very long and this made it even more difficult to try to 'squeeze in' patients who required urgent Consultant Psychiatrist reviews. [T34.1] Due to the lack of Consultant Psychiatrists at DCMH [redacted] the SP was placed on a waiting list for a routine appointment on [redacted] Mar 22, which was seven weeks from completion of the Consultant Psychiatrist's paper review. Unfortunately, the SP died approximately five weeks and two days before he was due to attend this appointment.[150]

136. **Consultant Psychiatrist's seven week wait for a routine face to face review.** Due to the shortage of Consultant Psychiatrists as well as the length of the waiting list, Consultant Psychiatrists would often try to leave at least one urgent assessment per week available, in case of a crisis. [T23.11] The alternative was that if an SP patient was deemed to requiring an urgent risk assessment, then this would be to the detriment of a routine appointment. A patient awaiting a routine appointment would then lose their place on the waiting list and be re-booked for a later time. The Consultant Psychiatrist who carried out the paper review stated when asked if she thought that the [redacted] Mar 22 was an appropriate period of time for the SP to have to wait to be seen by a Consultant Psychiatrist. *"...I think it was what we had at the time. It was what we had to work with. In an ideal world I would see that patient sooner. We could say that for many patients. Unfortunately, that's not the case, either in the NHS or [NHS] mental health services."* [T23.14]

137. The SI Panel are of the opinion that had DCMH [redacted] been fully staffed with three Consultant Psychiatrists it is likely that the SP would have been seen earlier, even as a routine appointment. It is also the SI Panel's opinion that a full complement of Psychiatrists would have afforded more management options than a same day paper review.[151] It is also the opinion of the SI Panel that DCMH [redacted] should be fully staffed with its full complement of Consultant Psychiatrists (military or civilian), thus addressing the risk created by the current shortfall of Psychiatrists. During the period of time when the SP was under the care of DCMH [redacted] they were established for 112.5 Psychiatrist hours per week but due to a lack of Psychiatrists they were only able to deliver 15 hours per week, or 13.3% of their established hours.

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[149] Hard gapped is an expression used by the military when an appointment cannot be filled and remains vacant.
[150] See recommendation section 3q.
[151] More Consultant Psychiatrists would have provided DCMH [redacted] with more appointments for patients and offered CMHN's with better flexibility outside that of the MDT.

138. **DCMH [redacted] review with the SP [redacted] Jan 22.** The SP attended his next review with the CMHN via telephone.[152] The CMHN recorded no significant changes since the previous review on Mon [redacted] Jan 22. The SP reported that his mood was still low, and that he was only getting four hours of broken sleep per night. He continued to have suicidal ideations which occurred mainly during the night.[153] [F22.10] The CMHN recorded that the SP keeps telling himself *"...I am getting help now I need to give it time."* He also said, *"I have given my word that I won't do anything, and I won't...I want to get better and have kids to think about."* The SP reported that the doctor he spoke with regarding his medication was not very helpful and appeared to the SP to be reluctant to prescribe the medication that had been recommended by the Consultant Psychiatrist, following her paper review. He stated that he did not want to see this doctor again before he then shifted the focus of the conversation to the difficult consultation that he had experienced with the duty doctor back in Sep 21. [F22.10]

139. The SP then discussed his experiences with the duty doctor in Sep 21 at length.[154] The CMHN reassured the SP that the duty doctor should not have treated the SP in this manner and that the SP should consider lodging an official complaint. The CMHN then discussed the complaint process with the SP who stated that he wanted to think about it and then get back to the CMHN at the next session.[155] The CMHN completed the SP's care plan and discussed the SP's next appointment which, owing to the CMHN's illness, needed to be conducted by another CMHN. [F22.10]

140. **DCMH [redacted] review with the SP [redacted] Jan 22.** The SP attended his next review with the replacement CMHN as planned. The CMHN recorded no significant changes since Fri [redacted] Jan 22. The SP reported, apart from a small social interaction in the corridor, that he had spent most of the weekend in his room.[156] The SP also reported that he could barely function as he was so 'exhausted and overwhelmed.' The SP stated that he still had daily suicidal thoughts.[157] When considering the SP's level of risk, the CMHN once again offered the SP the opportunity to be admitted as an inpatient, but again, he declined. The SP stated that he kept the option for admission in the back of his mind and would continue to consider it. He also reported having a little bit of hope now that he had been prescribed medication and DCMH [redacted] could help him feel better and improve his life. The SP further reported that he had had daily contact with his CoC, including the Padre. The CMHN also reviewed the SP's medication and recommended that the MO now consider increasing both his medication at the next MO review. [F22.9 F22.13]

141. **MDT meeting [redacted] Feb 22.** The SP's case was presented for a second time at the MDT meeting. The CMHN reported that the SP continued to experience all biological symptoms of depression including poor sleep, and the SP continued to have daily suicidal ideation with no current plans or intent to act on these ideations. The MDT agreed to the suggested increase in medication and identified the need for the RMO to downgrade the patient and produce an Appendix 9 in order to ease some of the SP's anxiety regarding pressures at work.[158] It was agreed that his next review would be face

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[152] It is unsure as to why this review took place as a telephone call and not a patient facing encounter. The telephone review lasted one hour.
[153] The CMHN records that these were thoughts with "...no intent or plan at this time." [F22.10]
[154] The SP reported that the encounter in Sep 21 wasn't helpful and lead to the SP feeling unable to ask for help and that it was soon after this appointment that the SP tried on three occasions between Sep/Oct 21 to attempt [redacted]
[155] There appears to be no evidence to suggest that this subject was discussed again at the next meeting.
[156] The SP reported that he cannot tolerate being around people and he finds this incredibly stressful. [F22.13]
[157] The SP reported that he had no intent or plans to end his life and had not had any plans or intent since seeking help following the last suicidal attempt.
[158] Appendix 9 is a form used to notify the soldier's unit of their functional restrictions in relation to their illness. It is carried by soldier like a light duties chit and allows them to focus more on their recovery and less on their role.

to face the next day. Finally, the MDT ratified the management plan predicated on the SP's risk, which remained assessed as moderate. [F22.9]

142. **DCMH [redacted] review with the SP [redacted] Feb 22.** The SP attended for what was to be his last physical contact with DCMH [redacted] prior to his death. He reported being 'slightly better' since his previous review. [F22.11] The SP felt that his recent appointment with the RMO was a *"breath of fresh air"* owing to the fact that he at no point felt judged and had been generally helped. The increased medication had resulted in six hours unbroken sleep, and this had pleasantly surprised the SP as he felt better following this. He also reported feeling less pressure from work and had also managed to complete his agreed activity of going out for a coffee. The SP observed a big improvement when a friend came into his room, and they had sat for twenty minutes and watched the end of a film together. The CMHN discussed with the SP some handwritten notes which he had produced the previous evening.[159] This was an expression of how he was feeling, presented in the format of a military concept which summarised his understanding of the situation he was in and the help he was receiving in order to avoid taking his own life. [F22.11]

143. The SP set a significantly higher goal than during his previous session by intending to attend the gym three times during the forthcoming week. The SP disclosed that despite still seeing comfort in death his hope for the future had increased. He was content to continue working with DCMH [redacted] and his RMO in order to see more improvement. The SP expressed guilt at the death of his friend who had [redacted] [redacted] The CMHN briefly discussed the grief cycle with him. At the end of the session the SP and CMHN agreed a plan going forward which included going for coffee, speaking to friends, watching the six nations rugby, and going to the gym. The CMHN closed the session by highlighting the importance of small steps and being compassionate to himself. She also recorded a [redacted] state examination similar to that of those recorded during the previous sessions with DCMH [redacted] [F22.11]

144. When considering the SP's level of risk, the CMHN noted that his suicidal ideation had reduced in intensity, but still remained. The CMHN still felt it necessary to offer him a same day inpatient admission. He once again declined. He also reported his continued daily engagement with the CoC and the Padre. The CMHN's plan was to review the SP again face to face on [redacted] Feb 22.[160] The SP expressed his relief at being granted sick leave. [F22.11]

145. **The missing journal.** Whilst under the care of DCMH [redacted] the SP kept a journal of his personal thoughts as well as his feelings with regard to his current poor [redacted] health. Throughout the SI, several witnesses recalled seeing the SP with his journal in hand or in close proximity to him. Likewise, many of these witnesses discussed the purpose of the journal with the SP and that he was quite open in his explanation of it. The SI Panel identified the importance in locating this journal in order to further explore the SP's thoughts during the period of time leading up to his death. Unfortunately, despite efforts to locate the journal, its whereabouts remain unknown.[161]

146. **The diagram within the journal.** The SP's spouse was able to provide a photograph of a single page taken from the journal. This was an expression of how he was feeling, presented in the format of a military manoeuvre which summarised his

[159] The SP's spouse provided the SI Panel a photo she had been sent by her husband on the night before the DCMH appointment which depicts the diagram/note that the SP shared with the CMHN. [F22.24]
[160] Despite the intention to review the SP on Monday, owing to the sick leave he had been granted, this appointment was scheduled for the following Tuesday. [F22.11]
[161] See recommendation section 3gg.

understanding of the situation he was in, and the help he was receiving in order to avoid taking his own life. The CMHN and a friend of the SP who saw the diagram both felt that it was an expression of the SP's aim to get well and not a plan of intention to take his own life. Having reviewed the diagram, the SI Panel on the whole felt that the diagram was indeed a positive attempt by the SP to express his desire to get well. The CMHN recalled that the SP *"...reported that he can see another route [with] the target/goal...being getting back to [his] old self."* [T34.1]

147. **Quality of care whilst under DCMH** [redacted] The SP was under the care of DCMH [redacted] for a total of fifteen days leading up to his death, was seen by a CMHN on five separate occasions and was discussed at MDT meetings on two occasions. There is strong evidence to suggest that throughout the SP's care with DCMH [redacted] the communication was good between both DCMH and the SP's CoC.[162] After the initial DCMH review, the CMHN had suggested to the OC that they reduced the number of times that the CoC would check on the SP whilst he was in his room as the SP felt that the initial frequency of official checks when he was in his room was too intrusive.[163] [F22.17] This was later reported in the LA as a 'light touch'. [F8.8] The OC recalled that this request made him feel a little uncomfortable, but he agreed to it.[164] [F1.19] The option of the SP having time at home with his son was also discussed between the CMHN and the OC. However, according to the OC, sending the SP home had been tried in the past and had appeared to make things worse.[F22.17] With the SP remaining unwilling to enter an ISP, the CoC believed that the next best option was for the SP to remain in the SLA and therefore in close proximity to the unit and the support of his friends and colleagues.

