12 Conclusions and Recommendations

Introduction

12.1 This Chapter serves three purposes. First, it summarises the conclusions reached in Chapters 5, 6, and 10 about the immediate circumstances of the three deaths the Review has examined.[1] Secondly, it notes the broader circumstances relating to all four deaths that appear to the Review to be relevant. Thirdly, it presents the recommendations that it considers appropriate having regard to the matters considered previously and in the first two sections of this Chapter.

Section 1: Conclusions as to the responsibility for the deaths

The responsibility for the deaths

12.2 The Review has concluded, on the balance of probabilities, that the deaths of Sean Benton, Cheryl James and Geoff Gray were self-inflicted[2] and that the opportunity for self-infliction was afforded by the policy of frequently assigning Phase 2 trainees to armed guard duty at Deepcut, unsupervised by experienced soldiers or members of the Military Provost Guard Service (MPGS).[3]

12.3 Each death needs to be treated separately, on the basis of what was known, or should reasonably have been known, by the time of the death in question.

(i) Sean Benton

12.4 Sean Benton was known to have become emotionally distressed and had engaged in at least two attempts at self-harm in the months before he died. It was Sean's own insistence that he wanted to stay in the Army, coupled with the absence of any medical evidence of psychiatric disorder, that led the Officer Commanding B Squadron to give him another chance to make a success of his military career.[4] The Squadron had previously taken measures to deny Sean access to a weapon on guard duty. On the night before Sean's death, Squadron staff sought to ensure that he did not become drunk and did not perform armed guard duty after he had been notified that his discharge from the Army was being applied for. Until the normal closing hours of the NAAFI, at least, he was under the regular supervision of an NCO. The full circumstances of Sean Benton's death are dealt with in Chapter 5.

12.5 The opportunity for self-harm was, therefore, created by Sean when he acquired a weapon from another trainee on false pretences and took the chance to be by himself. He then used the weapon on himself with fatal consequences. These acts were pre-planned only hours before his death. There was no opportunity for anyone else to have become aware of them or alert those in authority of the risk of harm to Sean.

12.6 There is no evidence that Sean had been bullied shortly before his death, nor that he had ever complained of bullying to his close friends or anyone in authority in the frequent meetings he had with officers about his future. There is no consistent and reliable evidence that over-harsh discipline caused him to become depressed. Any over-harsh discipline to

[1] See paragraph 1.30 ff for an explanation as to why the Review could not examine the immediate circumstances of the death of James Collinson.

[2] For the Review's conclusions on the deaths of Sean Benton, Cheryl James and Geoff Gray, see paragraphs 5.197 ff, 6.181 ff and 10.140 ff, respectively.

[3] For an explanation of the MPGS, see paragraph 11.113 ff.

[4] See paragraphs 5.174-175.

which he may have been subject during his military career did not cause him to take his life. The conclusion of the Review is that he was neither bullied to death nor was his death caused by the negligence or breach of duty of the Army.

(ii) Cheryl James

12.7 Cheryl James was not known by anybody in authority in the Army to have been unhappy, or to have had a pre-disposition to self-harm. Any conversations she had with her friends or others about self-harm were insufficient to alert them to a risk and nothing was passed on to anyone in authority. There is no reliable evidence that she had been the victim of sexual harassment by NCOs or officers during her training. There is no reason to believe that any such treatment was affecting her mind on the day of her death. There is no evidence that bullying was a factor in her death. The full circumstances of Cheryl James's death are dealt with in Chapter 6.

12.8 Whatever may have caused her to self-harm cannot be identified with certainty.[5] It would appear to include personal factors during a period of unresolved complications in her private life, at a time when she may have been vulnerable and lacking in self-esteem. This was not an aspect of her personality that was apparent to those who did not know her well.

12.9 Cheryl should not have been assigned the lone static guard duty at a remote post that she volunteered for, but this failure to apply Army policy only created the opportunity for her to be by herself. The circumstances of the other deaths show that this opportunity could easily have been created by anyone in unsupervised possession of a weapon and ammunition. In the conclusion of the Review, this failure did not cause her death.

(iii) Geoff Gray

12.10 There was nothing in Geoff Gray's past to suggest to anyone that he posed a risk of self-harm or that he might misuse his weapon. There was nothing in his conduct or his treatment by the Army that would suggest he was at risk of self-harm. There is no reason to believe bullying was a factor in his death. The full circumstances of Geoff's death are considered in Chapter 10.

12.11 Although Geoff was under 18, he had performed armed guard duty successfully before and was fully trained in the use of a weapon.[6] Army policy permitted trainees over 17 to perform armed guard duty unsupervised by an experienced person in authority. Assuming that a local policy had been adopted and implemented at Deepcut by the time of his death, assigning Geoff to guard duty would not have been in breach of it as he was over $17^{1}/_{2}$.[7]

12.12 Geoff should not have gone off on an unaccompanied prowler patrol with his weapon whilst on guard duty. He had been instructed to that effect a few hours earlier and both his comrades on guard with him volunteered to accompany him. The decision to proceed on a sole prowler patrol was his alone. In the conclusion of the Review, neither the Army nor his comrades caused his death.

[5] See paragraphs 6.189-190. See also paragraph 6.97.

[6] As were Sean Benton and Cheryl James.

[7] See paragraphs 10.48 ff and 11.70-74.

Section 2: Conclusions as to the circumstances surrounding the deaths

Factors contributing to the deaths

12.13 In the cases of Cheryl James and Geoff Gray, frequent armed guard duties at remote locations unsupervised by an NCO, or experienced person in authority, afforded them the opportunity to self-harm. In both cases, the frequency of guard duty in the weeks before their deaths may have contributed to their unhappiness and, combined with other personal factors, may have made them more susceptible to self-harm on the occasions of their deaths.[8]

12.14 In the case of Sean Benton, his prolonged progress through Phase 2 training, together with attendant disciplinary penalties, informal sanctions (including extra guard duties), and possible restrictions on weekend home leave added to factors that made him unhappy.[9]

The training environment

12.15 Low morale can be induced by factors in the physical environment at Deepcut. Concerns noted by the Review include: the quality of the accommodation blocks, and particularly the sanitary and washing facilities there;[10] the delicate balance between effective security denying unauthorised access to the dormitories and the ability of responsible adults to lead a private life;[11] the limited range of recreational activities provided on site;[12] and the practical ability to leave the Barracks in off duty hours.[13] The extended configuration of the camp and the additional demands it imposed for guard duty have been noted throughout this Report.[14]

12.16 Added to the physical environment there is the psychological one, best described as the indeterminate and unpredictable length of Phase 2 training at Deepcut. The effect this has had on trainees has been considered throughout this Report.[15]

12.17 These general aspects of the Deepcut regime may have contributed to making any one of those who died unhappy. They need to be addressed in any future planning of military training.[16] They are reflected in some of the more general recommendations made below. A number of specific factors deserve attention.

Unsupervised access to weapons

12.18 In all three cases considered in detail by this Review, the regime for unsupervised armed guard duty for inexperienced soldiers afforded an opportunity to either acquire a weapon or to move with it to an isolated spot to use it. While after each death some changes were made to local orders regarding the handing over of weapons, it is clear that the orders

[8] See paragraphs 6.21, 10.44 and 10.75.

[9] See paragraph 5.150 ff.

[10] See paragraphs 4.76-77, 7.55, 8.44, 8.53, 9.71-72 and 11.123. However, note paragraph 11.99.

[11] See paragraphs 4.89-92, 6.9, 6.129, 7.16, 7.24, 7.89 ff, 8.7 ff, 10.13, 10.29 and 11.124-125.

[12] See paragraphs 4.95-96, 5.192, 8.22 and 9.57 (including Figure 9.2).

[13] See paragraph 5.194

[14] See for example paragraphs 6.55, 9.120, 10.52, 10.58, 10.68, 11.44 and 11.102.

[15] See paragraphs 4.71-72, 5.10, 5.111, 10.31 ff, 11.98 and 11.117. See also footnote 166 in Chapter 5.

[16] See paragraph 11.124.

could be easily disobeyed.[17] From the evidence given at the inquest, this also appears to have been a factor in James Collinson's death. In summary, James was under 17½ and not issued a weapon when he was assigned to guard duty at the Officers' Mess. He acquired a weapon from a fellow guard member in breach of standing orders. According to the guard member, James asked for a weapon so that he could have an excuse to go for a smoke. The third member of the guard at the Officers' Mess post has stated that he was making a call on his mobile phone at around this time. The Coroner noted in his summing up to the jury that it was now clear that several military orders had been breached: the handing over of the weapon; the use of a mobile phone whilst on guard duty; smoking whilst on duty; patrolling alone; and failing to inform someone in authority that a patrol was taking place.

12.19 With hindsight, it appears that for each of the four young people who died there were factors in their lives troubling them that may have prompted thoughts of self-harm. In James Collinson's case there was some evidence at the inquest that he had told other soldiers of an intention to harm himself if he had access to a weapon, although there was no clear evidence of a motive to self-harm and the jury returned an open verdict on 10th March 2006. There is evidence to suggest that Cheryl James and Geoff Gray both expressed intentions to self-harm before their deaths.[18] The personal histories of Cheryl James and Sean Benton revealed factors that objectively made them more vulnerable to self-harm.[19] For the Review, age itself is also a relevant factor. Geoff Gray and James Collinson were under 18. Cheryl James had just turned 18. Sean Benton was older but had been recognised by medical staff as having an immature personality.[20] Further, there are a number of factors to be considered that diminished the ability of the Army to predict such susceptibility to self-harm and prevent it from occurring on guard duty.

Supervision

12.20 Apart from Cheryl James, none of the four young people had completed their Phase 2 training. None were part of closely supervised Troops with a structured support system and good working relationships with NCOs who knew them well.[21] Geoff and Cheryl were both dealing, to different degrees, with complications in their personal lives, as many young people do. Sean Benton was known to have self-harmed in the recent past and had been considered doubtful or unsuitable by way of temperament for a military career, before his discharge was ultimately applied for.[22]

12.21 The Army appears to have been slow to have analysed all the data in its possession about the nature and scale of the risks posed to young trainees by unsupervised armed guard duty, particularly in remote locations.[23] When it did analyse this data under intense public scrutiny, it took measures to invest in Deepcut by way of alternatives to trainees performing armed guard duty by greater use of the MPGS.[24] Where trainees continued to perform armed guard duties, the Army also provided more staff to directly supervise them. The provision of more staff to supervise trainees generally, thus, resulted in the adoption of recommendations that had previously been suggested by senior officers over the preceding eight years.[25]

[17] See paragraphs 5.169 (particularly footnote 174), 10.88-90 and 11.79-81.

[18] See paragraphs 6.98 ff and 10.129 ff. See also footnote 172 in Chapter 5 in respect of Sean Benton. See also paragraph 9.14.

[19] See paragraphs 5.4 and 6.99, respectively. See also paragraphs 6.104 and 12.50.

[20] See paragraphs 5.14 and 5.21.

[21] See paragraphs 4.72-75, 5.119, 5.191-192, 6.6 and 11.99.

[22] See paragraphs 5.4, 5.14, 5.16 and 5.21.

[23] See paragraphs 6.191, 7.4-6, 9.42-9.47, 9.119-120 and 10.56-57.

[24] See paragraph 11.113 ff. See also paragraphs 9.78-79.

[25] See paragraphs 9.122-123 and 11.106-11.110.

12.22 On the basis of these factors, the Review considers that, although the Army did not cause any of the deaths, there were institutional failures to identify potential sources of risk and address them. Those failures increased as more information became available but the factors creating risk were still not comprehensively identified and, therefore, not addressed adequately.[26]

Discipline, bullying and informal sanctions

12.23 In only one of the three deaths reviewed, that of Sean Benton, might bullying or over-harsh discipline have played any role in undermining the morale of the trainee. There is insufficient reliable evidence to conclude that it did so. There is no evidence that any of the trainees were bullied to death.

12.24 Nevertheless, the evidence obtained by Surrey Police and this Review suggests that from 1995 to 2002 a number of trainees at Deepcut had, at various times, experienced, or claim to have experienced, harassment, discrimination and oppressive behaviour from NCOs, as well as from other trainees.[27] Such claims may well only be from a small minority of trainees, but such experience cannot be dismissed as non-existent or not a cause for concern.