148. The SI Panel are of the opinion that the care provided to the SP by DCMH [redacted] during this period far exceeded that which the SP would have received outside of the military. The SI Panel also feel that the [redacted] health clinicians at DCMH [redacted] were likely somewhat disadvantaged for three reasons. Firstly, the inadequate application of Read codes on the DMICP system made it very difficult to identify a significant past psychiatric history. Secondly, the SP's unwillingness to be admitted to a psychiatric ward, despite it being the opinion of all of the DCMH [redacted] staff that admission was the best management option throughout his care. Finally, a patient who despite his claims of abstaining from alcohol, was consuming alcohol to a harmful degree throughout his time with DCMH [redacted] and thus significantly increased his risk of harm to self.

The Event

Narrative, Findings and Analysis leading up to the death of the SP

149. **The SP following his last consultation with DCMH** [redacted] **Feb 22.** Despite now being on sick leave the SP planned to remain on camp over the weekend and not to return home to [redacted] This would be the first weekend after pay day which would likely have resulted in a large proportion of the [redacted] SCOTS personnel heading home. This would significantly reduce the number of personnel remaining within the SLA and further isolate the SP, who in essence would be alone in the accommodation block. The CQMS remembered speaking with the SP and inviting him to his home to watch the rugby. He recalled *"...I think it was Wales-England...and he seemed quite keen for that, so I told him I'd come pick him up about 11 o'clock..."* [T23.4]

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[162] The changeover of CMHN's during this time did not appear to impact on the communication between the CoC and DCMH [redacted]

[163] The SP didn't want as many people focused on him or looking into what he was up to. [T23.7]

[164] The OC recalled saying to the CMHN *"I said that I would do that, but she had to understand that I have a duty of care to him as the CAP lead, and that we had to check on him at least a few times a day."* [F1.19]

150. **The evening of Thu [redacted] Feb 22.** Upon his return from DCMH [redacted] the SP met up with a close friend in the SP's room. His friend recalled that he would always wait for the SP to get back from his consultation with DCMH. *"I would always wait for him to get back from the meetings because he'd been [in] [profanity] rag."* [165] [T23.5] The friend was of the belief that the SP would be safer in hospital and recalled asking him to admit himself after every DCMH session. He felt that the SP never agreed to be admitted because of the perceived stigma [166] surrounding [redacted] health within the Army and especially within the Infantry. He recalled the SP *"...didn't want...everyone to like think he was a failure."* [T23.5] The friend left the SI Panel with the impression that the junior soldiers of [redacted] SCOTS had the mentality that they would *"simply get on with it."* He described that most soldiers would rather have a drink and generally confide in each other as opposed to seeking help from the CoC.

151. The friend remembered the last time that he saw the SP was on the early evening of Thu [redacted] Feb 22. He recalled *"We were all sat having a drink in his room."* [167] [T23.5] The friend recalled the conversation started with the SP talking about his journal and his recent consultation with DCMH and that after a few drinks the SP started cheering up and we were *"...having a bit of a crack...We were just talking...we were just having like a good laugh."* The friend stated that they drank a bottle of wine between them and then started drinking beer. [T23.5] The friend stated that later that evening they started playing music and singing along to it.[168] [T23.5 F8.14] The friend remembered leaving the SP's room at around 22:30hrs as he was getting a lift from a friend who was traveling up from [redacted] and had agreed to pick him up en-route and take him home.[169] The friend recalled that he and the SP were *"quite drunk."* [T23.5]

152. The friend stated that he did not want to leave the SP on his own and always worried on weekends when he was not there. He recalled *"...it was just that particular weekend because my mate...who lives across [from] him, he's usually there, so he could always sort of check in...[he] was away that weekend and that whole corridor was empty."* [T23.5] The friend stated that it was the SP himself who convinced him to go home.[170] He also recalled that when he would leave the SP on his own, the SP would give an assurance that he would be safe. He recalled the SP as saying *"I can promise you today, but I can't promise tomorrow..."* [171] [T23.5] This reassured the friend but also prompted him to try and communicate with the SP in some form on a daily basis.

153. Throughout the remainder of the evening and well into the early hours of the morning the SP continued drinking alone whilst messaging his friend and talking to him on the telephone. The SP sent the friend the following text with a picture of him in bed at 02:52hrs on [redacted] Feb 22, thanking him for the evening. *"In bed as promised lad cheers for coming down dude!! Life saver..."* [F19.7] The friend later replied to the SP's message, expressing his relief that all was well with the SP. *"Best message [I] could have hoped for*

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[165] The friend recalled after returning from DCMH the SP's mood would vary. *"...and we'd just have a drink and just talk [profanity]..."* [T23.5]

[166] The Army has actively delivered focused health promotion campaigns aimed at breaking down the stigma associated with mental ill health and encouraging help seeking since 2011 (initial roll-out of the Army's 'Don't Bottle It Up' campaign against MH stigma) and are continuing to progress activity in this area so that all personnel at an individual level know the avenues of support that are available to them when needed and also feel able, without fear or recrimination, to reach out for support when it is needed.

[167] It was just the friend and the SP alone in his room drinking.

[168] The SP recorded this event on his phone and later sent it to the friend who played it to the SI Panel during interview. The SI Panel were of the opinion that the recording captured a convivial moment between two friends.

[169] The friend recalled that he had been in the SP's room for around four hours.

[170] SP told the friend to go home as he had a family. They agreed to stay in daily contact with each other.

[171] The SP's friend took this as confirmation that the SP would not take his own life that day but that the friend would do well to check on him daily.

this morning brother, love ya xx." [F19.18] The friend would have no further contact with the SP until the evening of that day.

154. **The day of Fri [redacted] Feb 22.** The SI Panel are unable to definitively confirm the SP's precise movements during the day of Fri [redacted] Feb 22. Evidence suggests that he collected his medications from the Garrison pharmacy at some point during the afternoon. [F22.30] Likewise, two friends may have spoken with him on the afternoon but during interview, they could not definitively state whether they spoke to him on Thu [redacted] Feb 22 or Fri [redacted] Feb 22.[172] [T23.4 T23.10] His sister's statement for the Coroner reported that she had received a telephone call during the day, but that she was unable to answer because she was at work. Later, his sister received a text message that evening from the SP, who was wanting to talk about his recent hospital visit and to wish his nephew a Happy Birthday. The SP's sister was unable to talk and so messaged the SP back stating her intention to speak with him the following day. [F1.19]

155. **The evening of Fri [redacted] Feb 22.** At 19:46hrs that evening, the SP attempted to video-call the close friend with whom he had been drinking the previous evening. The call was not answered but the friend returned the call at 20:14hrs. Unfortunately, the SP missed this call, so the friend immediately followed this up with a text message *"You good brother."* [F19.5] The SP did not immediately respond to this message but did initiate another videocall at 21:22hrs which again was also missed by his friend. Following this failed attempt at a video-call, the SP immediately followed this up with a text message. *"I'm good bro just letting you know I'm good! Got my meds the day [redacted]."* [F19.5] Approximately forty minutes later at 22:03hrs, the SP sent a number of photographs to his friend.[173] [F19.7] At 22:24hrs the SP sent another friend a nostalgic photo. The other friend received the photo but did not respond to the SP. [F19.30] At 22:29hrs the SP sent another nostalgic photograph to a third friend. This friend responded immediately, and an exchange of further messages and photos took place and culminated with a final message to the third friend from the SP at 22:48hrs. [F19.22]

156. **Location of the recipients of nostalgic messages from the SP.** The SI Panel was aware of a rumour circulating that during the hours leading up to the SP's death, he only messaged friends who were away from the barracks and would not be able to get back to the barracks in time to help him. The SI Panel have been able to categorically prove that two of the recipients of these messages during the evening and morning leading up to his death, were in fact located at the same location as the SP at the time of his death. [F19.29 F19.30]

157. **A video call Fri [redacted] Feb 22.** At 22:50hrs the SP received a video-call from the close friend with whom he had been drinking the previous evening. The friend at the time was playing poker around the table with former serving friends. He noted at the time that the SP appeared happy, and they proceeded to have a laugh and a chat lasting seven minutes. [F19.2] When asked at interview the friend described the SP as *"happy drunk"* and claimed that he estimated the SP as being as drunk as he had been the previous evening. [T23.5] The friend also voiced his concerns to the SP with regard to the SP consuming alcohol whilst taking [redacted] The friend's poker partner also warned the SP about the dangers of doing so. The friend reports that on receipt of this advice the SP *"Just [profanity] shrugged it off like it was nothing."* [T23.5]

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[172] One of these friends recalled speaking to him and suggesting that they meet for a cup of tea on the Sunday evening or Monday following the weekend. The other was the CQMS who cannot recall on which of the two days, he arranged to pick the SP up to watch the rugby on the Sat [redacted] Feb 22.

[173] The SP sent 6 nostalgic photos of the SP posing with friends and three videos, 2 nostalgic and one from that evening (Fri [redacted] Feb 22), which shows the SP intoxicated and addressing the camera.

158. Following the video-call the SP sent a nostalgic photo to a fourth friend and got an almost immediate response asking him how the SP was doing, however on this occasion the SP did not reply to this response until approximately four hours later at 03:30hrs. [F19.29] The SP's sister claimed in her statement to the Coroner that during this gap, she believed that the SP was consuming alcohol and playing on his phone until 03:00hrs and that she also knew that the SP was talking with other people. [F1.19] However, the SI Panel have been unable to confirm how she came about this information.[174]

159. **The final messages Sat [redacted] Feb 22.** During the early hours of Sat [redacted] Feb 22, the SP sent his final messages. At 03:30hrs he replied to the fourth friend who had messaged him to see how he was four hours previously. The SP messaged. *"Opening pandoras box with pics dude."* [F19.29] The fourth friend never replied to this message. At 03:46hrs, The SP messaged his close friend with whom he had been drinking on the [redacted] Feb 22. *"I'm sorry dude but I cant Kee[p] that promise L[ove]."* [175] [F19.2] The friend responded to this message 12 minutes later with a video-call which went unanswered. The friend then sent a message to the SP at the same time. *"We [profanity] off brother don't say that just hold on a couple more days till a [Sic] get back xxxx."* [F19.3] The message went unanswered. The friend then initiated an audio-call at 04:00hrs. [F19.3] This too went unanswered.

160. **Growing Concerns.** The SI Panel found a number of contradictions with the individual witness accounts of what followed next. However, with the use of telephone records and incident book recordings, as well as witness statements, the SI Panel believe the following is the most likely account of what transpired. The last message sent by the SP, along with the SP's non-response to both the calls and messages sent by his close friend, caused the friend to become gravely concerned for the SP's safety. The close friend, who had also been consuming alcohol, recalls being overtly distressed in the presence of his fellow poker player and the poker player's girlfriend (PPG). [T23.5]

161. Following the close friend's last failed attempt to call the SP at 04:00hrs, the friend then called a Junior Non-Commissioned Officer (JNCO) who he believed was located in the same accommodation block as the SP. However, the JNCO did not answer this call when it was made at 04:04hrs. The friend reports becoming even more exasperated and concerned. He then made another call to the same JNCO at 04:05hrs. Again, the JNCO did not answer this call.[176] [F19.21] The friend described becoming inconsolable with concern and frustration and at some point, but no later than 04:08hrs he proceeded to destroy his phone *"I [profanity] smashed the phone."* [T23.5]

162. **The Guardroom is contacted.** With no phone and increasing concern, the close friend now relied on the PPG to call the guardroom and communicate their worries and request a welfare visit to the SP. The PPG's phone records show that the first call to Richmondshire Lines guardroom was attempted at 04:08hrs. [177] [178] [F19.28] A second call from the PPG's phone to the guardroom was successful at 04:15hrs. During this call, the friend's concerns and the SP's details, including SLA location were passed on to the

[174] In her statement to the Coroner, the SP's sister claimed that she had been messaging the SP on her phone and this is the likely source of her information, but despite her initially intending to share these messages with the SI Panel, she never did and so the SI Panel cannot categorically confirm that this is how she came by her information.
[175] The SI Panel are of the opinion that the 'unkeepable' promise the SP communicates is in respect of his previous statement to his friend regarding keeping safe. *"I can promise you today, but I can't promise tomorrow…"*
[176] The JNCO was located within the same accommodation block as the SP but unfortunately was asleep at the time of the call and didn't see the missed calls until 07:41 later that morning.
[177] The Richmondshire Lines Guard Room was the single point of access to a number of camps within the same perimeter fence in the west of the Garrison area.
[178] This call for some reason was not successful. Whilst the SI Panel are unable to definitively establish why, they are of the opinion that the call was 'physically' not connected, the line was engaged, or the call was not physically answered at the guardroom end.

Guard Second in Command (2IC).[179] [F19.28 F37.1] The 2IC and another soldier of the duty guard drove to the SP's SLA block in order to conduct a welfare check. Approximately nineteen minutes following on from the PPG's call to the guardroom, the SP's close friend received a call, on the PPG's phone, from the 2IC at 04:34hrs, requesting further information in order to specifically locate the SP's room within the SLA block.[180] [F19 28] The 2IC eventually located the SP's room by identifying a Welsh flag pinned above the door. [T23.5] From receiving the initial call at 04:15hrs, to gaining entry to the SP's room at approximately 04:40hrs, twenty-five minutes had elapsed.[181]

163. **Delays during the Guardroom's response.** During subsequent investigations, the SI Panel established a number of factors which likely contributed to the delay. Both members of the guard who attended the SP's room were not from the SP's unit and therefore were not familiar with that part of camp. They did not know where [redacted] SCOTS specifically housed their soldiers in respect to the other units' soldiers who were also housed in the same area. They had poor ground awareness with no mapping or electronic aids. Finally, the guard were given an address but had no directions and no means of navigating to this location. It is the opinion of the SI Panel that anyone given an address in an area with which they are unfamiliar, with no mapping or electronic aids with which to find it, would likely struggle to have found it any quicker than the guard that morning. It is also the SI Panel's opinion that the Guard 2IC was correct to call the SP's friend back for further directions.[182]

164. **Entry into the SP's room.** The 2IC and his colleague gained entry into the SP's room with the use of a master key at approximately 04:40hrs and immediately found the SP unresponsive. The 2IC cut the SP down and commenced cardiopulmonary resuscitation (CPR). [F9.7] At 04:48hrs, the 2IC called 999 and an ambulance car and ambulance were dispatched. [F18.6] At some point the Guard Commander arrived at the scene and took over the delivery of CPR from the 2IC. [F18.7 F18.16] Throughout this time the Emergency Services Operator verbally assisted and directed the CPR which continued up until the arrival of the paramedics at 05:02hrs. The paramedics confirmed cardiac arrest and took over the CPR at 05:02hrs. The SP remained unresponsive throughout this period and at 05:29hrs the CPR was stopped. The Paramedic recorded resus ceased at 05:29hrs. [F18.8]

165. **Inability to locate the on-camp defibrillator.** The SI Panel also noted that during the emergency which ensued, the on-camp defibrillator could not be located and was therefore not deployed at the time. The SI Panel note that the cardiac rhythm observed when the ambulance crew first arrived was 'asystole.' The SI Panel feel it is important to note that asystole is a non-shockable rhythm that would not have been treatable with a defibrillator. However, the SI Panel are unable to definitively say that asystole was the rhythm when the Guard 2IC initially arrived at the scene and so consequently cannot categorically state that the defibrillator would not have been of some use at some point during the emergency.[183] [F18.7 F18.16 F18.6]

166. **Events immediately following the death.** In the immediate aftermath of the death, the duty officer attended the SP's room and further managed the incident. [F5.3] The Police arrived and commenced their investigation of the scene as well as notifying their colleagues in [redacted] in order for them to inform the Next of Kin. The [redacted] SCOTS duty

[179] Guard 2IC is the 'Second in Command' of the guard on duty that night.
[180] At this point the friend was using the PPG's telephone, having destroyed his own.
[181] The SI Panel have driven the route from the Richmondshire Lines Guardroom to the SP's accommodation under guidance. It took approximately two minutes.
[182] See recommendation section 3hh.
[183] See recommendation section 3ii.

officer informed CO [redacted] SCOTS via the [redacted] SCOTS CoC. [F5.3] The CO then directed his Adjutant to report the incident up to their Higher Formation.[184] Police CID arrived at the scene and informed the Duty Field Officer that they did not suspect foul play. [F1.19] The CID officers removed a number of electronic devices belonging to the SP. The Coroner attended later in the morning departing a short time afterwards, taking the SP's body to the local hospital for post-mortem. The recording of the incident was reported by the unit in line with policy.

167. **The social network in the weeks leading up to the SP's death.** In the weeks leading up to the SP's death there is an abundance of evidence which suggests that the SP was surrounded by a social network that was aware of his difficulties and was supporting him in any way that they could. The CoC had gone to great lengths to support the SP and maintain regular contact with him. They also signposted him to the relevant medical services immediately upon establishing his vulnerability in Jan 22. His friends who shared the SLA block with the SP were equally supportive in both their levels of concern for the SP's welfare and the measures they took in order to ensure that he remained safe and did not become isolated. The medical services, specifically the clinicians within CGMC and the staff at DCMH [redacted] worked quickly to assess and manage the immediate risk, support the SP, and encourage the SP to set goals in order to avoid isolation.

168. It has already been established that during this time the SP was regularly consuming harmful quantities of alcohol, despite claiming that he was not. It is well-established that alcohol misuse can exacerbate low mood, and can significantly increase the risk of self-harm, suicide or impulsive acts. However, it is the opinion of the SI Panel that the social support the SP was receiving from the CoC, the medical services and his friends, played a significant role in mitigating this risk during these occasions when the SP was consuming excessive quantities of alcohol.

169. **Isolation and loneliness on the evening of Fri [redacted] Feb 22.** The SI Panel are of the opinion that on the evening of [redacted] Feb 22, due to circumstance, the SP's social network of support was weakened. DCMH [redacted] had a plan in place in case of crisis over the weekend. However, this plan was reliant on the SP actively reaching out and requesting help. The SI Panel have established that during every presentation involving poor [redacted] health, the SP only presented for help after been directed to do so by the CoC or by his spouse.[185] The SI Panel also discerned a greater reluctance by the SP to seek help after his reported loss of trust as a result of the difficult consultation with the duty doctor in Sep 21.The SI Panel also observed a perception by the SP that 'He is in the way, feels he is a problem and hindrance [and] keeps apologising to the CoC as he feels he is causing them more problems.' [F22.27] In light of these factors, the SI Panel have concerns that the SP may have been reluctant to have reached out for help in time of crisis.

170. The CoC had reluctantly agreed to adopt a light touch approach in monitoring at the request of the SP via DCMH [redacted] However, this still resulted in twice daily welfare checks.[186] In addition to these checks, the PI Comd had volunteered to regularly visit the SP on a nightly basis but had to deploy to Scotland on a range package on the 31 Jan

[184] The higher formation at this time was 1st Armoured Infantry Brigade which has since merged to become 1st Deep Reconnaissance Strike Brigade Combat Team.

[185] During the previous periods of poor [redacted] health and/or [redacted] in 2012, 2014, [redacted] Sep 21 and Jan 22, the SI Panel established that it was the observation of others which lead to his poor [redacted] health and the severity of it, coming to light. The SP never self-presented in the first instance.

[186] The twice daily checks consisted of either a physical visit, a verbal telephone call, or text messaging. They were carried out during the morning and early evening.

22.[187] [T34.9] A welfare check was conducted on the morning of Fri [redacted] Feb by the CQMS via text message. [T23.4] The CQMS also took the opportunity to confirm their intentions to meet up and watch the rugby on [redacted] Feb 22. No evidence was found to indicate that the anticipated check was completed during the evening of Fri [redacted] Feb 22. The SI Panel are of the opinion that had these checks been formalised and subsequently actioned, there may have been an opportunity to physically observe and engage with the SP, to establish his wellbeing that evening. The SI Panel believe the lack of any face to face engagement with the SP during that evening represented a missed opportunity to ensure the SP's well-being at the time.

171. Throughout this period, the SP had always been surrounded by his close friends and colleagues who occupied the same accommodation block as him. Unfortunately, by the evening of Fri [redacted] Feb 22, many of those occupants had taken advantage of having been paid recently to go home that weekend. This would have significantly reduced the number of personnel remaining within the SLA and further isolate the SP, who was now alone in the accommodation block and separated from his closest friends and those who up until this point, had been there as the last line of support and to assure the SP's safety. The SI Panel are of the opinion that the lack of close friends and acquaintances remaining within the SLA that weekend resulted in the absence of one of the most important elements of the safety net, which had kept the SP safe up to this point.