12.25 Resentment of informal sanctions (particularly guard duty),[28] denial of weekend leave in the context of prolonged exposure to a tedious regime awaiting trade training, and the behaviour of fellow soldiers are also likely to have made a number of trainees disillusioned and unhappy.[29] Throughout this period, trainees had self-harmed or threatened self-harm and some of those who had were subsequently to explain that they were unhappy with the military regime at the time.[30]

Ventilation of grievances

12.26 Some of those who were unhappy about their treatment or their situation as Phase 2 trainees complained to the chain of command. Others, who subsequently expressed their unhappiness to Surrey Police during their investigations, did not complain at the time. A number of those who did not complain explained they had little confidence that the system could or would redress their grievance.[31]

[26] See paragraphs 9.119-120.

[27] See the Surrey Police Duty of Care Schedules reproduced as Appendices 5 and 6 to this Report.

[28] See, for example, paragraphs 4.109, 5.152-155, 6.22, 6.28, 6.125, 6.175 ff and 8.33.

[29] See paragraphs 5.195 and 10.31 ff.

[30] See paragraphs 6.72-75 and 9.48-57 (including Figure 9.2).

[31] See paragraphs 5.99 and 10.38. See also paragraphs 6.162, 6.170 and 6.173-174.

12.27 In at least some cases considered by the Review, it can be said that such concerns clearly had substance. Many of those who were undoubtedly the victims of indecent assaults by Leslie Skinner, whose conduct is considered in Chapter 7, did not complain until a long time after the event.[32] Similarly, the events described in Chapter 8 demonstrate, to the satisfaction of this Review, that there was reluctance by trainees to complain against NCOs; those who did complain about a senior NCO were vulnerable to reprisals and received an ineffective response by their immediate superiors.[33]

12.28 The efficacy of the military complaints system and any other measures for independent oversight of the welfare of recruits, trainees and young soldiers, is, therefore, an issue that arises from the circumstances surrounding the deaths and requires further consideration in this Chapter.

The efficacy of the investigations into the deaths

12.29 The issue as to who had primacy for investigation of sudden deaths on military property has already been noted in Chapter 3. A new protocol between the Secretary of State for Defence and the Association of Chief Police Officers (ACPO) dating from September 2005 (see Appendix 16) re-affirms that primacy for investigating all such deaths rests with the civilian police. Even so, as noted at paragraph 3.17 above, an internal Surrey Police policy document seen by the Review in late 2005 referred to them having primacy in cases of 'suspicious', rather than 'sudden', deaths. Clear and unambiguous language should be used to accurately reflect the Protocol and avoid confusion that could diminish the scope and nature of future investigations.

12.30 Where the Royal Military Police (RMP) has primacy for an investigation, the quality of the investigation may vary according to resources, training and the context of the investigation. In the case of Leslie Skinner, considered in Chapter 7, the Review has noted occasions when the scale and persistence of his misconduct was not revealed by RMP investigations. The question of how best practice and high standards of investigation can be maintained by the RMP will be the subject of recommendation later in this Chapter.

Issues relating to instructors

12.31 There is some reason to doubt that a number of those put in charge of training and supervising the trainees at Deepcut had the requisite personal skills or training to successfully achieve this task.[34] The challenge for these instructors was increased by the decisions related to Single Entry in 1993,[35] and the phenomenon of delayed throughput in trade training.[36] Poor supervisory ratios exacerbated this problem and reduced opportunities to detect unhappiness or ventilate grievances.

12.32 The system for selecting and vetting instructors, and other members of the permanent staff, for training posts, reporting on their progress and recording concerns that reflect their suitability to perform such a challenging task appears, to the Review, to be in need of revision and improvement.[37]

[32] See paragraphs 7.65, 7.68 and 7.78.

[33] See paragraphs 8.50, 8.75 ff and 8.103 ff.

[34] See, for example, paragraphs 5.196, 6.131 ff, 6.160 ff, 6.169 ff, 7.31 and 8.24 ff.

[35] See paragraph 4.30 ff.

[36] Described elsewhere in this Report as SATT, Soldiers Awaiting Trade Training. See paragraph 4.72.

[37] See in particular paragraphs 6.133, 7.92 ff, 8.20, 8.24-25 and 8.112.

Selection of recruits and parental involvement

12.33 Other issues arising from the narrative of the Deepcut events include whether recruit selection is sufficiently rigorous and well-informed and whether parents are sufficiently involved in the selection and training of their son or daughter in the Army.[38]

12.34 The Review has also highlighted the need for parents to be well-informed and briefed in the tragic event of their son or daughter meeting a sudden death, particularly where there is uncertainty as to how or why they died.[39]

Section 3: Recommendations

12.35 In the light of these matters, the Review will now proceed to make recommendations for consideration by the Minister of State for the Armed Forces, and others, before finally considering whether there is a need for a public inquiry.

The age of recruitment

12.36 There is a case for restricting the recruitment of soldiers into the Army to those who are over 18 on enlistment or commencement of training. There is simplicity about such a proposal that makes it attractive. Problems of access to alcohol or *in loco parentis* welfare obligations to trainees[40] would be replaced by a single duty of care – to protect soldiers from foreseeable harm not inherently connected to their role as soldiers. Although being over 18 is no guarantee of individual maturity, it is the formal moment of transition from the status of minor to adult. It could be argued that employment in the Army, with its particular features, is inappropriate for minors.

12.37 The Army in 1993, in its consideration of Single Entry and, more recently, in the Deputy Adjutant General's interim report in October 2002, was unwilling to lose the capacity to recruit those under 18.[41] There is no doubt that such a move would diminish the present ability of the Army to recruit the numbers it needs to perform the tasks the government asks of it.

12.38 The case to move to an adult only Army might be compelling if the only justification for recruiting those under 18 rested on the Army's manpower needs, particularly if those needs could be said to be inconsistent with the principle of the best interests of the child. Such a principle should be a prime consideration for all public authorities in the United Kingdom.[42] However, the Review is satisfied that a military career is an exciting and challenging career for many young people who otherwise may not have an opportunity to lead structured and fulfilling lives.

12.39 Civilian society has not been notably successful in providing the opportunities for rewarding life-long careers for young people whose talents are not in the field of GCSEs and higher academic qualifications but lie, rather, in the technical trades or other careers offered by the Army. To deny these young people the chance to start training for such a career when they are of school-leaving age may deprive them of the opportunity they need

[38] For examples of the Army's previous acknowledgement of the importance of involving parents see paragraphs 4.40 and 4.54. See also paragraphs 4.52, 8.21 and 11.139.

[39] See paragraphs 2.9, 2.17 and 2.38. See also Annex C for the opinion of Fiona Murphy.

[40] See paragraph 4.36 ff.

[41] See paragraph 11.94.

[42] See paragraphs 4.41-44 and 4.51 (see also footnote 29 in Chapter 4).

to get away from difficult social circumstances and acquire new skills, and social discipline, before it is too late to adapt. As the Review has noted in Chapter 4, although the Army is not designed as an agency to improve the quality of life of young people, it does offer broad opportunities for the acquisition of new skills and career development that schools and colleges may not.[43] For many young people the 'boarding' experience may provide an effective chance to develop self-discipline and independence.

12.40 Unless and until educational opportunity for 16 to 18 year olds in the United Kingdom becomes so diverse and well-resourced that it provides everyone the opportunity of acquiring better life skills in civilian society, this Review is of the opinion that there is not a sufficient case to prevent the recruitment to the Army of those over 16 but under 18. There is a mutual benefit to individual recruit and the Army alike to continue to permit those of this age to have the chance to start a military career and acquire a range of new skills. However, such recruitment and training must take place in an appropriate environment where there are sufficient staff skilled in understanding and addressing the particular vulnerabilities of young people in general, as well as being alive to any specific issues any individuals may have.

RECOMMENDATION 1

Young people with suitable qualities for a military career should continue to be able to enlist at 16, with a view to fully participating in all aspects of military duties from the age of 18, so long as their training takes place in a suitable environment dedicated to the needs of such young people, and particular care is taken for their welfare.

The training environment for minors

12.41 For the Review, the regime offered at the Army Foundation College (AFC) in Harrogate is certainly an appropriate environment for 16 year olds. There is good accommodation, recreational and training facilities and the 42-week long course provides an opportunity for acquiring enhanced educational skills and personal self-discipline, as well as purely military and technical ones.[44] In the opinion of the Review, AFC Harrogate offers the best model for enlisting young people into the Army. It means that young people will not start Phase 2 training until they are at least 17 years old and, depending on the length of their trade training, even the youngest trainee would only join the field army shortly before their 18th birthday. Soldiers need to be 18 before they can be deployed on operations.[45]

12.42 The Review is aware that resources do not, at present, permit the universal implementation of the best practice at AFC Harrogate throughout the Army Training and Recruiting Agency (ATRA). Further, it has been pointed out that some of the educational and technical input AFC Harrogate provides is not always appreciated by the recruits, or is, indeed, necessary for all trades.

12.43 As an alternative, the Army Training Regiment (ATR) in Bassingbourn is a dedicated facility for those who are recruited under 17 but who do not meet the entry requirements of AFC Harrogate. It has many of the features that make it a suitable environment for young people to learn to become soldiers.[46]

[43] See paragraphs 4.8-10.

[44] See paragraphs 4.10 and 4.60 ff.

[45] See paragraph 4.41 ff.

[46] See paragraphs 4.10 and 4.60 ff.

The duration of training for minors

12.44 The Review believes that the present balance between fast-track throughput and setting a pace for the training regime that allows the young people who pass through ATR Bassingbourn to develop the skills, fitness, and robustness of personality needed for a successful military career, should be revisited. The length of the Army Development Course there in 2005 (17 weeks) seems, even with the proposed increase by one week, too short to achieve all the added value that may be necessary for a smooth transition into Phase 2 training.[47]

12.45 There should be sufficient time to address any deficits in basic functional numeracy and literacy skills,[48] and sufficient time to adjust to living away from the home environment, as well as learning about the military one. The Review believes that the Phase 1 course at ATR Bassingbourn should be at least 26 weeks to achieve all these functions.[49] First, this is the period needed for a young person to become accustomed to living away from home and to the disciplined life of the Army. Secondly, the young person will have some opportunity to enhance their basic educational skills. Thirdly, it will reduce the number of minors in Phase 2 training and in the field army. No trainee should arrive at a Phase 2 training establishment under 17 years of age.

Provision for minors during Phase 2 training

12.46 For the Review, it would be preferable for the Army not to mix adults and minors at all in either Phase 2 training or in the field army. Such a scheme would require either Phase 1 training for minors to be prolonged or some structured delay in starting their training after school-leaving age is reached. The Review is not convinced that any such deferral of training would be fatal to the Army's future prospects of attracting sufficient numbers.

12.47 However, if minors are to continue to start Phase 2 training in a Single Entry regime, the physical environment, the supervisory ratios, the selection of instructors and other factors affecting the psychological environment must be designed to reflect the particular needs of young people.

12.48 The Review appreciates that any recommendation it makes about the improvement of the regime for young people in the Army makes greater demands on the public purse. The question, however, should not be whether these measures can be afforded but, rather, whether the Army can afford to do without them. In the opinion of the Review, they are part of the necessary price to pay to be permitted to recruit young people into military service.

RECOMMENDATION 2

The training environment for those under 18 should have the following features:

(i) Those under 17 should be trained in establishments exclusive to this age group.

(ii) ATRA should aim to provide the facilities and the length of training presently provided by AFC Harrogate to all recruits under 17.

(iii) In the meantime, Phase 1 training at ATR Bassingbourn should be extended progressively to 26 weeks.

[47] See paragraph 4.60.

[48] See paragraphs 4.8, 9.66 and 9.68.

[49] The Review understands this was the length of Junior Entry training, see paragraph 4.26.

RECOMMENDATION 3

Where young people over 17 but under 18 are trained together with adults in Phase 2 training, special provision should be made for their safety, welfare and development in the design of the training regime and the environment in which it is delivered. The Army should plan to eliminate the need for soldiers to join their units in the field army on completion of Phase 1 and 2 training until they reach the age of 18.

The screening of recruits

12.49 The Review accepts that it is difficult to predict, from a medical and social profile alone, who will have a successful and happy career in the Army. Everyone who has the necessary qualities to become a soldier should have an equal opportunity to do so, whatever their past experience.

12.50 However, the Army would benefit from greater and more accurate information about the medical and social background of its recruits than was available in 1995, as demonstrated by the cases of Sean Benton and Cheryl James. In both those cases, the Army was unaware of previous attempts at self-harm prior to enlistment which were known to medical professionals. The procedures for self-certification, or certification by parents, did not bring these facts to light.[50] These are considered to be relevant indicators of future propensity to self-harm.[51]

12.51 The Review would expect that the applicant's consent for disclosure of medical records and other confidential data should be part of recruitment practice. Such data should be obtained, not to screen classes of recruits out but, to enable the Army to be aware of all factors that may affect suitability for military life, or life in a particular cap-badge, and to make any necessary personal assessment.

RECOMMENDATION 4

The Army should routinely seek confirmation from others of self-declared medical and social histories, including access to medical or other confidential records. Such data is necessary to make a full assessment of the applicant's suitability and enable training centres to be aware of any particular vulnerability that may need addressing.

Parental involvement in the recruiting process

12.52 The Review would also endorse all efforts to encourage a parent of the applicant, or other responsible adult, to participate in the interview and selection process. This role should involve more than merely signing a consent form for the recruitment of those under 18. There should also be an invitation to attend the recruiting centre so that the overall process is understood. The parent, or other responsible adult, may be able to add information about factors in the social and medical history overlooked by the applicant. An information pack should be made available and provided before consent is given to recruitment of a minor.

[50] See paragraphs 5.3-4 and 5.15 and 6.1 and 6.99, respectively. See also paragraph 7.11.

[51] See paragraphs 6.104, 9.15 and 9.28. See also the evidence of Professor Hawton to the House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev 73.

RECOMMENDATION 5

The Army should encourage maximum involvement in the selection process by the parent, or other responsible adult, of the applicant under 18.

RECOMMENDATION 6

A clear and concise information pack should be made available for the parent, or responsible adult, before consent is given to recruitment of a minor, explaining:

(i) what the commitment to a military career involves;

(ii) where and when training will take place;

(iii) where and how further information can be obtained;

(iv) who to turn to if the young person encounters difficulties and problems;

(v) how long service will be for; and

(vi) when and how the options to leave the Army can be exercised.

12.53 This communication in the selection process should only be the beginning of attempts by the Army to involve parents, or other responsible adults, in the progress of the recruit through the various stages of training, and to provide them with information.

12.54 In due course, both the parent, or responsible adult, and the recruit should be supplied with information about the code of conduct expected of recruits and instructors alike, with specific reference to the nature of permissible sanctions, behaviour that is not tolerated and how to complain about any violation of acceptable norms.

12.55 Where the recruit has encountered difficulties and unhappiness in the training process, procedures should encourage the sharing of information between the military authorities, the recruit and the parent or responsible adult. There should be consultation as to whether a trainee who has reached their 18th birthday will exercise their right to discharge if they are uncertain as to their future. Where the trainee is encouraged to 'soldier on' to the end of the training process this should be without prejudice to the right of discharge.

RECOMMENDATION 7

Recruits who joined the Army as minors and who have reached a settled decision that they are unhappy with pursuing a military career before they reach the end of their Phase 2 training, but after their 18th birthday, should be able to discharge as of right.

The practical content of the Military Covenant

12.56 It is clear that military life is very different from any other form of employment. The deprivations endured and the risks accepted are clearly set out in the Military Covenant.[52] The ATRA Code also spells out what the Commanding Officer commits the Army to provide during training and the standard of behaviour that the recruit commits to.[53]

12.57 The Army needs to ensure that it meets its side of the Military Covenant by looking after the soldier and providing acceptable accommodation. The training environment should both be free of harassment and afford the trainee privacy.

12.58 In the opinion of the Review, the spirit of self-sacrifice referred to in the Military Covenant should not mean that soldiers have to put up with sub-standard accommodation and sanitary and washing facilities because there are other pressing demands on the defence budget. As a people-based organisation, the Army must put the welfare of its people first. The discharge of the mutual commitments in the Military Covenant should not start with a 'credit note' to explain inadequate staffing ratios, recreational and welfare facilities.

12.59 The Commanding Officer of every training regiment needs to be provided with sufficient resources to deliver on all these obligations to an acceptable minimum standard. Where facilities are sub-standard, the Commanding Officer needs to be able to explain when and how they will be improved. The temptation to defer expenditure on training establishments until operational commitments and new military equipment is paid for should be resisted. The Army must be satisfied that it has provided decent, safe and otherwise appropriate facilities for its personnel, where the needs for private life and personal development are catered for as well as the military training. If these standards are not met, it must immediately plan to provide them.

12.60 What is appropriate for a 16 year old in Phase 1 training will differ from what is needed for someone over 18 in Phase 2 training, and thereafter. Recreational facilities, sporting facilities, opportunities for guests to visit and access to civilian facilities are all factors to consider. The quality of the environment affects the morale of the trainee and this affects whether or not he or she endures the rigours of the training process and makes a successful military career.

RECOMMENDATION 8

ATRA should maintain a regular audit of its training estate:

(i) It must be satisfied that it has provided decent, safe, and appropriate facilities for its personnel where the needs for private life and personal development are catered for as well as their military training.

(ii) The physical and psychological environment should combine to inspire and motivate the trainee.

(iii) If it does not, ATRA must immediately plan to redress this.

[52] See paragraph 4.2.

[53] Annex A to G1 'Conduct and Behaviour' of the ATRA Handbook.

12.61 The problem of delays in trade training causing the phenomenon of SATT should be regularly monitored to ensure that the trainee does not regress or stagnate after Phase 1 training. Where delays remain inevitable, the trainee must be kept informed with a progress card, or something similar, explaining what has been achieved and what remains to be do done before he or she is posted to a unit in the field army.

RECOMMENDATION 9

All reasonable measures should be taken to reduce or eliminate delays in Phase 2 training. Wherever there are delays, the trainee should be informed in a written record of the progress to date and the future timetable.

Supervisory ratios

12.62 The role of adequate supervisory ratios has been emphasised enough in the course of this Report to ensure that future defence planning must never forget the consequences of budgetary paring in a training establishment.[54] The Review considers that sufficient NCOs of the appropriate calibre for a training regiment, with the skills, commitment and the patience to turn young people into effective soldiers, is the essential pre-condition for anything else that the Army aspires to deliver. If ratios fall to unacceptable levels, pressure will build on staff, potentially resulting in oppressive behaviour.[55] There will be fewer NCOs to observe and deter such behaviour. With poor supervisory ratios, trainees may not have the confidence of solid relations with staff to be able to turn to the chain of command to report abuse within it.

12.63 The events at Deepcut have generated a profound crisis in the relationship between the public, the parents of future soldiers and the Army because of the perception, whether or not justified, that the Army neglected to deliver on its duty of care. There can be no Army without soldiers. There will be no soldiers without tomorrow's recruits. There is unlikely to be enthusiasm amongst tomorrow's parents to encourage and support a military career unless there is confidence that the Army can deliver on its promise of 'zero tolerance' of bullying and harassment and provide a career in which all can progress with equality and fairness.

12.64 To achieve this, the Army must invest in its instructors throughout ATRA in terms of both quantity and quality. Instructor to trainee ratios of over 1:40 are unlikely to be acceptable. Deepcut has had a high profile in the public mind for the past four years and has received corresponding attention by way of resources. It may not continue to do so indefinitely. Other training establishments may have similar problems now or in the future. They should not have to risk a repetition of the events that gave rise to this Review for adequate resources to be made available. A duty of care is not delivered by fire-fighting measures of throwing resources at the latest crisis only to divest them again when attention is diverted elsewhere.

[54] See paragraph 12.20 above. See also paragraphs 5.119, 6.168, 7.14, 8.25, 9.58-97 and 9.100-106. The conclusions of Chapter 9 (Suicide Prevention and Supervisory Ratios) are set out in paragraph 9.107 ff.

[55] See paragraphs 5.112, 5.156 and 9.63.

RECOMMENDATION 10

ATRA should require all its training regiments to identify the supervisory ratios it needs to train future generations of trainees in accordance with the effective duty of care principles outlined in this Report. Those ratios should be taken as the necessary minimum, in the absence of any subsequent comprehensive risk assessment to revise them.

The quality of instructors

12.65 The Review is aware that in 1995, and thereafter, a training posting was not seen as a particularly desirable one that would lead to the advancement of an instructor's career. Instructors who resent their posting could bring their resulting frustrations to bear on trainees and are unlikely to set the inspiring standards demanded.

12.66 The Army needs to ensure that changes in perception in this respect are permanent and that a successful tour of service in a training regiment is seen as a positive commendation to career progression. Training is a demanding function requiring patience, integrity, imagination and hard work. It requires instructors, themselves, to be trained in the requisite skills of handling the kind of young people they are likely to meet, so they can understand, inspire and motivate them.

12.67 The Adult Learning Inspectorate (ALI) have made this point in their report.[56] The Review is aware that this is the aim of the present Director General of Army Training and Recruiting. The budget to be allocated to the training organisation must ensure that this does not remain an aspiration.

RECOMMENDATION 11

Instructors must receive essential training in how they are to achieve the tasks they are to meet before they take up their post. A tour in a training regiment should be recognised as a difficult and demanding job, leading to enhanced career prospects.

12.68 In addition to the careful selection and training of instructors and supervisory staff, checks should be made to ensure that they are suitable people to work in close quarters day and night with young people.[57]

RECOMMENDATION 12

Instructors should be vetted for their suitability to work with young people, applying standards that are no less rigorous than those applied to civilian establishments educating or training people under 18.

Information on standards of conduct

12.69 ATRA statements of policy as to the expected conduct of trainees and instructors alike should be revised and simplified. They should be issued to all recruits on enlistment and to all instructors, and members of staff, of training regiments before taking up their

[56] Adult Learning Inspectorate: 'Safer Training – Managing risks to the welfare of recruits in the British Armed Services', pp 25-26, March 2005.

[57] See paragraphs 4.37 and 4.45-47.

appointment. The Army style of inserting important statements of policy as Annexes to Appendices does not assist to ensure clarity and understanding. Important documents, such as the ATRA Handbook, should include a clear index of contents to assist those using it. Each statement of policy should be dated with a version number.

12.70 The Review understands that the documentation now in existence includes:

(i) a booklet called 'Values and Standards of the British Army' that is issued to every recruit and trainee;

(ii) the ATRA Code, a covenant with the Commanding Officer, that is issued to, explained to and signed by every recruit and trainee;[58]

(iii) a booklet called 'Basically Fair – Equality and Diversity in the British Army' that is issued to all recruits and trainees;

(iv) the ATRA Code of Practice for Instructors that is issued only to instructors;[59] and

(v) Guidance contained in the ATRA Handbook in relation to 'discipline', 'conduct and behaviour'[60]and 'relations between permanent staff and recruits under training'[61] that sets out some useful examples of unacceptable conduct but is not issued to recruits and trainees.

12.71 Despite these various policy statements and guidance, it is apparent to the Review that many recruits remain unclear as to their content and the limits of what can be done to discipline them.[62]

12.72 It should be clear what sanctions are available in respect of failures in the training context. It must be clear whether an instructor can order a trainee to do press-ups and, if so, how many can be required. It must be clear whether other sanctions, such as running around the square or pulling heavy weights and the like, can be awarded by a training instructor and, if so, what for. Trainees should be made aware of what behaviour the Army considers to be bullying or harassment and non-exhaustive examples should be given.