172. Throughout the evening of Fri [redacted] Feb 22 and into the morning of Sat [redacted] Feb 22, the SP engaged with several friends via text messaging and telephone calls. He sent numerous nostalgic photos to these friends and there appears to have been frequent dialogue back and forth. The SI Panel feel this may have been an attempt by the SP to make up for the quiet environment and isolation in which he now found himself. The SI Panel are also of the opinion that the lack of friends in physical proximity to the SP during this period meant that any advice and welfare checks they would usually conduct when with him, could not take place.[188]

173. **The consumption of alcohol and prescribed medication leading up to the SP's death.** During witness interviews it was established that the SP was likely to have been consuming excessive quantities of alcohol whilst taking regular [redacted] from the time the medication was first dispensed on the [redacted] Jan 22, up until the SP's death on the [redacted] Feb 22. The subsequent toxicology report from the post-mortem identified alcohol, [redacted] present in the SP's blood. The toxicology report quantified the blood level of alcohol in his system as being around twice the drink drive limit in England. These levels are associated with double vision, violence, disorientation, confusion loss of coordination, vasodilation, stupor, vomiting and sweating. The report also noted that the Central Nervous System effects of alcohol may have been exacerbated by the presence of [redacted] [F1.19] The SI Panel are of the opinion that the SP's excessive consumption of alcohol whilst taking [redacted] exacerbated the effects of the alcohol and that owing to his intoxication, the SP was at a greater risk of disinhibition and impulsive acts at the time of his death.

174. **The period of time leading up to the event.** During the SI Panel interviews there was an abundance of evidence gathered which suggests that the SP was enjoying a period of renewed optimism following his referral and engagement with DCMH in Jan 22.

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[187] The PC had also been asked to conduct twice daily checks during the previous weekend ([redacted] Jan 22), as he had been on duty, but was not on duty over the weekend in which the SP died.

[188] The evidence highlighted that when present in the SLA, the SP's close friends had a positive impact on his welfare. The evidence also suggests that advice regarding drinking alcohol whilst taking medication was given via telephone that evening, but the SP laughed this off. [T23.5]

The Padre recalled *"...he's grateful that there was an intervention that appeared to stop him from going and taking his life..."* [T23.1] The CQMS commented on the improvement the SP had shown since coming under the care of DCMH *"...the way he was talking about it [the SP's outlook], it was quite positive...he seemed more confident about the way forward. He seemed more happy about the process that was going on with him... he seemed more calm..."* [T23.4] The CSM also noted a change in the weeks leading up to the SP's death. *"...he seemed open and he was communicating with everyone."* A good friend of the SP said *"...at the time it was strange, because the time that he did kill himself...he almost seemed to get better."* [T23.7] His PI Comd also noticed an improvement before he died. *"...those last three weeks before his death...he had a really good three weeks...the demeanour, he was smiling, he was laughing...he seemed like he was getting better."* [T34.9] It is the opinion of the SI Panel that following the referral to and engagement with DCMH, those around him noticed a marked improvement in the SP's outlook and demeanour.

175. The SP's final session with the CMHN at DCMH [redacted] also supports this impression of improvement which was perceived by those who dealt with him on a daily basis. The SP set a significantly higher goal than during his previous session by intending to attend the gym three times during the forthcoming week. The SP disclosed that despite still seeing comfort in death his hope for the future had increased. He was content to continue working with DCMH and his RMO in order to see more improvement. At the end of the session the SP and CMHN agreed a plan going forward for that weekend which included going for coffee, speaking to friends, watching the six nations rugby and going to the gym. The SI Panel are of the opinion that there are a number of observations from both his friends and CoC as well as notes recorded by DCMH staff, which corroborates a more optimistic outlook portrayed by the SP. The SI Panel also note that the evidence gathered confirms that the SP had arranged to watch the rugby with a friend and had also verbally made plans with other friends beyond that weekend.[189]

176. The improvement perceived by those who came into contact with the SP during the fifteen days in which he was under the care of DCMH [redacted] seems to stand at odds with the tragic outcome which occurred during the early hours of [redacted] Feb 22.The SI Panel are of the opinion that there was a combination of several factors which were unique to the situation on the morning of [redacted] Feb 22 and which may have played a significant role in the death of the SP. The SI Panel also feel that despite his engagement with DCMH and high levels of support by his friends and CoC, the salient factors which had contributed to this recent episode of poor [redacted] health remained.

177. During the last two days of his life, the SP was still consuming alcohol to excess. He was taking prescribed sedating medications. He was still experiencing significant financial difficulties. He was separated from his family and was still experiencing relationship difficulties with his spouse. His career had never progressed, and his peers had long since promoted and moved on. He was still struggling to cope with the death of his friend. On top of this he had a well-established history of poor [redacted] health and had recently disclosed feeling low in mood for several years. He was still suffering with poor sleep. The SI Panel are of the opinion that these factors had had a visible and negative impact on the SP's wellbeing and had done so since before Sep 21.[190] The SI Panel also felt that the factors identified on this occasion were strikingly similar to those identified as

[189] The SP had arranged on the Thu/Fri to be picked up by the CQMS on Sat [redacted] Feb 22 to watch the rugby and discussed having a 'brew' with another friend, late Sunday evening or on the Monday.
[190] There is evidence provided by the SP's spouse and SP, which supports the presence of these factors being present when the SP was serving at home in [redacted] as far back as 2019.

being responsible for the SP's poor [redacted] health in 2012 and 2014. It would therefore be unrealistic to expect that three weeks of observed improvement under DCMH care would have solved all of these problems.

Post Event

Narrative, Findings and Analysis following the death of the SP

178. **Possible suicide cluster and suicide contagion.** A 'suicide cluster' describes a situation in which more deaths by suicide occur than is normally expected in terms of time, place, or both. A suicide contagion refers to the process whereby one suicidal act increases the likelihood that others will attempt or die by suicide. Suicide contagion can lead to a suicide cluster. A suicide cluster usually includes three or more deaths, however, two suicides occurring in a specific community or location over a short period of time, should also be given attention. [F27.11] From 2018 until 2022 [redacted] SCOTS had four deaths which were over a short period of time, same location (Barracks) and each of the SPs died as a result of sudden unexpected deaths. The SI Panel are of the opinion that [redacted] SCOTS experienced several sudden and unexpected deaths within a short period of time and within a specific location. All four deaths were very similar in the method used and may require further investigation to rule out a suicide cluster.[191]

179. **CGMC internal review.** The Senior Medical Officer (SMO) of CGMC delegated the task of carrying out an internal review to a junior RMO, following the unexpected death of a Defence Primary Health Care (DPHC) patient. This should have been completed by the SMO as directed at the time in policy DPHC SOP G33. [F8.3] The SOP states that on receiving notification of the death of a SP, a senior clinician of an MMC is required to carry out a review of the clinical care of the deceased. The SMO or Deputy Senior Medical Officer (DSMO) is to carry out the actions and review the DMICP record unless the SMO or DSMO has been delivering care to the deceased. CGMC is not established for a DSMO. Therefore, the completion of the internal review was the responsibility of the SMO. The SI Panel are of the opinion that the SMO was not involved in this case and so should, in line with DPHC SOP G33 policy, have completed the review rather than delegating it to a junior RMO. [192]

180. **Defence Primary Healthcare (North) independent review.** An independent review into the practices of DPHC (N), in relation to the SP's care prior to his death, was carried out by the Patient Safety and Quality Improvement Working Group (PSQI(WG)). The SI Panel are of the opinion that whilst the independent review was very thorough and in keeping with a lot of the SI Panel's own findings, the SI Panel struggled to establish if the recommendations made by the independent reviewer, were subsequently actioned. None of the independent recommendations put forward appear to have been created with an end state in mind which would have clearly indicated that the recommendation had been achieved.[193]

181. **Distribution of the internal and independent reviews.** Early receipt of both the internal and independent clinical reviews by the SI Panel greatly assisted them throughout the SI. However, the SI Panel felt that a significant quantity of red tape needed to be navigated in order to gain access to the information from these two reviews. The SI Panel are of the opinion that future medical reviews should be easily

[191] See recommendation section 3nn, 3oo.
[192] See recommendation section 3jj.
[193] See recommendation section 3kk, 3ll.

available and form part of the decision making process prior to convening any future SI.[194]

[194] See recommendation section 3mm.

Section 3 – Recommendations and Observations

182. The following recommendations and observations are made, noting that progress may have been made in resolving these issues in the period between the incident and the publication of this report.

Terms of Reference One, Two, Three.

a. **Recommendation 1.** Command DPHC must remind all clinicians of the importance of correctly recording patients past medical history and to ensure all significant past medical events are correctly recorded.	Para 12 – 15
b. **Recommendation 2.** Home Command DACOS must remind all units in their CoC of the importance of adhering to the policy set out in AGAI 110, AGAI 78 and AGAI 57. Careful attention must be given to ensuring the effective management and leadership of all soldiers; if they are progressing in their careers, and especially if they are not.	Para 25 – 26
c. **Recommendation 3.** Field Army DACOS must remind all units in their CoC of the importance of adhering to the policy set out in AGAI 110, AGAI 78 and AGAI 57. Careful attention must be given to ensuring the effective management and leadership of all soldiers; if they are progressing in their careers, and especially if they are not.	Para 25 – 26
d. **Recommendation 4**. Field Army Support Medical DACOS must look to investigate further the serious concerns raised over the clinician's performance in this case specifically related to a single interaction on 23 Sep 21.	Para 46 – 50
e. **Recommendation 5.** Army HQ, Senior Health Advisor (Army) (SHA(A)) should consider before the next VRMIS upgrade including a data capture system which would allow the unit the ability to record the meeting outcome of Case Conferences where the service person is not added to VRMIS.	Para 72
f. **Recommendation 6.** Army HQ, Senior Health Advisor (Army) (SHA(A)) should consider adding a paragraph to Vol 3, AGAI 110, during the next rewrite, which offers units appropriate guidance when recording the meeting outcome from Case Conferences when the service person has not been placed on VRMIS.	Para 72
g. **Recommendation 7.** Army HQ, Senior Health Advisor (Army) (SHA(A)) should consider providing enhanced guidance on giving due consideration to potential friendships, loyalties, and conflicts of interest in order to mitigate those issues through clear direction.	Para 99 – 103
h. **Recommendation 8.** Army HQ, Senior Health Advisor (Army) (SHA(A)) should review policy used by the CoC that provides direction on alcohol consumption by SPs when individuals are deemed at a greater risk of impulsive behaviours and adverse outcomes when consuming alcohol.	Para 120 – 122

i. **Recommendation 9.** CO [redacted] SCOTS must review their unit alcohol policy and provide a more effective method of monitoring alcohol consumption within the SLA.	Para 121
j. **Recommendation 10.** Field Army Support Medical DACOS must ensure that all GPs are adequately educated and regularly reminded of the importance of following the GMC duties of a doctor.	Para 50
k. **Recommendation 11.** Field Army Support Medical DACOS must consider investigating whether or not an opportunity to diagnose poor [redacted] health was missed by the duty doctor.	Para 55
l. **Recommendation 12.** Command DPHC must consider further investigating the support to CMTs to ensure that any negative clinical cultures within CGMC are identified and resolved.	Para 63 – 65