RECOMMENDATION 13

A single booklet should be issued to, and signed for by, recruits and trainees when introduced in the induction course. The contents of such a booklet should seek to explain concisely:

(i) what is meant by bullying and harassment;

(ii) examples of the type of conduct that is considered inappropriate or unacceptable;

(iii) the nature and extent of acceptable sanctions that can be properly imposed and by whom;

(iv) that blanket punishments imposed on a group for the failings of an individual are unacceptable; and

(v) what a soldier should do if he or she witnesses a breach of these principles or has been a victim of bullying or harassment.

[58] See paragraph 12.56 above.

[59] See paragraphs 4.83, 4.105 and 8.70 ff for references to the 1998 version of this Code of Practice.

[60] See paragraph 4.86.

[61] See paragraphs 4.80-4.83.

[62] For anedoctal evidence, see paragraph 4.110. See also paragraph 4.107.

12.73 Onerous duties that have to be undertaken by trainees should be fairly distributed to all eligible to undertake them.[63] If weekend leave previously awarded as a privilege is to be cancelled by way of penalty, this should only be as a result of a formal sanction of Restriction of Privileges awarded, following a fair hearing, by the Officer Commanding, or above, and formally recorded. The trainee should be made aware that NCOs have no authority to cancel such leave at the last minute as a penalty and that he or she can complain about any attempt to do so.[64] Equally, the assignment of guard duty should never be used as a punishment.

12.74 The grant of such leave may be subject to unforeseen emergency requirements, in which the urgent factor needs to be explained and the unit should endeavour to mitigate against the consequences, if at all possible.[65] The trainee must not be left with a sense of profound injustice with respect to a privilege that forms an important part of social life and a welcome relief from the rigours of the training regime.[66]

RECOMMENDATION 14

Cancellation of weekend leave by an NCO is not a permissible informal punishment. This should be explained in the booklet issued to trainees.

Leave that has been granted should not be cancelled without good reason and the authority of the Officer Commanding. Good reason for cancellation should be explained to the trainee at the time.

The allocation of guard duty should never be used as a punishment.

12.75 Where these matters are spelt out in published codes and form the basis of mutual expectation between Commanding Officer, instructor, trainee and the family of a soldier, adherence to them should be reflected in unit standing orders or other procedures necessary to ensure that they are taken account of and consistently enforced.[67] The case of Sergeant BB discussed in Chapter 8 illustrates weaknesses in the application of the ATRA Code of Practice for Instructors in that case.[68]

RECOMMENDATION 15

The standards set by the ATRA Code of Practice for Instructors should be enforced by formal disciplinary sanctions. Training regiments should adopt standing orders that require adherence to the Code of Practice to enable charges under the Army Act, or for breach of standing orders, to be brought. Breach of such standards should also be admissible evidence in a charge of 'ill-treatment' of subordinates.

[63] See paragraphs 6.122-123, footnote 41 in Chapter 6, footnote 86 in Chapter 10 and paragraph 10.32.

[64] See paragraph 12.25 above. Colonel Josling accepted in a meeting with Mr and Mrs James that trainees may have been unaware that NCOs had no right to cancel such leave unilaterally, see Appendix A4/8.020 F – 021 B.

[65] Leave should not be cancelled without compensation where the trainee has already incurred expense. The Regiment should be particularly concerned that trainees do not miss important one-off social functions such as weddings and funerals.

[66] See paragraph 5.153.

[67] See paragraphs 8.70 and 8.80-82.

[68] See paragraphs 8.70 to 8.74.

Collective responsibility

12.76 Soldiers should be instructed that any intimation of an intention to self-harm by a fellow soldier, however casual it may appear, should be taken seriously and reported to a responsible person immediately.[69]

RECOMMENDATION 16

Every Officer, NCO, civilian instructor and trainee should be alert to both expressions of intention to self-harm, however trivial or jocular they may seem at the time, and to any breaches of standing orders designed to promote safety. Such matters must be reported through the chain of command, so prompt and effective action can be taken.

12.77 There should be a collective responsibility on the unit, at all levels, to deter unacceptable conduct and report it. It should not be left solely to the victim of bullying or harassment to make a complaint. Ill-treatment or harassment is unacceptable because it has occurred, not because the victim has the courage to complain about it.[70]

RECOMMENDATION 17

Every Officer, NCO, civilian instructor and trainee should be alert to any sign of abuse and be required to report it through the chain of command, so prompt and effective action can be taken.

RECOMMENDATION 18

Failure to report any sign of abuse of power should itself be a matter for disciplinary sanction.

12.78 The Review encountered some difficulty, at both the local and national level, in identifying and recovering policy documents generated by the Army that were applicable to events in the past. In the inquest into the death of James Collinson, the Coroner noted that records of the assignment of weapons for guard duty had gone missing. There have been similar problems in the earlier cases. It is not merely documents of transient importance that do not appear to have been kept. In the course of this Report, there has been reference to policies relating to the age for guard duty, the retention of documents relating to discipline, the reporting of cases of self-harm to the RMP and such like. It appears to the Review that the Army may benefit from adopting orders to ensure that copies of former policy documents are retained and that, when policies are updated and revisions made, records are maintained so that the evolution of a policy, and the reasons for any change, can be ascertained. The development of a collective memory is an important aspect of collective accountability and ensuring that previous lessons learned are not readily forgotten. The question of the retention of documents in the context of disciplinary complaints is specifically addressed at Recommendation 25 below.

[69] See paragraphs 6.104, 9.27, 9.31-32 and 9.46. See also paragraphs 5.167, (including footnote 174), 6.98 ff and 10.129 ff in relation to such expressions of intention to self-harm prior to the deaths of Sean Benton, Cheryl James and Geoff Gray, respectively. In these cases, and in some of the evidence adduced at the inquest into James Collinson's death, such remarks were assumed to have been made in jest or jokingly and were, therefore, not taken seriously.

[70] See paragraphs 8.112 and 8.117.

RECOMMENDATION 19

There should be an instruction that:

(i) policy documents be regularly reviewed in the light of experience;

(ii) previous versions of policies and instructions be kept centrally with a record of when and why changes were made; and

(iii) clear policies be established for the destruction or retention of classes of documents, the authority needed for destruction and the records needed to be kept of the fact of such destruction.

Making and responding to complaints

12.79 The Review understands that the efficacy of a military unit depends on mutual trust between soldiers, including trust between Privates and their NCOs.[71] Abuse of power destroys that trust. Detecting and deterring abuse of power by others enhances it. Thus, reporting such matters is an important aspect of the relationship between the trainee and the Army.

12.80 In a unit that is working well, the primary route for ventilation of grievances should, therefore, be the trainee's Corporal or other NCO with whom he or she has a close working relationship built on mutual confidence. This is one reason why appropriate supervisory ratios are so important in enabling strong bonds of awareness and understanding to be formed. But not all units will always work well. The chain of command should continue to be supplemented by trained Army Welfare Service and WRVS staff stationed at training regiments and elsewhere, who should raise questions of concern to the Commanding Officer of their own motion or encourage victims to do so.[72] The principle of confidentiality does not prevent the staff of the Army Welfare Service or the WRVS from reporting concerns to the Commanding Officer, or providing information to an investigation, maintaining the anonymity of the victim if express consent is withheld.

12.81 As a matter of practicality, a trainee who is unable or unwilling to ventilate a grievance at such a level of provision, is unlikely to see an 'Empowered Officer' as more accessible and approachable.[73] In the opinion of the Review, this innovation is not, therefore, a sufficient response to the problem of the unwillingness to make complaints.

12.82 The Army should structure the complaints system on the premise that the events at Deepcut, and the matters noted in the 1995 and 2001/2 Duty of Care Schedules, show that significant numbers of trainees had apparently credible grievances they felt unable or unwilling to ventilate at the time.[74]

12.83 The system of military complaints cannot depend on the efficiency of the individual Commanding Officer or the perception he or she creates that the chain of command is approachable and caring. The narrative of events connected with Sergeant BB outlined in Chapter 8 presents a substantial challenge to the present system, which has remained largely unchanged. First, there was the failure of other members of staff to bring unacceptable conduct witnessed by them to the attention of the Officer Commanding, or

[71] See paragraph 9.32.

[72] See paragraphs 8.46 and 8.105 ff.

[73] See House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol I, paragraphs 43 ff, 121, 149, 169 ff and 179 ff. See also Vol II, Ev 267. See also paragraphs 9.32 and 11.133.

[74] See paragraph 10.38.

the Commanding Officer.[75] Secondly, there was the issue of confidentiality where the alleged abuser was aware of visits to the Army Welfare Service, and to other members of staff.[76] Thirdly, there was the capacity of the person complained about to threaten, intimidate and deter complainants whilst still in post.[77] Fourthly, there was the risk that other trainees became complicit in the abusive conduct, tolerated it, denied its existence to investigators and retaliated against those who did report it.[78]

RECOMMENDATION 20

The Army should convene a multi-disciplinary case conference of all the interested military agencies to examine the available papers relating to the case of Sergeant BB, with a view to developing a common approach to the detection and deterrence of abuse.

12.84 If such circumstances are tolerated or perceived to be the norm, it is unlikely that an internal regimental investigation, followed by an internal ventilation of complaints up the chain of command, will be seen as an attractive or practical instrument for dealing with complaints.

12.85 The effective resolution of credible complaints requires the system to: encourage early reporting; initiate thorough and prompt investigation, independent of the unit whose members are the subject of complaint; adopt interim measures to protect the complainant from retribution; and provide information to the complainant on the outcome of the investigation. If there are grounds for it, those in authority must take the necessary disciplinary (the equivalent of criminal sanctions in civilian life) and/or administrative (the equivalent of employment sanctions in civilian life) measures.[79] Commanding Officers must be trained as to when and how to remove from the unit, people who are the subject of investigation whose continued presence may impede the interests of justice.

12.86 Army instructions point out that administrative action should not be a substitute for disciplinary action where there is credible evidence of wrongdoing that breaches the Army Act.[80]

12.87 However, the reverse is also true. A decision not to prosecute, an acquittal or, indeed, any outcome at a disciplinary hearing is not a substitute for separate consideration by the Commanding Officer of any necessary administrative action available to him. Criminal standards are not exhaustive of the duty of care owed in employment law and practice.

RECOMMENDATION 21

All reasonable steps should be taken to encourage early reporting of complaints against staff by ensuring:

(i) there is a prompt and thorough investigation, independent of the unit whose members are the subject of complaint;

(ii) all suitable interim measures are taken to protect the complainant from retribution, including removal from the unit of the alleged perpetrator of the conduct complained;

[75] See paragraphs 8.30-33.

[76] See paragraphs 8.38, 8.44 and 8.54.

[77] See paragraphs 8.50, 8.55 and 8.68.

[78] See paragraphs 8.28, 8.74 and 8.75 ff. See also paragraph 8.116.

[79] See paragraph 8.96 ff.

[80] See paragraph 8.96 ff for the difference between disciplinary and administrative action and for an explanation as to why use of one does not exclude use of the other. See also paragraphs 7.44, 7.72 and 8.115.

(iii) information is supplied to the complainant on the outcome of the investigation; and

(iv) appropriate disciplinary and/or administrative action is taken.

Investigating complaints

12.88 The Review accepts that the practical welfare of trainees and soldiers cannot be secured by inventing new external agencies to investigate and intervene to the detriment of the social cohesion of the unit. It would be both impractical and undesirable for all complaints about harassment and bullying to be investigated by the civilian police: many of these incidents concern offences purely under military law; many complaints can be sufficiently resolved at the administrative level; and incidents of harassment and bullying may take place overseas and, thus, outside the territorial jurisdiction of the civilian police.

12.89 The Review does not doubt that effective redress of complaints is possible within present arrangements, depending on the experience of the supervisory staff, the welfare staff, the Officer Commanding and the Commanding Officer in these matters, as well as the efficiency of the RMP in gathering all available evidence in the course of the investigation. The statements taken by the RMP in the events described in Chapter 8 show trainees are prepared to make complaints to the RMP if they can trust the independence and integrity of the investigators.

12.90 The Review has seen no evidence that the RMP are unwilling to investigate allegations against NCOs or officers, or are incapable of doing so. However, as the incidents described in Chapters 7 and 8 illustrate, a delay or failure to call in the RMP can compromise effective investigation and frustrate disciplinary proceedings.[81] In the field of sexual harassment and bullying, as seen in Chapter 7, particular expertise may be needed to encourage victims to make full and frank disclosure and to ensure the pursuit of all lines of enquiry to assess the full extent of the perpetrator's conduct.