Terms of Reference One, Two

m. **Recommendation 13.** Command DPHC must ensure that all clinicians are reminded of the importance of following up on all significant information disclosed by service persons pertaining to their past mental health.	Para 114
n. **Recommendation 14.** Command DPHC must ensure that all clinicians are reminded of the importance of following policy and procedures regarding the correct occupational grading of service persons.	Para 21
o. **Recommendation 15.** Senior Army Chaplaincy must produce additional guidance to all unit chaplains regarding the timely referral to the relevant support agencies when specialist intervention is required in line with policy Vol 3, AGAI 81.	Para 81 – 82
p. **Recommendation 16.** Command DPHC must ensure that the content discussed, and decisions made during all DCMH MDT meetings are recorded onto DMICP in line with the direction outlined in DPHCSOP-03-03-004 policy.	Para 125 – 127
q. **Recommendation 17.** Command DPHC must highlight the current significant shortfall of filled Consultant Psychiatrist PIDs within all DCMH establishments to their higher command.	Para 135
r. **Recommendation 18.** CO [redacted] SCOTS must consider whether there should be a limit to the quantity of alcohol permitted to be stored in the SLA by service persons.	Para 121
s. **Recommendation 19.** Home Command DACOS must remind all unit CoC of the importance of engaging with their SMO to report any issues when they suspect a breakdown has occurred in the Doctor/Patient relationship.	Para 79

t. **Recommendation 20.** Field Army DACOS must remind all unit CoC of the importance of engaging with their SMO to report any issues when they suspect a breakdown has occurred in the Doctor/Patient relationship.	Para 79

Terms of reference Two, Three

u. **Recommendation 21.** Army HQ, Senior Health Advisor (Army) (SHA(A)) should consider before the next VRMIS system upgrade including a systems programme change. The change must no longer allow units the ability to remove individuals from VRMIS earlier than stated in AGAI 110 for all those service persons who have self-harmed and automatically been placed on the unit VRM register for a minimum period of 12 months.	Para 5
v. **Recommendation 22.** Army HQ, Senior Health Advisor (Army) (SHA(A)) must consider whether the service persons Care Assessment Plan (CAP) should be made available to patient facing clinicians in order to provide holistic care.	Para 6
w. **Recommendation 23.** Command DPHC must ensure that all clinicians are reminded of the policy and processes to be followed when any Defence Medical Services personnel raises any concerns regarding patient care.	Para 61 – 63
x. **Recommendation 24.** Command DPHC must consider investigating the circumstances regarding the CMTs concerns not being raised in line with the JSP 950 1-2-13 and under Freedom to Speak Up policy.	Para 61 - 63

Terms of Reference Two

y. **Recommendation 25.** CO [redacted] SCOTS must remind all unit primary support staff that "Any situation where an adult is at risk of serious harm", they must be referred immediately to AWS as stated in Vol 3, AGAI 81.	Para 81 – 82
z. **Recommendation 26.** CO [redacted] SCOTS must ensure that all personnel are Moved and Tracked correctly on JPA in accordance with policy JSP 756.	Para 29
aa. **Recommendation 27.** Command DPHC must ensure all GPs fully understand the process involved in identifying and referring patients to AWS who would benefit from their direct support. GPs should be prepared to directly refer patients to AWS. Additionally, GPs and locums' induction programmes should now look to include all the relevant resources that are available to GPs/MOs in respect of making referrals.	Para 55
bb. **Recommendation 28.** Home Command DACOS must remind all unit COs of the importance of those within their primary level support referring service persons to AWS in line with policy AGAI 81, Vol 3.	Para 81 – 82
cc. **Recommendation 29.** Field Army DACOS must remind all unit COs of the importance of those within their primary level support referring service persons to AWS in line with policy AGAI 81, Vol 3.	Para 81 – 82

dd. **Recommendation 30.** Command DPHC must consider wherever possible the core constituents of an MDT meeting should aim to meet face to face. With only those who would otherwise be unable to attend adopting a hybrid approach.	Para 128 – 129

Terms of Reference Three

ee. **Recommendation 31.** Army Pers-Strat-Cbt-Inf-SO1 must ensure that due consideration is given to time served during future VENG boards when selecting individuals for VENG (Full) conversion in order to ensure that the offer is applied principally to those who are able and willing to progress from junior ranks.	Para 28
ff. **Recommendation 32.** HQ Pers Admin DACOS must ensure that on the next rewrite of JSP 756 that the Temporary Employed Elsewhere guidance to units is included.	Para 29
gg. **Recommendation 33.** People-AFPSP-Welfare must consider reviewing JSP 751 in order to emphasise the current direction being provided to units when securing and recording all personal effects pertaining to the deceased. As well as provide guidance to units, and the single service casualty/bereavement cells on how to manage any necessary sanitisation of personal effects prior to passing to the Next of Kin or family. Additionally, all units are to be reminded of the processes outlined in JSP 751 in order to correctly secure and accurately record personal effects.	Para 145
hh. **Recommendation 34.** Command Headquarters [redacted] Garrison must ensure that an updated list of all occupied SLA within Richmondshire Lines as well as adequate mapping is made available to all duty personnel within Richmondshire Lines MEP guardroom.	Para 163
ii. **Recommendation 35.** Command Headquarters [redacted] Garrison must review the Memorandum of Agreement (MoA) between Headquarters [redacted] Garrison and those units occupying Richmondshire Lines to include a chapter which covers Automated External Defibrillators (AEDs).	Para 165
jj. **Recommendation 36.** Command DPHC must ensure that all Principle Medical Officers (PMOs)/SMOs are reminded that an internal review is required following the unexpected death of a DPHC patient and that this review must be conducted in line with policy DPHC SOP 1-14-1.	Para 179
kk. **Recommendation 37.** Command DPHC must ensure that all medical recommendations made during any medical review are written in accordance with the JSP 950 Lessons Captured, in order to ensure that they maintain relevance and engender change.	Para 180
ll. **Recommendation 38.** Command DPHC must ensure that all recommendations made within a medical review following the unexpected	Para 179 – 180

death of a SP whilst under the care of DPHC are actioned within an acceptable time frame with all recommendations being assured.

mm. **Recommendation 39.** HQ APSG DACOS must, following an unexpected death, consider whether medical reviews should form part of the decision process prior to convening any Service Inquiry. If agreed a request must be made to Head DPHC to allow APSG to be added to SOP G33 distribution list. Para 181

nn. **Recommendation 40.** Army HQ, Senior Health Advisor (Army) (SHA(A)) must ensure that all units are adequately informed about suicide clusters and their response to them, ensuring they are also adequately resourced and supported. Para 178

oo. **Recommendation 41.** Army HQ, Senior Health Advisor (Army) (SHA(A)) must now look to investigate all recent deaths within [redacted] SCOTS from the period 2018 - 2022 in order to identify whether the unit had experienced a suicide cluster. Consideration of whether this should be expanded to include other units within [redacted] Garrison must be made. Para 178

Section 4 – Convening Authority Comments

1. **Convening Headquarters:** 1st (United Kingdom) Division.

2. **Introduction.** As the Convening Authority for this Service Inquiry (SI), I am grateful to the President and the Panel for the thoroughness of their Report and investigation both of which I judge to meet the Terms of Reference (TOR). I have reviewed fully the SI Report into the death of [redacted] Highlander (Hldr) [redacted] on 5 Feb 22 and I am content with their findings and the recommendations made in relation to TORs at Annex A to the Convening Order dated 3 Oct 22.

3. **Timelines.** The SI investigation has taken time to reach a conclusion. This is partly due to the medical complexity surrounding the case and partly because of the requirement to review evidence from the 12 years of Hldr [redacted] military career. It is also a factor of the thoroughness and detail into which the SI Panel delved as seen in the 41 recommendations they have made.

4. **Potentially Affected Persons (PAP).** Six individuals were identified as PAP during the SI and I am content that they were afforded the appropriate protections as per Regulation 18 of the SI Regulations.

5. **Findings of the Inquiry.** The report draws evidence from across Hldr [redacted] Service, but focuses predominantly on the period from Aug 21 where concerns for Hldr [redacted] health were raised, following the death of a close friend, until the morning of 5 Feb 22 when he was found unresponsive in his room. The report tracks the interactions from the duty doctor's assessment of him at [redacted] Garrison Medical Centre, the decision making at unit level leading to his inclusion on the Vulnerability Risk Management Information System (VRMIS) in Jan 22, the welfare support provided by [redacted] SCOTS and Hldr [redacted] consultations with the Department of Community Mental Health (DCMH) [redacted] The key findings include:

   a. **Causal factors.** Many of the factors believed to be present during Hldr [redacted] previous attempted [redacted] in 2012 and 2014 were present throughout the period of Aug 21 to Feb 22, namely reports of; relationship issues; dislocation from family members; debt; poor sleep; and the consumption of alcohol. However, the addition of grievance and career dissatisfaction were reported from Aug 21, as well as isolation in the day's prior to Hldr [redacted] death.

   b. **Clinical trust.** Hldr [redacted] appeared reluctant to seek help unless encouraged to do so by others. This reluctance appeared to become more prevalent following his interactions of Aug 21, presented through his unwillingness to be admitted as an inpatient during DCMH consultations and through his refusal to increase to twice weekly consultations.

   c. **Missed opportunities.** Inadequate reporting and 'Read coding' in Hldr [redacted] medical records hampered the understanding and potentially the actions taken by subsequent medical professionals. In addition, the shortage of Consultant Psychiatrists increased the waiting time for routine appointments for Hldr [redacted] beyond clinical best practice guidelines.

6. **Recommendations of the Inquiry.** The report makes 41 recommendations based on comprehensive analysis of the findings. These are focused into main areas:

a. **Unit-level actions.** Whilst the investigation's recommendations are directed to Hldr [redacted] unit, [redacted] SCOTS, they are equally applicable across all our units. Units must ensure adherence to and understanding of the policies surrounding VRMIS and the provision of Army Welfare Service (AWS) support for all adults at risk of serious harm. In addition, units should review their Alcohol policy, specifically the consumption of it within Single Living Accommodation (SLA). In addition, guardrooms should maintain an accurate list of SLA occupancy, finally unit personnel should flag cases where there appears to be a breakdown in the relationship between doctors and patients.

b. **Policy and Procedure.** The Chain of Command, and specifically Home Command and HQ Fd Army must reemphasise and seek to improve understanding of the policies detailed in AGAIs 57, 78 and 110 and the availability of Army Welfare Support as outlined in AGAI 81.

c. **Defence Primary Health Care (DPHC).** DPHC should reiterate the need to correctly record, review and highlight, significant events in patient medical records, especially where a patient discloses significant events that are not clearly flagged. This includes the recording of decisions made by DPHC during Multi-Disciplinary Team meetings and these meetings should be conducted face-to-face where possible. In addition, the culture in medical centres should be reviewed especially regarding the relationship between Combat Medical Technicians (CMTs) and clinical staff. This should specifically focus on their ability to raise concerns and to be listened to. DPHC, supported by the Chain of Command, must continue to fight for the correct provision of Psychiatric Consultants for our Service personnel.

d. **Army level recommendations.** These focus on changes to the management information systems that we employ; specifically, amending policy to mandate the recording of decisions not to include an individual on VRMIS and technical solutions that stop an individual from being removed earlier than policy allows.

7. **Summary.** I endorse fully the SI's findings and the recommendations made therein and submit it to Hd APSG as the final report. All recommendations have been disclosed to the relevant Senior Point of Authority, agreed, and endorsed. Eight recommendations have already been closed with the remainder due by the end of Dec 23.

Finally, on behalf of the Army may I also offer my sincerest condolences to the family, friends and loved ones of Hldr [redacted].

Major General TJ BATEMAN CBE 18 Oct 23

Section 5 – Reviewing Authority Comments

Introduction

I have reviewed the Service Inquiry report into the untimely and tragic death of Hldr [redacted] on 5 Feb 22. Our management of this soldier causes significant concerns. My observations are below.

Context

The issue. Hldr [redacted] had a history of poor [redacted] Health and instances of [redacted] which were not adequately communicated to the chain of command for an extended period. The result was that [redacted] SCOTS, during the period Jul 13 – Jan 22, were unaware of previous [redacted] attempts and the full extent of their responsibility to a particularly vulnerable serviceperson.

Service Summary. Hldr [redacted] enlisted into the regular Army in Oct 09.[195] He completed initial training at the Infantry Training Centre (ITC) [redacted] in Apr 10, and served with [redacted] SCOTS May 10 – Jul 13, including Op HERRICK 13.[196] He was assigned to [redacted] SCOTS in Jul 13 and served there until his death on 5 Feb 22. His time with [redacted] SCOTS included Op TORAL and a tour with the Regimental Support Team (RST) at [redacted]

Service Inquiry

On 26 Sep 22, GOC 1(UK) Div directed a Service Inquiry convene to investigate the circumstances surrounding the death of Hldr [redacted] at Richmondshire Lines, [redacted] Garrison on 05 Feb 22.

The Panel has identified key causal and aggravating factors – Hldr [redacted] had a well-established history of poor [redacted] health. Whilst in service he had previously attempted [redacted] in 2012 and in 2014. The factors identified during both these attempts, such as him experiencing relationship issues, debt, poor sleep, and consuming excessive quantities of alcohol, were also present during his recent episodes of poor [redacted] health in 2021 and 2022. However, the most recent episode also included additional factors such as the recent death of a very close friend, a lack of career progression and separation issues from his family.

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. A series of omissions and missed opportunities finally resulted in an appropriately collaborative effort to provide support in Jan 22. By then it was far too late. Some of these failings are more easily identified with hindsight. Many should never have happened.

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

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[195] SP had prior service as a Reservist with [redacted] Jul 08 - Oct 09. [F6.17]

[196] The SP's Initial Medical Assessment dated [redacted] Oct 09 records that he denied any current or past [redacted] health issues and no previous self-harm or attempted suicides were recorded. [F38.3]

a. Alcohol misuse

b. DCMH staffing, resource management and record keeping

c. Cultural failings leading to a loss of trust in medical support

d. Passage of critical duty of care information

e. Army and Defence policy and procedures

Recommendations. 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. **Alcohol Misuse.** Alcohol misuse remains a factor in many cases. While these recommendations deal with local alcohol policies and more practical, local supervisory arrangements, APSG are conducting a "deep dive" into alcohol as a factor.

b. **DCMH staffing and record keeping.** Had DCMH been more fully staffed, it seems clear that two risks would have been vastly reduced; that of patients not being seen early enough, and that of inadequate record keeping (and Read Coding). During the period when the SP was under the care of DCMH [redacted] they were established for 112.5 Psychiatrist hours per week. However, due to a lack of Psychiatrists they were only able to deliver 15 hours per week, or 13.3% of their established hours. This risk was not articulated to the local commanders or effectively rebalanced across the DCMH to mitigate any potential risk in reduction of care. Furthermore, the SI team were unable to determine whether a mechanism to highlight and address such issues exists.

c. **Cultural failings leading to a loss of trust in medical support.** It appears clear that the interaction between medical teams involved in Hldr [redacted] care negatively impacted his trust in medical support.

d. **Passage of critical duty of care information**. Already raised with DPHC as an enduring theme, the passage of information remains a significant concern. Much is being done to improve in this area, but I remain unconvinced that we have done all that is required. APSG (Organisational Learning and Lessons Fusion Cell) are to ensure that this is raised at the next Personnel Management and Policy Forum but I am convinced that there is also work to be done in evolving our medical professionals' training to ensure that their critical role as medical advisors to the chain of command is given appropriate emphasis. The chain of command holds the risk and duty of care obligations for its people, yet in many instances they are unaware of the risk they may be holding or the care that ought to be provided to their people due to a failure to pass on this information by the medical professionals. This challenge is exacerbated by the disconnect in relative prioritisation of unit support by the Defence Medical Services outlined below in the wider SSIC(A) observations.

e. **Army and Defence Policy and procedures.** Recommendations concerning Policies such as AGAI 110 and JSP 751 are important in refining these already

rigorous policies. In addition, there is a requirement to ensure that our exploitation of lessons identified keeps pace with issues identified during SI.

Management of the recommendations

Ownership. Defence Medical Services are responsible for 15 recommendations and Army Headquarters (Army Pers Health, Pers Strat and AFPSp) for eight. Field Army Headquarters are responsible for five and Home Command Headquarters for three. The remaining nine are divided between [redacted] SCOTS, APSG, Army Chaplaincy and the Command Headquarters of [redacted] Garrison.

Progress to closure. All recommendations have been endorsed and accepted by Senior Points of Authority and Support Action Managers ahead of this report's release, allowing them to be addressed and implemented. 41 of the recommendations have closure dates before Dec 23, with the remaining due to be closed by the end of Mar 24. At the time of writing, nearly half have been implemented.

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.

WIDER OBSERVATIONS AS THE ARMY'S SINGLE SERVICE INQUIRY COORDINATOR

The findings of the Service Inquiry provide a solid foundation for understanding the specific issues relating to Hldr [redacted] case, but as the Army's Single Service Inquiry Coordinator as opposed to as Reviewing Officer, I have concluded that this inquiry has again highlighted matters identified in other unrelated but similar cases. Key amongst these are inconsistencies with information sharing, risk ownership and the understanding of who is responsible to whom for what.

Achieving coherence is unlikely to be a simple issue as medical practitioners are directed and regulated by independent bodies such as the GMC which are beyond the MoD. They are consequently bound by strict regulations and ethical principles to safeguard patients' personal health data whilst concurrently being required to meet military requirements in their wider capacity as the MoD's 'in house' medical advisors – a reasonable employer requirement. A tension thus exists between balancing the duty to the patient and the duty to the employer which is most stark at the point where collaboration with the Chain of Command (CoC) as the Service Person's (SP) duty of care provider is required to effectively mitigate or manage risk.

Consequently, I have concluded that in addition to the recommendations of the Inquiry, the passage and sharing of medical information between medical care providers and the Chain of Command warrants further focus.

These comments are based on a growing body of evidence, primarily recommendations arising from Army Personnel Learning Accounts (LA) and Service Inquiries processed by APSG, in the following areas:

Communication between medical staff and the Army chain of command

The delicate balance between patient advocacy and the critical role as medical advisors to the chain of command has been a cause for concern in several cases over recent

years. Since 2015, 133 cases have highlighted poor communication between medical staff and the chain of command as a contributory factor in cases of death, VSI or SI which required a LA[197]. Since the establishment of APSG's Lessons Fusion Cell (LFC) in 2021, we have been able to carry out more detailed analysis. This higher quality of data and analysis demonstrates:

- Since Dec 21, there were 28 cases which highlighted poor communication (between medical staff and the chain of command) as a contributory factor. There were 11 cases in 2022 and 17 in 2023. Of these 28 cases:
    - Three cases resulted in death (suicide as the probable cause).
    - Two cases resulted in SI (one SH, one NC).
    - 23 cases resulted in UL (all SH).
- Additionally, further analysis shows that since 2015 there have been 12 cases of SH which led to (potential) suicide later, demonstrating the need for earlier effective communication to reduce the risk of death.

Resourcing and prioritisation

Similarly, the resource challenges faced by the Defence Medical Services are frequently acknowledged, particularly the demand / supply imbalance in Departments of Community Mental Health service provision. Since 2015, 40 cases cite inadequate DCMH resources as a contributory factor. All were SH or suicidal ideation cases:

- Three cases resulted in death (probable suicide).
- One case resulted in VSI (SH).
- 36 cases of SH and two cases suicidal ideation.

Our data show that the number of cases in which DCMH resources have been cited as an issue has increased markedly since 2016:

Year	2015	2016	2017	2018	2019	2020	2021	2022	2023
Cases	1	1	2	2	6	5	9	5	9

Concerns also exist about the relative coordination of roles and responsibilities between the Supported and Supporting commands. The Army as the supported command sets its relative priorities for the provision of medical support to its people as it is ultimately responsible for them and holds the risk for their care. The divergence of the respective prioritisation from the supporting medical command is concerning and, as evidenced in this case, results in decision making that effectively transfers risk, such as the resourcing of medical centres, to the supported commander without that risk ever being communicated. For example, the recently published (7 Nov 23) HQ DPHC Op Order 23/001 appears to prioritise UHCs and engagement with the chain of command as priority three (up from priority eight in the Defence Primary Healthcare – DPHC Mission-Priorities). However, the seven subsets of priorities one and two effectively mean there

[197] Caldicott Principle 7 states "the duty to share information for individual care is as important as the duty to protect patient confidentiality" (the Caldicott Report December 1997).

has been no change in how these meetings should rank in the wider context of the duties of those tasked to attend. In addition, using the term "Unit Health Committee" in priority three, sub-priority eight allows commanders and medical staff to regard CMCRs to be prioritised eighth. This should not be the case as CMCRs are the tool that COs use to appropriately manage the risk associated with vulnerable personnel. Without medical input, the meeting is arguably ineffective.