RECOMMENDATION 22

Complaints of mistreatment, bullying and harassment should be promptly assigned to the RMP to investigate and report on, so that appropriate disciplinary and/or administrative action can be taken.

12.91 The Review has noted that in the case of Leslie Skinner, opportunities to investigate the full scale of offending were missed and the full picture was only captured some years later by Surrey Police. It is likely that the greater experience of the civilian police in investigating sexual crimes against young people contributed to this outcome.[82] The lessons for Commanding Officers have been noted at paragraphs 12.85 and 12.87 above.

RECOMMENDATION 23

RMP training should be kept under review to ensure that investigators are skilled in best practice in interviewing complainants, recording their accounts, pursuing lines of enquiry in investigations and that they are aware of the particular problems that may arise where the alleged perpetrator retaliates, or others turn, against a complainant.

[81] See paragraphs 6.142-144, 6.156, 7.24 ff, 7.67, 8.14 ff and 11.138.

[82] See paragraphs 7.33 and 7.39. See also paragraph 5.95.

12.92 The Review discussed the issue of bringing the RMP within the remit of inspection conducted by Her Majesty's Inspector of Constabulary (HMIC) with the Deputy Provost Marshal in August 2005.[83] It was pointed out that the legislative regime for military and civilian police is not identical, the RMP has its unique issues and challenges and that an informal system of civilian peer review is used in major investigations. However, it seems much of the work of the SIB branch of the RMP applies civilian techniques of investigation and the Review sees no reason why this branch of the RMP, at least, should not be subject to regular independent inspections and public reporting on a similar basis as the civil constabulary. The HMIC would be able to examine the efficiency of the SIB to determine whether it is properly resourced and using available best practice, and whether improvements could be made. Such independent oversight could be beneficial to the reputation and efficacy of the RMP. Such an inspection regime could also ensure that the current Protocol regarding primacy for the investigation of deaths is working effectively and consistently. The Review has become aware that, since its meeting in August 2005, the Provost Marshal (Army) has had recent discussions with the HMIC to reach informal agreement on inspection.[84] The Review welcomes such developments and hopes that they will lead to a more formal arrangement.

RECOMMENDATION 24

The RMP should be brought within the regime of inspection of Her Majesty's Inspectorate of Constabulary (HMIC) so that the consistent application of best practice in the investigation of crimes and complaints can be monitored. HMIC can determine whether the RMP is sufficiently well-resourced and appropriately trained to perform the functions assigned to it.

Record-keeping

12.93 The general issue of keeping and maintaining records of policies has been noted at paragraph 12.78 and Recommendation 19 above. Given the importance of transparency in the field of complaints and the delivery of a duty of care, it is important that there should be Army-wide instructions as to record-keeping relating to self-harm, bullying, harassment and other serious complaints. The records should indicate the action taken and the outcome.[85] Such records should be stored for a minimum period, to at least ensure that they are available in the event of civil action before the expiry of a limitation period of six years (the current limitation period for complaints of deliberate harm).

RECOMMENDATION 25

There should be a minimum standard for the recording of information in respect of complaints. Such records should specifically explain what disciplinary and/or administrative action was taken, with justification, and note the outcome. A decision not to take any action should also be recorded in the same way. Documentation should be retained for at least six years.

An Ombudsman for the Armed Forces?

12.94 The Review is aware that, since 1983, there has been a Defence Force Ombudsman in Australia, whose functions are now performed by the defence section of the Commonwealth Ombudsman. According to its annual report for 2003-4, it has three

[83] See Appendix A4/15.063 E-F.

[84] See the uncorrected transcript of oral evidence to the Armed Forces Bill Select Committee for 1st March 2006, Questions 551 to 557. It is to be noted that, at the time of printing of this Report, a corrected version of the evidence was not available.

[85] See paragraphs 7.38 and 9.50.

investigative staff in Canberra handling the more complex complaints received. It regularly meets with the Resolution Complaints Agency of the Department of Defence and the Inspector General of the Australian Defence Force to consider the nature of the complaints and the most effective means of resolving them.

12.95 Since 1998, Canada has had an Ombudsman, reporting directly to the Minister of National Defence, who investigates complaints and serves as a neutral third party on matters related to the Department of National Defence and the Canadian Forces. The 2004 Annual Report noted that the Ombudsman's office:

> *"... has been working with great success to alter a tradition of closed ranks defensiveness within the military, and to help replace it with a culture of openness, equity and self-improvement ... The entire point in having an Ombudsman is to increase openness and transparency, and to identify and deal with problems that affect the welfare of CF [Canadian Forces] members."*

The report noted that of the 1,265 complaints received, 1,117 were resolved by brokering settlements through diplomacy, consensus building and investigation and moral suasion.

12.96 In its report following a year-long inquiry into the duty of care in initial training in the British Armed Forces, the House of Commons Defence Select Committee (HCDC) recommended that there be a Military Ombudsman with full investigative powers with respect to complaints and authority to make binding adjudications on them.[86] It did not believe that a Military Ombudsman or an external complaints mechanism would constitute an obstacle to the chain of command.

12.97 The Ministry of Defence's (MOD) response to the HCDC report was published in July 2005. It did not accept the case for an Ombudsman, but acknowledged that resolution of complaints was "*slow and may not always be perceived as accessible and fair.*"[87] In the Armed Forces Bill, published in November 2005, the proposal is to make military justice tri-service, enhance the role of the prosecutor and replace the Army Prosecuting Authority (APA) with the new 'Director of Service Prosecutions'. These measures are intended to speed up further consideration of a complaint after it has been considered by a Commanding Officer. The Review understands that it is intended to introduce an independent lay element into the body that considers complaints at the final stage. There will also be an annual report on how the complaints investigation system is performing. Further information as to the workings of the scheme had not been set out at the time that this Report was being printed for more detailed comment to be made. The Review is aware that in December 2005 the HCDC, with a new chairperson, reaffirmed its call for an Ombudsman. It said:

> *"The establishment of the service complaint panel may introduce, in limited circumstances, an independent voice in the consideration of complaints but we do not believe that is sufficient. We urge the Government to table amendments to strengthen the degree of independence in its proposals and to meet the requirements of the previous Defence Committee's recommendations. If it does not, we urge the Armed Forces Bill select committee to express a clear view on the inadequacy of the Bill as introduced and to amend the Bill accordingly."*[88]

[86] House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol I, paragraphs 122-114. See paragraph 1.18 ff above for further details on the HCDC's inquiry.

[87] 'The Government's response to the House of Commons Defence Committee's third report of session 2004-5, on Duty of Care', paragraph 118.

[88] House of Commons Defence Select Committee: Armed Forces Bill – First Report of Session 2005-06, paragraph 11.

12.98 The details of the scheme may remain hidden in the legislative details,[89] however, this Review believes that the present proposals in the Armed Forces Bill do not go far enough to ensure independent supervision and review of the discipline and complaints system. There is a danger that an historic opportunity will be lost for the Armed Forces to obtain independent assistance to achieve the goals they have set themselves to ensure the welfare of trainees and soldiers is effectively addressed. The public concerns that lead to the establishment of this Review underline the need for the Armed Forces to regain, secure and maintain the confidence of individual soldiers, their families and the public in the fair and effective working of the system.[90] According to military personnel quoted in the press, as well as in conversation with this Review, these concerns have had an adverse impact on the recruitment of young people into the Army, although clearly other factors are also in play.[91] The Review is aware that the parents of the recruits of today, and those of tomorrow, have understandable concerns as to how the welfare of their children is and will be protected in practice. Surrey Police's Fifth Report articulates those concerns, irrespective of the accuracy of the individual grievances contained in the Duty of Care Schedules.

12.99 It will be difficult for the Armed Forces to satisfy the public that they have nothing to hide in the running of their discipline and complaints system if there is a perception of unwillingness to accept meaningful independent oversight, which is increasingly seen as a necessary counterweight to the powers and prerogatives of military life.

12.100 For the Review, the establishment of the office of a 'Commissioner of Military Complaints' (or Armed Forces Ombudsman) is now an essential step in improving confidence, transparency and justice. The full role of such a Commissioner may require further reflection but, for the Review, it is essential that soldiers and their families have access to an established authority who understands the military and its ways of working, but stands outside of the chain of command, and beyond its influence, in order to ensure that best practice is adhered to.

12.101 The Review considers that at least four functions need to be assigned to the Commissioner:

(i) The ability to receive unresolved complaints from soldiers, or their families, about specific allegations of conduct prejudicial to their welfare. If these have not previously been the subject of complaint to the relevant authorities, the Commissioner will want to consider why this is and whether there are compelling reasons why such a complaint could not be made.

(ii) The second function is the supervision of the investigation of complaints that have been made to the authorities or to the Commissioner. As noted above, the Review accepts that the relevant military investigation force will normally be investigating these matters, subject to existing protocols with the civilian police. The Commissioner will need to be satisfied that investigations have been thorough, fair and effective and should have the power to recommend further steps be taken where necessary and practicable.

[89] *Ibid*, paragraph 12 where it recommended: "*that MoD publish the secondary legislation relating to the Armed Forces Bill, in draft if necessary, to inform the select committee's scrutiny of the Bill*."

[90] The Armed Forces Bill Select Committee took evidence from Lynn Farr and others connected with the Deepcut and Beyond Campaign on 2nd March 2006, when calls were repeated for an Ombudsman with a primary investigative jurisdiction both here and abroad.

[91] For a recent example see the G2 section of the Guardian, 2nd February 2006.

(iii) The third function is supervising how the authorities respond to the complaint. Where appropriate, the Commissioner should be consulted on decisions as to whether to bring disciplinary action and/or institute formal administrative action, including where it is intended that no such action is to be taken.[92] The Commissioner should be given the opportunity to tender advice at this stage. Where the Commissioner is not satisfied with the outcome, despite the advice tendered, the Commissioner could intervene in the hearing of the complaint at the next level of redress. In an important case, the Commissioner should be able to institute legal proceedings to set aside legally flawed decisions not to prosecute.[93]

(iv) Finally, the Commissioner should report annually, in public, to the Minister of State for the Armed Forces on issues relating to the welfare of all soldiers, based on the evolving practical experience, complaint surveys, a programme of visits and such other means as deemed necessary or desirable to keep abreast of developments.

12.102 The tasks discussed above are designed to promote the effective operation of existing military proceedings rather than to replace them with alternative investigators or decision makers. The object is to provide independent assurance that the procedures are working as effectively as they can and that systemic issues of concern are addressed.

12.103 The Review has informally discussed the possible role of such a Commissioner with Commanding Officers and others and has understood that there is no objection in principle, or practice, to such independent oversight of the system, nor concern that it will undermine military discipline. If the system is already working well, there will be little need for concern in the military hierarchy and the Commissioner's principal role will be reporting to the Minister to provide an independent audit. If the Commissioner's existence stimulates better use of the system, it enhances the objective set out in Recommendation 21 above.

12.104 The Review notes that some of the issues that led to its establishment, including the Surrey Police Duty of Care Schedules, could have been satisfactorily addressed by an independent Commissioner of Military Complaints, in whom parents and others could have had confidence, even when distrustful of the Armed Forces themselves. Such an office must be viewed as an opportunity for balanced and objective handling of unresolved complaints, and not be seen as a threat to the chain of command.

12.105 The establishment now of such an office presents the Armed Forces with an opportunity for the effective ventilation and resolution of some of those concerns whose resolution have fallen outside the scope of this Review but, nevertheless, still trouble former soldiers or their families.[94] It would also go some way towards restoring public confidence in the handling of complaints by the Armed Forces, and avoid past mistakes being repeated. The Review concludes that establishing an Armed Forces Ombudsman is the only effective means by which confidence can now be fully restored and public trust maintained in the future.

RECOMMENDATION 26

There should be established a Commissioner of Military Complaints (the Armed Forces Ombudsman) who should be a person independent of the three Services with at least the functions set out in paragraph 12.101 above.