I therefore conclude that there remain two ongoing issues which require greater focussed effort, the resolution of which has the potential to save lives.

I recommend DG DMS considers the following areas of support to the Army in order to determine whether improvements are required:

- The assurance of specialist provision, particularly where resources are scarce, to ensure that timely decisions on prioritisation are enabled within both DMS and the Army;

- Policy, training, and guidance on the communication of medical information to the Army Chain of Command, to ensure that well informed and timely decisions on the management of Soldiers are supported.

This will be added to the DLIMS record as a 43rd recommendation of this SI and tracked and managed in the same way as the others. As I have added it in my capacity as the SSIC(A) it has the same underpinning statutory authority as the other recommendations and must be accorded the same attention.

SUMMARY

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

I acknowledge the Convening Authority's remarks.

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

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

28 Nov 23

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

Section 6 - Addendum to Service Inquiry Report

1. **Further information obtained during brief to Family [redacted] Jan 24.** A member of the SI Panel travelled to [redacted] in order to brief the SP's [redacted] and other [redacted] During this process, several pieces of new but relevant information were obtained. The briefing lasted approximately 8 hours and was a good opportunity to discuss the SI report and consider any factual discrepancies that may have occurred. The main issues raised by the family have been discussed in this addendum and are summarised here:

- The SP's [redacted] divulged that evidence that the SP had been involved in an altercation via text-messaging with his alleged [redacted] during the time directly leading up to his death.

- The SP's [redacted] provided a screenshot of the final photograph taken from the SP's mobile phone which shows a silhouetted image of what appears to be the SP taking a photograph of himself with [redacted]

- The SP's [redacted] also alleged that during the period of time that the SP and the SP's alleged/former [redacted] were exchanging messages on the evening of 04 Feb 22 and the early hours of 05 Feb 22, the SP's [redacted] [redacted] (SP's [redacted] was also messaging the SP's alleged/former [redacted] The SP's [redacted] was frustrated because at no point does it appear that the alleged/former [redacted] passed on information regarding the likely established vulnerability or worrying frame of mind that the SP appears to be demonstrating in the messages he was sending to his alleged/former [redacted] at the time.

- The SP's [redacted] refuted the findings of the SI panel that the Doctor at [redacted] Medical Centre was not aware of the SP's likely poor [redacted] health. She claims that she accompanied the SP to the appointment in [redacted] and that following the consultation, the SP returned to the car feeling as though the doctor he had seen was dismissive and suggested that the SP discuss his poor [redacted] health with his parent-unit's Medical Centre at [redacted]

2. **The altercation via messaging between the SP and his alleged/former [redacted]** The SP's [redacted] discovered evidence on the SP's personal mobile-phone which suggested that the SP had been involved in an altercation via text-messaging with his alleged [redacted] during the time directly leading up to his death. The SP's [redacted] agreed to share this information with us and subsequently passed on screenshots of the text-messaging interaction between the SP and his alleged/former [redacted] [redacted]

3. **The interaction between the SP and his alleged/former [redacted] in the hours leading up to his death.** The aim of the SI has always been to establish the facts in the time leading up to and following the death of the SP. However, the SI Panel are of the

opinion that it is not within our scope to scrutinise, criticise or assume that the interaction between the SP and his alleged/former [redacted] is cast iron fact, predicated in isolation on a number of text messages sent between one another. To this end the SI Panel will consider the new evidence and what it likely tells us but will also inform the coroner of the latest information and let them make any conclusions they think are appropriate.

4. The messages sent between the SP and his alleged/former [redacted] was initiated by the SP during the evening of Fri 04 Feb 22 at 22:18hrs and appears to be following the SP's discovery of a video saved on his phone, of himself and his now deceased close friend, (see para 32). The SP's deceased close friend's [redacted] also happened to be the SP's alleged/former [redacted] This behaviour of sending a video, is in keeping with other similar behaviour demonstrated by the SP that evening. Namely, trawling through his phone and sending several nostalgic photo's/videos to his friends, (see para 155/156). The SP's behaviour is also explained by his own admission contained within a text message he sent to another friend that evening. *"[I'm] Opening Pandoras box with pics dude."* The SI panel are of the opinion that it is more likely than not, that during the SP's review of nostalgic pictures on the evening of 04 Feb 22, the SP came across a video of his now deceased close friend and sent it to the deceased close friend's [redacted] (who also happened to be the alleged/former [redacted]

5. The video sent by the SP, appears to have then initiated a significant and what appears to be at times, an argumentative exchange of messages. The text message interaction appears to have taken place between the hours of 22:18hrs, 04 Feb 22 and 03:21hrs, 05 Feb 22. The SP's last message to the alleged/former [redacted] took place approximately nine minutes prior to the '*Pandoras box'* message, which the SP sent at 03:30hrs and the SP's final, *'I'm sorry dude but I can't keep that promise' m*essage, which was sent at approx. 03:46hrs, some 25 minutes later. The latter of these messages being the final message he appears to have sent prior to death.

6. The theme of the exchanged messages was predicated on the alleged/former [redacted] opinion that her deceased [redacted] would have hated the SP for the manner in which the SP had treated her. The SI Panel are of the opinion that the exchange of messages also hints at the negative frame of mind that the SP was likely experiencing during the hours and minutes leading up to his death. The following are examples of some of this content that was written and sent by the SP. *"He [the SP's deceased friend] doesn't need to hate me!!! I already hate me myself I'm sorry like I said if I could switch with him I would."* The SP also revealed to her that he had tried taking his own life, *"...three times in the last month."* Of his problematic alcohol consumption: *"...[I] was trying to suppress the absolute minefield going on inside of me."* At various points the exchange appears to become quite heated. Throughout the exchange the SP makes several references of intention to discuss the matter with his deceased close friend, potentially inferring that he may have been experiencing suicidal ideation or intention at times during the exchange. *"Ok guess I'll just need to ask him [SP's deceased close friend]"* and, *"I'm going to get absolute [profanity] hammered just now finish me beers and wine!! Be amazing to see [deceased friend's name removed] again!!... Well I tell you what I'll walk into the darkness with your [redacted] then no one has to worry."*

7. During the exchange the SP sends two videos to the alleged/former [redacted] The first video is of a song playing on his TV, which is about the mass drowning of Scottish sailors. The song is somewhat melancholy and tragic in its nature and likely sheds further

light on the SP's state of mind at the time he sent it. *"Through the cries of war I hear you…Killed in vain I see them falling…from hope and joy to wrenching sorrow…tears of love and deep relief become the tears of tearing grief.."* The SP sends a second video. The time it was sent is not known but the time stamp suggests it was recorded at 00:14hrs 05 Feb 22 three hours and thirty-two minutes prior to the final message he sent to his friend and four hours twenty-six minutes prior to him being found unresponsive in his room. The video is twenty seconds in duration and appears [redacted]

8. The exchange of messages ends at 03:21hrs with the SP sending his final message to his former/alleged [redacted] *"At least now I know [deceased friend's name removed] hates me so I guess this is good bye xx"*. The alleged/ former [redacted] responds to this message, some six hours and twenty-five minutes later, at 09:46hrs *"He wouldn't hate you I shouldn't of said that! Enjoy the rugby I will be cheering on Wales [Welsh flag emoji]…* [redacted] *Answer your Phone!!!...Please I need to talk to you please…* [redacted] *I'm so sorry* [redacted] *wouldn't hate you please you better not…"* Unfortunately, by this point, the SP was already deceased.

9. **The last photograph.** The SP's [redacted] also provided a screenshot of the final photograph that the SP took with his phone, prior to his death. The photograph appears to have been taken by the SP in his room, close to the time of his death. The photo is of a presentation that is mounted on the wall of his room. It contains a Glengarry (ceremonial headdress of [redacted] SCOTS), The Royal Regiment of Scotland cap badges and a 7th Infantry Brigade and 16 Air Assault Brigade TRF. It is not known if the SP ever sent the photo. It does not appear on any of the screenshots that the SP's [redacted] provided for the panel. The SP's [redacted] was unsure as to the significance of the photograph, but on receipt of the screen shot by the SI Panel Member, the SI Panel Member immediately identified that a reflection in the presentation clearly shows a silhouetted image of what appears to be the SP taking a photograph of himself [redacted] The time stamp on the photograph reads '[redacted] *Garrison –* [redacted] *5 February 03:37.'*

10. The SP's [redacted] was of the opinion that the SP probably took the photo in order to send it as part of the exchange between himself and the alleged/former [redacted] but because the alleged/former [redacted] stopped replying to the SP's messages beyond the last message the SP sent to her, (at 03:21), he likely didn't send the photo and/or any accompanying statement. The SI Panel are unable to establish the full significance of this photograph. It was taken approximately nine minutes before he sent the final message prior to his death. The SI Panel are unable to say definitively why the SP would have taken such a photograph but not sent it.

11. **Further allegations made by the SP's** [redacted] During the Family brief, the SP's [redacted] also alleged that during the period of time that the SP and the SP's alleged/former [redacted] were exchanging messages on the evening of 04 Feb 22 and the early hours of 05 Feb 22, the SP's [redacted] [redacted] was also messaging the alleged/former [redacted] The SP's [redacted] was frustrated because at no point does it appear that the alleged/former [redacted] passed on information regarding the likely established vulnerability/worrying frame of mind of the SP. The SI Panel have not seen any evidence which corroborates the SP's allegations but suggest that the coroner will likely want to be made aware of this significant allegation.