[92] This should include scrutiny of advice from the Army Prosecuting Authority or its successor (currently intended to be the Director of Service Prosections, see paragraph 12.97 above).

[93] See for example the challenge in the case of *R v DPP ex parte Manning* [2001] QB 330, discussed in paragraph 8.92. It may be impracticable to expect a complainant to take such action themselves if a serving soldier.

[94] That is to say anyone who wants to make a complaint of conduct unconnected with the four deaths at Deepcut.

Guard duty

12.106 The Review has already discussed the Army's policy on armed guard duty for young people in Chapter 11. The opportunity for self-harm afforded by unsupervised armed guard duty was the one clear common factor behind all four deaths at Deepcut with which this Review is concerned.[95] The task of learning lessons and preventing repetition, not just at Deepcut but elsewhere throughout the Armed Forces, requires a broad statement of general policy.

12.107 For the reasons discussed in Chapter 11, in addition to measures designed to identify those who are at risk of self-harm, of whatever age, and the present policy ensuring direct supervision of trainees, there should be a minimum age to conduct unsupervised armed guard duties.[96]

RECOMMENDATION 27

(i) **The performance of armed guard duty by a trainee of any age should be directly supervised by an NCO, experienced adult soldier or MPGS guard.**

(ii) **To ensure that there is no unsupervised access to weapons, trainees under 18 should only perform guard duty (whether armed or unarmed) as part of training and when directly supervised by an NCO, experienced adult soldier or MPGS guard.**

(iii) **The minimum age for trained soldiers in the field army to conduct unsupervised armed guard duty should be 18.**

Sudden deaths

12.108 The case for revision of the Casualty Notification Orders has been addressed by Fiona Murphy in her opinion commissioned by the Review (see Annex C to this Report).

RECOMMENDATION 28

There should be full and prompt disclosure of information to the nominated next of kin of the fact of, and the circumstances then known about, the death of any soldier. Trainees should be encouraged to nominate both parents as their next of kin.

RECOMMENDATION 29

After the death of a soldier, there should be appointed a military liaison officer, as well as a civilian police liaison officer. The military liaison officer should be the single point of contact to explain procedures for the funeral, the return of property of the deceased soldier and, where the RMP have primacy, the progress of the investigations.

[95] See in particular paragraph 11.102.

[96] *Ibid*. See also paragraphs 11.56-67.

12.109 The law relating to access to an inquest or equivalent public inquiry into every sudden death of a soldier, wherever the location of the death or the place of residence of the soldier's family, has been addressed in Chapter 2.[97] The following recommendations are accordingly made.

RECOMMENDATION 30

There should always be an inquest, or, in Scotland, a Fatal Accidents Inquiry, into a sudden death of a soldier, wherever the death has occurred.

12.110 The inquest or Fatal Accidents Inquiry (FAI) is the primary means whereby the state discharges its duties under the Human Rights Act to effectively investigate deaths. The participation of the family of the deceased in such inquiries is of general benefit in the interests of a thorough investigation whose outcome can be accepted by all. Such participation is assisted by the ability of the family to have experienced legal professionals to advise them whether there are reasons for concern, and how they can be properly addressed. It seems unfortunate that a family who is suffering the trauma of having lost a child in military service should also have to spend significant sums of money on legal fees to understand whether and, if so, how they should participate in an inquest. Since death in service is an inherent risk of military service, and an inquest or FAI is an inevitable outcome of such deaths (given Recommendation 30 above), in the opinion of the Review there is a good case for the Military Covenant to be interpreted as requiring the provision of reasonable assistance to families with respect to legal costs arising in such proceedings. Reasonable funds should be provided for the purpose of obtaining legal advice so that a family is not required to deplete its own resources to participate in such an inquest, or FAI, or required to seek discretionary funding from the civil legal aid authorities. As already noted, there is a mutual benefit to the Armed Forces and the family in having a prompt, full and effective inquest, or FAI, into such deaths. The participation of lawyers experienced in this area can promote this objective. Where the circumstances are such that representation is necessary at the inquest or FAI, it is invidious for the Army to be legally represented at such an inquest at public expense whilst the family is not.

RECOMMENDATION 31

As part of the Military Covenant with the soldier, the MOD should ensure that the family of a deceased soldier have access to legal advice and, where appropriate, legal representation prior to, and during, the inquest or FAI.

12.111 There is now extensive case law, reviewed in Chapter 2, on how, in certain cases, a family should be able to participate in official inquiries into a death. As noted, the inquest is the statutory means of inquiry into a death. In a recent Court of Appeal case,[98] the Court was concerned with a case of attempted suicide in a prison where, although serious injury was sustained, there was no death and, consequently, no inquest. It was held that the matters of public concern related to the events required a form of inquiry where relevant evidence could be tested in public, although not all of the inquiry need be held in public, and that it was not always necessary for the families to be able to cross-examine witnesses for themselves. Similar situations might arise in the Armed Forces where service personnel are injured but not killed. The Review understands that the form of inquiry likely to be adopted

[97] See in particular paragraphs 2.11 ff and 2.23. The Review uses 'sudden' to mean the circumstances set out in s.8(1)(a) and (b) of the Coroners Act 1988, i.e. a sudden, violent or unnatural death, see paragraph 2.3 above.

[98] *R (on the application of D) (a patient by his litigation friend the Official Solicitor) v Secretary of State for the Home Department* [2006] EWCA Civ 143. See also paragraph 2.70 above.

would be the Board of Inquiry (BOI) procedure, although at present this sits in private and the attendance of family members, and their ability to raise concerns for examination, is limited. In the opinion of the Review, families should have an opportunity to attend a BOI established to examine the circumstances surrounding the death or injury of their child in order to learn lessons, and be able to examine the evidence, where compelling reasons of national security or the like do not preclude it.[99] In cases where there has been no other form of inquiry held in public, the BOI procedure should be permitted to evolve to encompass a form of family participation consistent with human rights principles.

RECOMMENDATION 32

Where there is a Board of Inquiry (BOI):

(i) The family of a deceased or injured soldier should be permitted to attend and be offered the opportunity to add information that may be relevant and otherwise participate as circumstances require.

(ii) The family should receive all statements and reports into the death that they indicate they would like to see, and should receive a copy of the BOI's final report.

(iii) Such participation and disclosure of information should only be restricted by particularly compelling public interest considerations. The privacy concerns of witnesses to such a procedure would not generally suffice to justify restriction of access and disclosure.

Disclosure and confidentiality

12.112 The question of the need for disclosure of material gathered in the course of Surrey Police's investigations has been considered in Chapter 2,[100] and is dealt with fully in the opinion of Fiona Murphy.[101] That opinion points out that, under contemporary practice for custodial deaths and police complaints investigations, full disclosure can be afforded, including access to the report of the investigating officer, save where a compelling public interest precludes it, weighing up the relevant harm likely to be caused by disclosure with the consequence of non-disclosure.

12.113 In the opinion of this Review, where statements are taken for the purpose of investigation into a death or a complaint, the person providing the information will be aware that the statement may be provided to an interested party in due course and there is unlikely to be any issue of confidentiality arising that would interfere with the normal process of disclosure. Where disclosure is given for the purpose of an inquest, there may be an implied undertaking only to use the statement for the purposes of that inquest, potentially enforceable in proceedings for contempt of court, to ensure that premature publicity is not given to the material. Current practice also appears to be that formal undertakings are no longer generally needed so as to preserve the material from improper use. Material that is used at an inquest, or other public proceedings, will enter the public domain and cease to have any confidentiality attached to it.

[99] The Review notes that the issue of family presence at a BOI was raised in evidence before the Armed Forces Bill Select Committee on 16th February 2006 and 1st March 2006. The Review does not believe that presence of family members will deter frank disclosure by witnesses. Witnesses will be aware that transcripts of their evidence are likely to be disclosed in any event.

[100] See paragraphs 2.38 and 2.52.

[101] See Annex C, Section 16.

12.114 As noted in Chapter 1,[102] the Review understands that the families of Sean Benton, Cheryl James and Geoff Gray have been extensively briefed by Surrey Police as to the results of their investigations since 2002, but have not been provided with copies of the underlying witness statements, or the investigating officer's report to the Coroner. This appears to be the result of a combination of circumstances. In particular, a more restrictive approach was adopted because no inquest was outstanding into those deaths. If an inquest had yet to be held, disclosure would have been required for the purpose of participation in the inquest and, where necessary, limits on onward disclosure or use could be implied or requested. The outstanding inquest into the death of James Collinson may also have led to greater caution in disclosing documents to the families of Sean Benton, Cheryl James and Geoff Gray, for fear of prejudicing the inquest by incidental reporting. The experience of extensive media reporting of the allegations with respect to Deepcut, and a consequential anxiety by witnesses not to have their statements disclosed to some interested parties and the media, led to express limits on disclosure being placed by those who had given witness statements when consulted by Surrey Police.[103]

12.115 In any event, the absence of disclosure has been a source of concern and potential conflict between some of the families and Surrey Police. The Review regards the continued absence of disclosure unfortunate and an unnecessary source of tension. In a normal case, the opinions of witnesses as to whom their statements may be copied to would not be sought, and would not confine the interests of fairness and the ability of the family to participate in the investigation into the death. It is difficult to see that fundamentally different principles are involved where the family need access to the statements in order to participate in the inquest and where they need access to the statements and supporting material in order to decide whether they should apply to the Attorney General for a *fiat* to bring proceedings for a fresh inquest.

12.116 It may be that the fact that there were no proceedings outstanding, to which implied limits on further disclosure attach, made some difference, but the current practice suggests that quite informal understandings can be reached in correspondence as to the purpose of disclosure. In most future cases, the Review would expect informal agreement to be reached in such cases, applying the spirit of the practices and protocols referred to in Fiona Murphy's opinion.

12.117 Where the nature of the material is particularly sensitive, or has been the subject of prior undertakings, and where onward disclosure would have a potentially damaging impact on outstanding proceedings, there may be a case for more formal agreements to be reached. The Review is in no doubt, that an enforceable agreement can be reached in sufficiently clear terms to prevent onward disclosure. Whether such a formal agreement is necessary in an individual case is another matter. It has been suggested that disputes about disclosure in such circumstances could be resolved by the aggrieved party seeking judicial review of refusals to disclose for the purpose of examining whether there is a case to re-open the inquest. In a strong case the police could themselves approach the Attorney General for a *fiat* to quash an inquisition where a fresh inquest is needed. Whatever the position, in the opinion of this Review, the question of disclosure should be resolved by sensible arrangements without the need for adversarial litigation. It is unfortunate that these questions have not been resolved to date in the present cases.

12.118 If the only way of resolving an impasse in a historically controversial case were a formal undertaking pursuant to an agreement, then an example of such an agreement is identified in Annex D. The Review does not commend such an agreement as a routine

[102] See paragraph 1.9.

[103] See paragraphs 1.10, 1.68 and 1.70.

solution. Its terms may well be considered onerous and such a formula should not be used to restrict disclosure to which the families otherwise have a right of access on less restrictive terms. The agreement has been drafted merely to indicate that legal practice can draw up effective and enforceable arrangements to prevent unnecessary use of material that may be confidential in the narrow sense of the terms discussed above.

The need for a public inquiry?

(i) Introduction

12.119 The Review finally addresses the question of whether the issues identified in this Report require a public inquiry into the deaths at Deepcut, taking into account the legal background and suggested criteria for such an inquiry set out in Chapter 2.[104]

12.120 The Review is conscious of the unprecedented public attention and concern that the four deaths at Deepcut have generated since 2002. From time to time there have been reports in the press quoting soldiers or former soldiers recounting lurid suggestions of sexual misconduct, harassment and oppressive behaviour by trainees and NCOs at Deepcut and, indeed, elsewhere in other military establishments. Finding credible, consistent and first hand evidence of such allegations has been another matter. The Review publicly invited anyone with relevant information about the background circumstances into the events at Deepcut to make contact with it, whether in confidence or otherwise. Save as indicated in Chapter 1,[105] there has been no new information adding to what is known from the guardroom daily occurrence logs, the RMP investigations and the investigations conducted by Surrey Police.

12.121 This Review is not a detective investigation. It was not set up to duplicate the considerable resources expended over the past four years by Surrey Police. Its brief was to examine all "*available material*" and it has looked hard to find where such material may be available. In Chapter 1 of this Report, the Review explained its functions and methods of proceeding.[106] The Review is conscious that it is not a public inquiry. It has not heard evidence in public and it has not reached any conclusions of fact on the allegations summarised in Surrey Police's Duty of Care Schedules, and noted in Part 2 of this Report (Chapters 5 to 10).

12.122 Since the death of James Collinson, there have been a significant number of investigations, reports and internal reviews. There have been the four Surrey Police reports into each of the deaths, seen by HM Coroner for Surrey and this Review. There has been the Learning Account established in 2002 between the Adjutant General and Surrey Police, that has resulted in a mass of activity.[107] Much of the product of the Learning Account is summarised in the MOD's evidence to the HCDC and is available for public inspection.[108] There has been the report of the Directorate of Operational Capability noted in Chapter 11.[109] There has been the Deputy Adjutant General's final report into the deaths at Deepcut, a copy of which is reproduced as Appendix 15 to this Report.[110] There has been the Fifth Report by Surrey Police that called for a broader inquiry into aspects of the duty of care for military trainees generally, and which appears to have directly resulted in the

[104] See paragraphs 2.72-79.

[105] See paragraph 1.41. See also paragraphs 4.95-96.

[106] See paragraphs 1.34, 1.41 ff, 1.49 ff and 1.63 and 1.73.

[107] See paragraph 1.13 ff.

[108] See the House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev 254-367.

[109] See paragraph 11.130 ff.

[110] See also paragraph 11.95 ff.

decision of the HCDC to set up its year-long inquiry into the duty of care in the Armed Forces.[111] The families of the four soldiers who died at Deepcut were amongst those who contributed to that inquiry in the form of written and oral evidence. While it was acknowledged that the HCDC's inquiry was prompted by the deaths at Deepcut, it was not intended to be a fact-finding inquiry into those deaths.[112] The very large quantity of evidence gathered and reviewed by the HCDC is, itself, an impressive testimony to the scale of public concern the four deaths have generated. There has also been the report of the Adult Learning Inspectorate, published in March 2005, which provides some significant experienced civilian oversight of the training regime, its achievements and the areas where improvement is needed.[113]

12.123 The Review has benefited from early meetings with each of the four families and communications from their solicitors. It has been able to arrange for two of the families to meet the Commanding Officer of the Training Regiment at Deepcut at the time of their child's death, in order to belatedly address any questions they wanted to pose. The agreed transcripts of these exchanges, and other meetings that the Review arranged, are reproduced by mutual consent in the Appendices to this Report.[114] It is apparent from these meetings, and the written representations made by two of the families to the Review,[115] that concerns about the immediate circumstances of the death of their child, concerns as to whether bullying or harassment played any part in the death, some continued unease about the scale and quality of some of Surrey Police's investigations and outstanding disclosure issues with respect to the product of those investigations predominate.

12.124 The Review is aware of some unresolved issues concerning the methodology or mindset of Surrey Police's investigations. These have been identified and considered in a report, commissioned by Surrey Police, written by Devon and Cornwall Police (the Devon and Cornwall Review).[116] The Review is aware that certain relevant matters are presently under consideration by the Independent Police Complaints Commission (IPCC).[117] The Review has met the lead officer of the Devon and Cornwall Review, as well as responsible members of the IPCC to discuss these matters. The precise conduct of the investigations by the civilian police is not within the constitutional remit of the Minister of State for the Armed Forces, and cannot, therefore, be a matter of recommendation by this Review, although, as noted in Chapter 3, the question of who investigates deaths on military land plainly is and has been addressed. However, the Review has noted that Surrey Police's investigations from 2002 onward have been thorough and exhaustive. It concludes that no new reliable evidence as to how the four trainees met their death is likely to be available.

[111] See paragraphs 1.15 ff and 1.18 ff.

[112] See the House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol I, paragraphs 118 ff and 441 ff. See also paragraph 1.18 ff above.

[113] 'Safer Training – Managing risks to the welfare of recruits in the British armed services'. See paragraphs 1.62 and 11.112 above.

[114] See Appendix 4. For the meeting between Mr and Mr James and Colonel Josling and the Meeting between Mr and Mrs Gray and Colonel Laden see Appendices A4/8 and A4/11, respectively.

[115] The Review asked the MOD to make funding arrangements to enable the legal representatives of the families to make written representations and direct the Review's mind to issues of outstanding concern. Mr and Mrs Gray and Mr and Mrs Collinson made such representations. Mr and Mrs James and Mr and Mrs Benton did not.

[116] See paragraph 1.53.

[117] See paragraph 1.59.

(ii) An inquiry into how each of the four trainees died?

12.125 This Review was established to examine the circumstances surrounding the four deaths at Deepcut, rather than to reach an adjudication on the deaths themselves. It was never intended to operate as a parallel inquest and it has been anxious not to interfere with, or prejudice, the inquest into the death of James Collinson. Nevertheless, in light of the concerns of the general public and the families, the Review has spent much time scrutinising the available material as to how Sean Benton, Cheryl James and Geoff Gray died, and it has reached conclusions as to how those deaths probably occurred in order to be able to look at the broader questions as to what factors may have contributed to them.

12.126 The open verdicts of the inquests into the deaths of Cheryl and Geoff mean that there has been no certainty, to the standards required by the criminal law, as to whether their deaths were self-inflicted. Suicide was the only alternative to an open verdict left to the Coroner, sitting without a jury, in those inquests, given the evidence then available and once accident had been considered and excluded.[118] The Review has anxiously considered whether a public inquiry into any one of these deaths is likely to result in more information relating to them becoming available or greater certainty being reached. Despite the concerns expressed by some as to the nature of Surrey Police's investigations, the Review has felt able to reach the conclusions it has on the basis of the available material it has seen. It has no reason to believe that avenues of investigation are outstanding, or new relevant information relating to the deaths could now come to light. In particular, it considers it highly unlikely that Mr Swann will be able to provide material about the deaths of Sean Benton, Cheryl James and Geoff Gray that contradicts the expert scientific conclusions noted earlier.[119]

12.127 This leaves the families of Sean, Cheryl and Geoff in the unhappy position of not having seen the available material, to which this Review has had access, relating to their child's death that has come to light since the original inquests. The families are, therefore, unable to form their own judgement, by reference to that material, as to whether the Review's conclusions are the appropriate ones. This is one important reason underlying their call for a public inquiry.

12.128 In the opinion of the Review, however, the answer to this dilemma is that the families and their legal advisers should have access, on the principles discussed in paragraphs 12.112-118 above, to the product of the Surrey Police investigations into the respective deaths and the reports summarising their conclusions. The presumption should be for disclosure of the whole product of the investigations. If necessary, disclosure could be subject to such undertakings as to confidentiality and non-disclosure to the press or unconnected third parties as may be necessary to prevent misuse of the evidence. Some editing of names or personal information may be legitimate in accordance with the principles of public interest immunity. The implication of confidentiality arising from the general context in which a statement is made to the police is not, however, sufficient to limit or prevent disclosure to a properly interested party for a proper purpose. The Review notes the opinion of Fiona Murphy and the supporting material to which she refers.[120]

[118] See paragraphs 2.27-30.

[119] See paragraphs 5.53 ff, 6.87 ff and 10.119 ff, respectively. See also paragraph 1.48, and Appendix 3 for the Review's correspondence with Mr Swann.

[120] See Annex C to this Report.

RECOMMENDATION 33

The Review recommends to Surrey Police that the families of Sean Benton, Cheryl James and Geoff Gray be provided with copies of the respective Surrey Police report, and supporting witness statements, into their child's death, solely for the purpose of considering whether an application should be made to the High Court to set aside the previous inquest into their child's death. Such disclosure may need to be subject to an agreement or undertaking by the families, and their legal advisers, as to disclosure to third parties and/or subject to editing of any highly confidential information to which public interest immunity may apply.

12.129 The proper purpose of such disclosure is to see whether any, or all, of the families of Sean Benton, Cheryl James and Geoff Gray would wish to apply to re-open the inquisitions into their child's death pursuant to s.13 of the Coroners Act 1988. For reasons discussed in Chapter 2, the Review is satisfied that any applicant would not need to demonstrate that a different verdict is likely to be returned, whether or not the criteria for family participation set out in the human rights case law apply to the first two deaths.[121]

12.130 For the Review, the similarity in circumstances between these four deaths are such that it would be grossly unfair for different levels of participation by the families in the inquests into the deaths to be justified by the happenstance of the date of each tragic event. Mr and Mrs Collinson have been able to participate, with the assistance of a solicitor and counsel, in an inquest with a jury lasting some 13 days that was infinitely broader in scope and more detailed and transparent in its pre-inquest disclosure process than has hitherto been the case for the previous three deaths. As discussed in Chapter 2, as Geoff Gray died after 2nd October 2000, Mr and Mrs Gray are clearly entitled to participate into an inquest meeting similar standards under the terms of the Human Rights Act.[122] A great deal more information has come to light about the circumstances surrounding the deaths of Sean Benton and Cheryl James than was available to anyone in 1995. The families have been unable to explore this material for themselves and, as similarly discussed in Chapter 2, it may be that an application by them under s.13 of the Coroners Act will result in the setting aside of the original inquest and the granting of a fresh inquest applying current human rights principles.[123]

12.131 It is not for this Review to decide whether there should be a fresh inquest in any, or all, of the three deaths discussed above. The existing inquests can only be set aside by a Court that is satisfied that sufficient reason is shown under the law as it stands. However, if the families want the opportunity provided by a fresh inquest to examine for themselves the product of the Surrey Police investigations, the Review believes it would be appropriate that they have it. It may well be that, on receipt of the material, consultation between the families, the police and others may identify some commonality of approach. In the opinion of this Review, a fresh inquest offers the best opportunity for a focused examination and, to the extent possible, closure of issues that remain of concern for the families.

12.132 Shortly before this Chapter of the Report went to press, the Review had the benefit of the jury's verdict in the inquest into the death of James Collinson. It has been provided with a copy of the Coroner's remarks at the conclusion of the inquest, and is aware of the comments made by the families and others. Of itself, the open verdict does not strengthen the case for a public inquiry. As with the three previous deaths, the only alternative verdicts were accident or suicide. The Review is aware that there was no evidence to suggest that

[121] See paragraphs 2.37 ff and 2.60 ff.

[122] See paragraph 2.41 ff.

[123] See paragraphs 2.34 ff, 2.54 ff and 2.63 ff.

James had been killed by others, and the broader question of harassment or bullying at Deepcut was not an issue because there was no evidence at all to suggest that such conduct caused, or contributed to, James's death. If there had been, the Review is confident, on the principles discussed in Chapter 2, that the jury would have heard about it. The Review is aware that the broader scope of an inquest, required by Article 2 of the European Convention on Human Rights (ECHR) was accepted by the Coroner to be applicable. Whether James may have been bullied and, if so, whether bullying contributed to his death would have been a prime question for consideration at the inquest if there was credible evidence to support such a proposition. There was not. If fresh evidence comes to light, or had wrongly not been brought to the Coroner's attention, then a fresh inquest may be a possibility for his family, as it is for the other three families.

12.133 The Review expresses no conclusions on James Collinson's death in light of the very full and recent public inquest into his death, and the procedural history of this Review noted in Chapter 1. The Review is aware that the Coroner, in accordance with the law as it stands, directed the jury to the high criminal standard of proof of 'satisfied beyond reasonable doubt' necessary before it could return a verdict of suicide.[124] As explained previously, a lack of satisfaction as to this issue does not make any other hypothesis more probable.[125] The Review is also aware that there was no suicide note or other written material to suggest an intention by James to take his own life and that, from what was known about him, he did not fall into a high risk within his age group.[126] However, neither the fact that there was no note,[127] nor the fact that James died six months after Geoff,[128] is a factor pointing away from the hypothesis of self-harm. In the opinion of the Review, there comes a point when further clarity as to the precise circumstances of the deaths is unlikely to be achieved.