12. **The presentation of the SP to [redacted] Medical Centre.** The SI Panel had already established that during his time working with the Regimental Support Team (RST) in [redacted] the SP's [redacted] insisted that he attend the Medical Centre at [redacted] because of her concerns for his poor [redacted] health (See Para 22). The SI Panel also established that the SP did present to the doctor at [redacted] and that this doctor was the same doctor with whom the SP had the *"difficult"* consultation in Sep 21 at GMC. Further to this, The SI Panel established that during his time in [redacted] the SP was likely suffering with poor [redacted] health but that it was unlikely that the Officer Commanding the [redacted] SCOTS, CoC or the doctor at [redacted] were ever made aware of this (See Para 23). During the Family brief. The SP's [redacted] refuted the findings of the SI panel that the Doctor at [redacted] Medical Centre was not aware of the SP's likely poor [redacted] health.

13. The SP's [redacted] discussed this at length during the family brief and also via a text message to the SI Panel member afterwards. She claims that she accompanied the SP to the appointment in [redacted] and that she. "..h*ad had the [redacted] health] conversation with him on their way to the medical centre…he finally agreed to do it [seek medical help for his poor [redacted] health]."* The SP's [redacted] then added that on his return to the car following his appointment with the doctor: *"…when he came out [of his appointment] he wasn't happy at all with how it [the consultation at [redacted]] went… as he [the SP] said that the doctor was very dismissive of him [and] said that if he had issues to go back to his own camp [in [redacted] and see a doctor there… [name of SP removed] said that he won't try again [to seek further help for his [redacted]] that he was done trying and that he would deal with it himself…I could see that he was really upset [about the consultation]… I offered to take him [the SP] to my doctor instead but he refused that as well…It really upset him that after all of my nagging him for so long to get help…when he tried he was told to basically go away… After that [SP's name removed] just held it all in and struggled [and] turned to drink."* The SI Panel have not seen any evidence which corroborates the SP's allegations but would like to take the opportunity to acknowledge her disagreement with the SI Panels findings and to thank her for her account of the SP's visit to [redacted] Medical Centre. The SI Panel also feels that the coroner will likely want to be made aware of this significant difference between The SI Panels findings and the SP's [redacted] newly submitted evidence.

This concludes the addendum summarising and discussing the new information gathered following the SI Panel's brief to the family.

Section 7 – Convening Authority Comments following the Addendum

Convening Headquarters: 1st (United Kingdom) Division.

The Service Inquiry report was re-submitted on 7 Mar 24, following additional evidence which came to light during the brief to Hldr [redacted] Next of Kin on [redacted] Jan 24. I note no amendments or additional recommendations made as a result to the original report which I reviewed and signed off on 18 Oct 23.

I am very grateful to the SI panel for highlighting the new evidence, and particularly grateful to the to the family of Hldr [redacted] for providing the additional details to the Panel. Whilst this added further delay to the process for which I apologies, it was important to consider the additional context provided and to review the recommendations in light of this evidence.

After reviewing the addendum at Section 6, I agree with the SI panel findings that the initial recommendations stand and that there are no additional recommendations as a result of the addendum evidence.

On behalf of the Army, I wish to reiterate my sincerest condolences to the family, friends and loved ones of Hldr [redacted].

Major General TJ Bateman CBE 12 March 2024

Section 8 – Reviewing Authority Comments following the Addendum

1. The Service Inquiry report was re-submitted to GOC 1 UK Div on 7 Mar 24 following additional evidence which came to light during the brief to Hldr [redacted] Next of Kin on [redacted] Jan 24. This additional evidence was captured as an addendum in the original report. I can confirm the Next of Kin and Coroner were kept abreast of the situation.

2. The convening authority and I are very grateful to the SI panel for highlighting the new evidence, and particularly grateful to the to the family of Hldr [redacted] for providing the additional details to the Panel. Whilst this added a further unwelcome delay to the process, we felt it important to consider the additional context provided and to review the recommendations in light of this evidence.

3. After reviewing the addendum at Section 6, I agree with the SI panel findings and the Convening Authority that the initial recommendations stand and that there are no additional recommendations as a result of the addendum evidence.

4. I am grateful for the panel member who travelled to Scotland to complete the brief to the Next of Kin. I am content that the Service Inquiry has covered the additional evidence that was provided and confirm this report is now finalised.

5. I apologise to the family of Hldr [redacted] for this additional delay, I again offer my condolences to Hldr [redacted] family, and I hope that the finalisation of this report might offer some solace and closure after this tragic loss.

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

18 March 2024

Annex A to
GOC
SI Convening Order
Dated 25 Jul 23

CONVENING ORDER FOR A SERVICE INQUIRY

BY ORDER OF

MAJOR GENERAL TJ BATEMAN CBE

GENERAL OFFICER COMMANDING 1st (UNITED KINGDOM) DIVISION

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] Highlander [redacted] who died of Violent / Unnatural Causes in Single Living Accommodation on 05 Feb 22.

2. An SI is to assemble in York on 26 Sep 2022. The SI is the Panel's priority task and takes precedence over any other duties.

3. The SI Panel comprises:

   a. President: [redacted] Maj [redacted] (APSG PPSI).

   b. Member: [redacted] Maj [redacted] (QARANC) (Army Reserve).

   c. Member: [redacted] SSgt [redacted] (3XX).

   d. Medical SME: [redacted] Maj [redacted] (1XX).

4. Legal Advisor to the SI is: [redacted] Maj [redacted] (AGC, ALS) (1XX).

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 Appendix 1. The Panel is not to attribute blame, negligence or recommend disciplinary action.

5. General Officer Commanding 1 (UK) Div 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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

12. 1 (UK) Div 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. Stationary 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.

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

TJ BATEMAN
Major General
General Officer Commanding 1 (UK) Div Date: 3 October 2022

Appendix 1:

1 Terms of Reference.

Appendix 1 to
Annex A to
GOC
SI Convening Order
Dated 25 Jul 23

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

1. The Panel is to investigate the circumstances surrounding the death of [redacted] Highlander (Hldr) [redacted] The Highlanders, [redacted] Battalion The Royal Regiment of Scotland, who died of Violent / Unnatural Causes in Single Living Accommodation on 05 Feb 22.

Terms of Reference

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

f. ToR 1 – Identify contributing, causal, or other factors by examining the events prior to [redacted] Hldr [redacted] death and establish the facts surrounding it.

g. ToR 2 – Critically assess the care and support afforded to [redacted] Hldr [redacted] by both the Medical Chain and the Chain of Command, prior to his death.

h. ToR 3 – Which changes are recommended in order to prevent recurrence? Consider any other matters relevant to the inquiry.

Output

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:

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

j. Make appropriate recommendations for the unit(s), the Army and Defence. If any result from examination of ToR 2 you are to specifically consult with the SH(A).

k. 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.

l. 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.

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

Annex B to
GOC
SI Convening Order
Dated 25 Jul 23

Annex B – Glossary

Acronym / Abbreviation	Definition
Adjt	Adjutant
AED	Automatic Electronic Defibrillator
AGAI(s)	Army General Administrative Instruction(s)
APSG	Army Personnel Support Group
AUWO	Assistant Unit Welfare Officer
AWS	Army Welfare Service
CAP	Care Action Plan
CGMC	Catterick Garrison Med centre
CMHN	Community Mental Health Nurse
CMT	Combat Medical Technician
CMCR	Commander's Monthly Case Review
CO	Commanding Officer
CoC	Chain of Command
Comd	Command
COS	Chief of Staff
COVID	Coronavirus disease
CQMS	Company Quartermaster Sergeant
CSM	Company Sergeant Major
DACOS	Deputy Assistant Chief of Staff
DCMH	Defence Community Mental Health
DCOS	Deputy Chief of Staff
Div	Division
DMICP	Defence Medical Information Capability programme
DMS	Defence Medical Services
DPHC	Defence Primary Health Care
DSMO	Deputy Senior Medical Officer
DSM-V	Diagnostic and Statistical Manual of Mental Disorders (Ver 5)
GDMO	General Duties Medical Officer
GOC	General Officer Commanding
GMC	General Medical Council
GP	General Practitioner
Hldr	Highlander
HQ	Headquarters
ICD	International Classification of Diseases
IED	Improvised Explosive Device
ISP	Inpatient Service Provider
ITC	Infantry Training Centre
IVEE	Infantry Versatile Engagement Expansion
JMES	Joint Medical Employment Standards

JNCO	Junior Non-Commissioned Officer
JPA	Joint Personnel Administration
JSP	Joint Service Publication
LANCS	The Duke of Lancaster's Regiment
LA	Learning Account
LD	Light Duties
Maj Gen	Major General
MPHCTP	Medic's Primary Health Care Treatment Protocol
MDT	Multi-Disciplinary Team
MEP	Main Entry Point
MFD	Medically Fully Deployable
MHP	Mental Health Practitioner
MLD	Medically Limited Deployable
MMC	Military Medical Centre
MND	Medically Not Deployable
MO	Medical Officer
MOA	Memorandum of Agreement
MSK	Muscular Skeletal
NCO	Non-Commissioned Officer
NHS	National Health Service
NoK	Next of Kin
OC	Officer Commanding
Op	Operation
QARANC	Queen Alexanders Royal Army Nursing Corps
Para	Paragraph
Pl Comd	Platoon Commander
PID	Position Identification
PJNCO	Potential Junior Non-Commissioned Officer
PMO	Principle Medical Officer
POSM	Post Operational Stress Management
PPG	Poker Players Girlfriend
PPSI	Permanent President Service Inquiry
PSQI(WG)	Patient Safety and Quality Improvement Working Group
PT	Physical Training
PTSD	Post-Traumatic Stress Disorder
PULHHEEMS	Physical Capability, Upper Limbs, Locomotion, Hearing, Eyesight, Mental Capability, Emotional Stability
RAMC	Royal Army Medical Corps
RAO	Regimental Administration Officer
RE	Royal Engineers
RMO	Regimental Medical Officer
RMU	Risk Management Update
ROG	Rear Ops Group
RSM	Regimental Sergeant Major
RST	Regimental Support Team
SAH	Sick at Home
Sgt	Sergeant
SHA(A)	Senior Health Advisor (Army)

SI	Service Inquiry
SJAR	Soldiers Joint Appraisal Report
SLA	Single Living Accommodation
SMO	Senior Medical Officer
SNCO	Senior Non-Commissioned Officer
SOP	Standard Operating Procedure
SP	Service Person
Sp	Support
SPA	Senior Point of Authority
SVRM	Suicide Vulnerability Risk Management
TEE	Temporary Employed Elsewhere
ToR	Terms of Reference
TRIM	Trauma Risk Management
UWO	Unit Welfare Officer
VENG	Versatile Engagement
VRM	Vulnerability Risk Management
VRMIS	Vulnerability Risk Management Information System
WISMIS	Wounded Injured and Sick Management Information System
WHO	World Health Organisation
2IC	Second in Command