(iii) A case for a broader public inquiry?

12.134 The Review now considers the case for a wider public inquiry, prompted by and focused on the events at Princess Royal Barracks, Deepcut but beyond the circumstances of the four individual deaths that could be addressed in a fresh inquest. No one has identified draft terms of reference for a public inquiry that go beyond those deaths but are not as broad as an inquiry into all non-combat deaths in the Armed Forces. The Review has already concluded that there is no evidence of collusion, cover up, breach of legal duty of care or any other failure to foresee or prevent any individual death. There is no evidence that any of the trainees were bullied to death. Following the investigations of Surrey Police, the Review does not accept that the absence of evidence of complaints of bullying from trainees is, itself, suspicious. There is no reason to believe that following the events of alleged abuse described in Chapter 8, any of the instructors at Deepcut were behaving in a similar way.

[124] See also paragraph 6.69 for the Coroner's self-direction at the end of the inquest into the death of Cheryl James.

[125] See paragraphs 2.29 and 6.70.

[126] The Review notes its conclusion at paragraph 9.34 that: "*In the opinion of the Review, being young, under or about 18, and living 24/7 within the disciplined regime of an institution such as the Army is, itself, a significant factor indicative of risk.*" See also paragraph 12.19 above.

[127] The Review refers to Part 2 of Dr Walton's research ('Correlates of Suicide', April 1997, see paragraph 9.7 in Chapter 9 above) that revealed suicide notes were left by 52% of those whose deaths she studied and were considered self-inflicted, but were "*hardly ever left by those aged under 20*".

[128] See the oral evidence of Professor Hawton, to the House of Commons Defence Select Committee: Duty of Care – Third Report of Session 2004-05, Vol II, Ev73, Question 404, where he stated: "*Another important factor of which we have become increasingly aware of is that exposure to suicidal behaviour in other people may be very important; so exposure to suicidal behaviour, such as through a family suicide but also amongst an individual's peers. This can lead to clusters of suicidal acts which it is well recognised can occur in young people. We also know that there is good evidence that exposure to suicidal behaviour in the media may in certain circumstances also be a vulnerability factor. Then, crucially, there is the availability of methods for suicidal behaviour and awareness and knowledge of them and how to use them.*"

12.135 The Deepcut and Beyond Group have continued to demand a broad inquiry into a large number of deaths and allegations of ill-treatment in a wide variety of different circumstances, with no apparent common denominator.[129] No evidence was received by this Review from members of that group as to any particular issues of common danger that needed addressing. The Review is, of course, aware of the general concern of an alleged link between bullying and deaths on Army premises and between bullying and self-harm. The Review is confident that if any evidence of bullying or harassment was available in the case of a military death, the Coroner, or anyone else conducting an inquiry into the death, would bring it to light. It is for this reason that the Review has concluded that there must always be an inquest in such cases (see Recommendation 19 above). In the few non-Deepcut deaths that the Review has noted, there has been no credible evidence that bullying made a contribution to the deaths.[130]

12.136 As for the deaths at Princess Royal Barracks, Deepcut, as already noted, there is no credible evidence that any of the four deaths considered was prompted by bullying or harassment. If there is no evidence that bullying or harassment by anybody caused or contributed to these deaths, the Review cannot recommend a public inquiry just in case some unforeseen evidence might conceivably emerge, despite the previous investigations noted earlier.

12.137 Of course, this is not to say that the Review is satisfied that there has never been bullying, harassment or abuse of power at Princess Royal Barracks, Deepcut from 1995 to 2002. Far from it, as noted at paragraph 12.24 above, the Review has seen credible evidence to this effect, including allegations that NCOs did abuse their authority. However, the Review has received no representations from those who gave statements to Surrey Police that a public inquiry should be held into the bullying or harassment they allege occurred.[131] It appears that many of those who could give direct evidence have been anxious to move on in their lives and are unwilling to return to these events. In the case of unsubstantiated allegations of harassment unconnected with any death, irrespective of when the conduct was alleged to have occurred, there is no legal duty on the state to hold a public inquiry, by contrast with the requirements of Articles 2 and 3 of the ECHR.

12.138 If bullying, harassment or abuse of power has occurred at Deepcut or elsewhere, the Review is satisfied that the Army does not tolerate it. It is not necessary to have a public inquiry to establish that bullying is abhorrent or should not be encouraged or condoned. Where there is reason to believe that someone, whether a Private, an NCO or a commissioned officer, has behaved in an unacceptable way, the Review is satisfied that the Army has the means and the will to investigate and discipline that person, where it can establish, to the requisite degree of probability, that such behaviour has occurred. The Army cannot act, or be expected to act, if there is no basis to believe that someone has acted in an unacceptable way. The issues for the Review have, therefore, been: how is unacceptable behaviour defined; how is such unacceptability communicated to all soldiers; what can be done to ensure that there is a collective responsibility to stamp it out; and how can confidence in the investigatory system be improved. Accordingly, the Review has made the recommendations it has in this Chapter. The Review has also made its recommendations arising out of the evidence it has seen about other matters that may have contributed to low morale and unhappiness in military training.

12.139 The families of the four soldiers who died at Deepcut have suggested that a public inquiry is necessary to restore public confidence in the Army. In making his comments at the end of the inquest into the death of James Collinson, HM Coroner for Surrey has expressed the

[129] See paragraph 1.35 ff.

[130] See paragraphs 3.36 ff, 9.24 ff, 9.26 ff and 10.23 ff.

[131] See paragraph 6.128. See also, for example, paragraph 6.151.

personal view that if such an inquiry were necessary to restore public confidence, then the Army would have nothing to fear from it. His remarks to this effect are worth quoting in full (with original emphasis), to avoid any misrepresentation by selection:

> *"I am sure that many of us have considerable respect for our armed forces and the tasks required of them and they deserve that these matters be addressed thoroughly and independently so that rumour and speculation can be met head on. It follows that we should encourage them to recruit, support and train the very best candidates and provide for their various needs. Those of us who saw the barracks at Deepcut have a better understanding of what it is all about, including the size and diversity of the place as well as the apparent enthusiasm of many of the recruits. James was one such recruit and by all accounts he was a keen and good soldier.*
>
> *"Yet many of the matters or problems of which we have heard obliquely do need further examination or at least balanced public exposure.*[132] *Thus my own personal view – and I emphasise that it is a personal view – is that the MoD should take whatever steps are necessary to restore public confidence in the recruitment and training of young soldiers whether at Deepcut or elsewhere. I personally believe that they should have nothing to fear from an inquiry held in public (if that is what is necessary) where the various issues (outside the direct causation of the deaths of James and others) can be explored in greater depth and where the MoD can demonstrate, as the jury, counsel and I had demonstrated to us in a very limited way on the Friday of the first week of this inquest, that there really is a lot of good in the system – it is not all bad, by any means – and that there are some who are desperately trying to preserve the good and build on it. I will be writing to the SoS for Defence accordingly."*

12.140 It will be for the Minister of State for the Armed Forces, as a matter of political judgement, to decide whether the restoration of public confidence does require such a public inquiry in light of the matters revealed in this Report or any material arising from the inquest into the death of James Collinson. Certainly, this Review has concluded that, as a matter of legal obligation or practical necessity, it is not required.[133] Unless there is reason to believe that some evidence or some issue of public concern has been ignored or not brought to light, it is not a realistic option to recommend a public inquiry to demonstrate that there is nothing to hide. As noted previously,[134] in the opinion of the Review, there has to be some evidence raising an issue that can be expressed with some precision, before the test of public concern in the Inquiries Act 2005 is engaged. The Review has concluded at paragraph 12.22 above that, although the Army did not cause any of the deaths, there were institutional failures before December 2002 that left, unaddressed, potential sources of risk that may have contributed to the deaths.[135] In the inquest into James Collinson's death, the Coroner found evidence of a breach of a number of local standing orders in the events surrounding the death. These relate to a period before the Army made a proper response to all four deaths. In the opinion of the Review, breaches of standing orders during guard duty can best be effectively addressed by direct supervision of those undertaking this task. Better supervision by experienced personnel and the elimination of

[132] The Coroner has informed the Review that the issues to which he referred were, generally, record-keeping, the issuing of weapons to persons under age and breaches of standing orders (see paragraphs 12.18 above, in relation to the Coroner's summing up, and 12.140 below).

[133] For a discussion of the criteria for a public inquiry, see paragraph 2.69 ff.

[134] See paragraphs 2.76-79.

[135] See Section 2 (Conclusions as to the circumstances surrounding the deaths) of this Chapter.

unsupervised guard duty by trainees at Deepcut, as a result of the Deputy Adjutant General's findings in his final report, mean that this Review is satisfied that these matters have been addressed. It is not aware of any other issues arising from these events that have not been addressed. If there were evidence that, since the implementation of new measures in 2003, the lives and welfare of young trainees continued to be put in jeopardy by inadequate training, supervision, supervisory ratios, abuse of power, official indifference to abuse or other factors creating a risk of harm, the Review would recommend a public inquiry.

12.141 It appears to the Review that one constituency that might have an interest in a public inquiry would be the Army itself, or its senior officers connected with these events or the formation of policy in response to them. The Army has not been able to address in detail the allegations in the Duty of Care Schedules for the reasons set out in Chapter 1.[136] It has not been party to a public inquiry about the events described in Chapters 7 and 8 of the Report. If senior officers consider the factual foundation for some of this Review's broader conclusions in this Chapter unstable and, therefore, the case for the recommendations made in it unconvincing, there may still be good reason for the kind of inquiry envisaged in Surrey Police's Fifth Report.

12.142 The Review has, however, devoted much of its time and resources to meeting senior Army officers in command during the period under review and those with responsibility for Army policy today. It has been concerned to ventilate their views and publish their responses to questions in the Appendices to this Report, notwithstanding the informal nature of the meetings and the understanding that nothing would be published without their consent.

12.143 The Review has been careful to avoid adjudication on disputed fact where the nature of the material precludes any such assessment, as is the case with the evidence behind the Duty of Care Schedules. The material quoted in this Report has been carefully selected as illustrating concerns that are not restricted to one individual and are made by those with no evident reason to misrepresent or distort the facts. As previously noted, at the least it suggests that a substantial number of soldiers, even if only a small percentage of those who passed through Phase 2 training in the years covered by these events, were unhappy and did not ventilate their grievance at the time. If the Army accepts that this is, or may well have been, the case, the Review sees little benefit in re-ventilating these issues. If the Army does not, then there may well still be an absence of consensus as to what may have happened, and what needs to be addressed for the future, that will undermine aspirations of closure and moving on.

12.144 With this proviso, and excluding the possibility of fresh inquests, on the basis of all the material available to it, the Review does not recommend that any further public inquiry into the immediate or broader circumstances surrounding these deaths is now called for.

Recommendation 34

In the opinion of this Review, for the reasons set out above, a public inquiry into the immediate or broader circumstances surrounding these deaths is not necessary.

[136] See paragraph 1.22 ff.

Epilogue

12.145 The Review returns to the four young people whose photographs appear at the front of this Report. Their deaths are tragic. The untimely loss of their young lives to their families and loved ones shattering and painful still.

12.146 Although the possibility of sacrifice and death in service must be ever present in the life of a soldier, as recognised in the Military Covenant, each of these deaths seems so unnecessary as to compound the grief of those they left behind.

12.147 This Review adds its profound condolences to each of the families concerned. It acknowledges their long and determined endeavours to obtain answers to questions that still trouble them.

12.148 The Review is, nevertheless, convinced that their loss has not been without consequence. The deaths of these four young people have had profound impact on the Army as an institution and the thinking of its Generals. The training agency that oversaw their progress, the Commanders of the place where they died and the staff of the Regiment they served in have all engaged in deep reflection and have responded with a commitment to improve what can be done to promote the welfare of young soldiers.

12.149 It is not just those who perform heroic deeds on the field of battle who deserve to be remembered:

> *"They also serve who only stand and wait."*

By their deaths, each of these young people have served to help protect others from harm and abuse. Their deaths will not be forgotten. Their lives have not been in vain.